Department of Health and Social Services

Executive Summary

Introduction to the Department

The Department of Health and Social Services (DHSS) was originally established in 1919 as the Alaska Territorial Health Department. With the formal proclamation of statehood on January 3, 1959, the department's responsibilities were expanded to include the protection and promotion of public health and welfare. These core duties are reflected in the mission of the department – to promote and protect the health and well-being of Alaskans – and are outlined in Article 7, Sections 4 and 5 of the Constitution of the State of Alaska.

Mission

To promote and protect the health and well-being of all for a strong Alaska.

Core Services

- Provide elderly pioneers and veterans quality assisted living in a safe home environment.
- Provide an integrated behavioral health system.
- Promote safer children, stronger families.
- Manage health care coverage for Alaskans in need.
- Address juvenile crime by promoting accountability, public safety and skill development.
- Provide self-sufficiency and basic living expenses to Alaskans in need.
- Protect and promote the health of Alaskans.
- Promote independence of Alaska Seniors and people with physical and developmental disabilities.
- Provide quality administrative services in support of the department's mission.

Core Values

The Department of Health and Social Services has five adopted core values as guiding principles in the delivery of services:

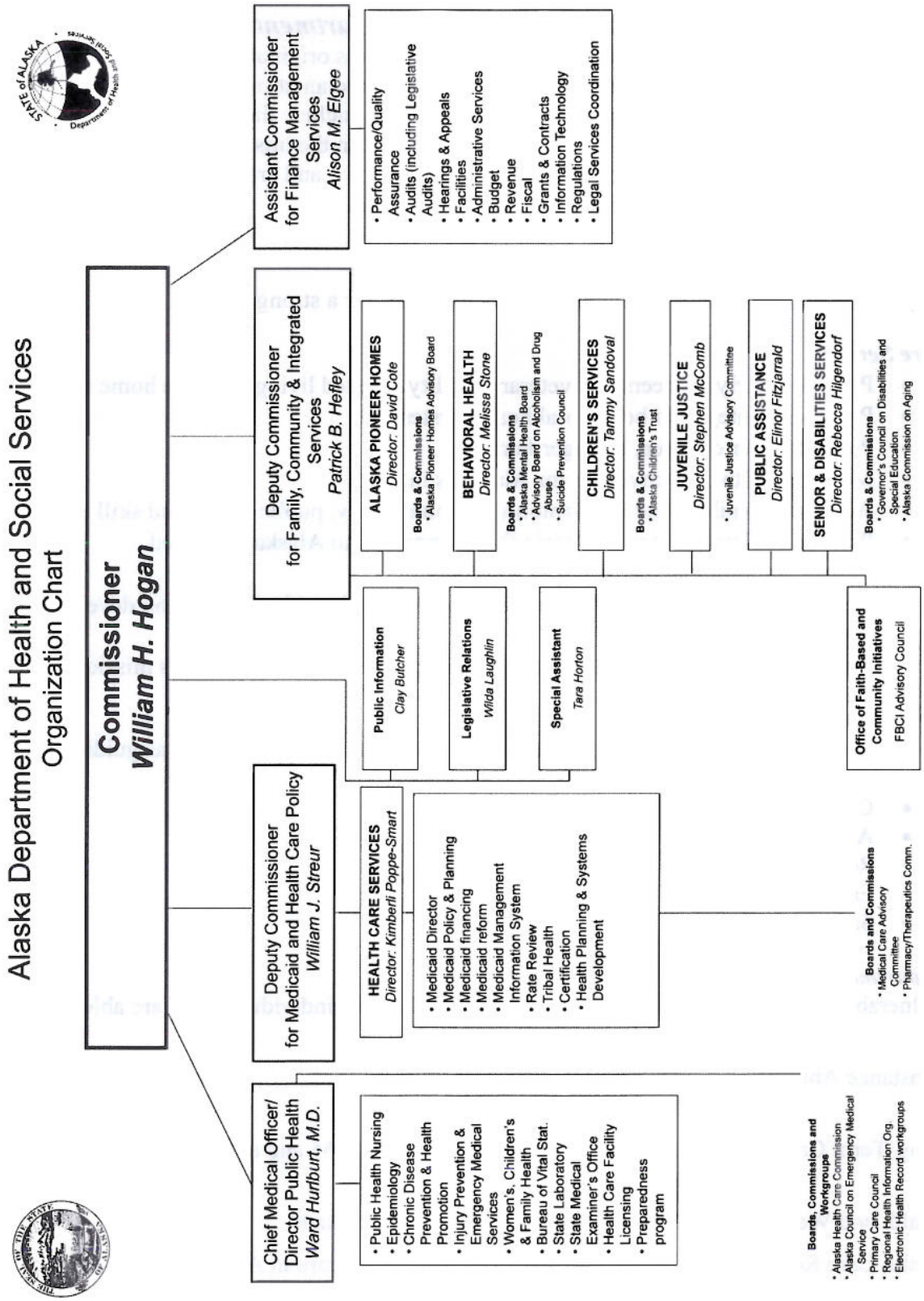
- Collaboration
- Accountability
- Respect
- Empowerment
- Safety

Department Priorities

Vulnerable Populations:	Increase the percentage of at risk individuals who are able to live safely in their homes in Alaska.
Substance Abuse:	Decrease the negative impacts of alcohol and substance abuse in Alaska.
Long-Term Care:	Increase the percentage of adults 65 and older living independently in Alaska.
Health and Wellness:	Improve the health status of Alaskans.
Health Care Reform:	Improve access to quality health care in Alaska.

Executive Management Organization

There have been minimal organization changes during FY10 and/or proposed for FY11.



Major Accomplishments in 2009

VULNERABLE POPULATIONS

- The Office of Children's Services (OCS) continued work toward a statewide Family-to-Family (F2F) program. F2F has been very successful in Anchorage in working toward change in the child welfare system through support and resources provided to families, building community partnership, and team decision making that includes not just foster parents and caseworkers but families and community members. The Anne E. Casey Foundation reports that in Alaska, 70% of the children who receive team decision making services are able to stay in their own homes or in a relative's home rather than a foster home. Over the course of the next few years, OCS plans to expand F2F services statewide with expansion to Fairbanks already started.
- A significant accomplishment in Juvenile Justice (DJJ) in 2009 was the development and implementation of a new version of JOMIS, the juvenile offender management information system.
- Rapid development and implementation of the new Alaska Heating Assistance Program (AKHAP) that serves households with incomes between 150% and 225% of the federal poverty guidelines for Alaska.
- The Bring the Kids Home initiative continues to be successful in reducing the number of distinct out-of-state residential psychiatric treatment center (RPTC) recipients served and increasing the number of distinct RPTC recipients who received services in state. Preliminary data indicates that from FY08 to FY09, there was a decrease of about 33.5% in the number of distinct out-of-state RPTC recipients served and an increase of about 2.4% in the number of distinct RPTC recipients who received services in state. Access to in-state non-residential services at lower levels of care has increased significantly.
- During FY09, the Division of Senior and Disabilities Services provided home and community-based services to 7,923 individuals and their families. By providing these services in the community setting, the division was able to delay the entry of these individuals into institutions, thereby reducing costs to the state.
- Worked with AMHTA to plan and implement strategies for the five focus areas (Bring the Kids Home, Housing, Justice, Trust Beneficiary Projects, and Workforce Development).

SUBSTANCE ABUSE

- In 2008, Behavior Health introduced the use of performance based funding. Performance measures hold providers in the state behavioral health system accountable. Further, it is an objective process to determine funding levels for grantees that will reflect an assessment of program and agency performance, utilization, client and community outcomes. Performance was a consideration in grant awards for FY10.

LONG-TERM CARE

- Served 577 Alaska Seniors and Veterans in the Pioneers Homes.
- In FY09 Senior and Disabilities Services (SDS) provided services to approximately 7,600 Medicaid beneficiaries at an average annual cost per person that approached $41,800. Almost 55% of the benefit payments were for disabled adults, about 41% for the elderly, and 4% were disabled children.
- Also, SDS served more than 17,193 seniors (age 60+) through Senior and Disabilities Services programs including direct service grants (17,472), general relief (577), Personal Care Attendant Services (3,552) and Medicaid programs (4,371).

HEALTH AND WELLNESS

- In FY09, the Adult Preventative Dentistry Program was reactivated and 7,336 individual recipients over the age of 21 received services.

HEALTH CARE REFORM

- Work continues with tribal health organizations to improve tribal opportunities to maximize Medicaid revenue, reimbursed at 100% by the federal government.

Key Department Challenges

The Department of Health and Social Services continues to make progress on the following overall strategies:

- Work toward more integration of services;
- Maximize resources for effective service delivery;
- Promote rural infrastructure development and standardization of regional structure;
- Promote accountability at all levels of the organization; and
- Use technology in strategic ways to accomplish the department's goals.

Some of the challenges facing priority programs are listed below. Some challenges facing the department affect more than one priority program.

VULNERABLE POPULATIONS

- Development of in-state residential and community-based treatment options for children and youth with an emphasis on minimizing the number and duration of out-of-state placements through the Bring the Kids Home project. Challenges include revision of the system of care while continuing to provide services.
- Improvements to child abuse prevention and protection efforts, particularly with Alaska Native partner agencies.
- Continued challenge in providing needed level of staffing to meet rapidly changing number of Alaskans needing assistance or asking about assistance programs, due to the economic environment.
- Continued fine-tuning of statutory and regulatory requirements relating to employment of persons with criminal histories.
- Identification and resolution of issues relating to the recruitment and retention of qualified employees to allow the department to fulfill its ongoing mission in a time of national and state workforce shortages.

SUBSTANCE ABUSE

- Working toward the appropriate capacity levels, especially for secure detoxification.
- Continued fine-tuning of statutory and regulatory requirements relating to employment of persons with criminal histories.
- Identification and resolution of issues relating to the recruitment and retention of qualified employees to allow the department to fulfill its ongoing mission in a time of national and state workforce shortages.

LONG-TERM CARE

- Hiring and training staff to complete initial and annual Medicaid Waiver and Personal Care Attendants (PCA) assessments and service plans in order to avoid another backlog, remain in compliance with federal requirements, and complete goals identified in the Corrective Action Plan.
- Continued fine-tuning of statutory and regulatory requirements relating to employment of persons with criminal histories.
- Identification and resolution of issues relating to the recruitment and retention of qualified employees to allow the department to fulfill its ongoing mission in a time of national and state workforce shortages.

HEALTH AND WELLNESS

- Preparation and planning with federal, state, and community partners for a potential influenza pandemic.
- Promotion of services that focus on enhancing health and well-being and preventing illness through development of a comprehensive state policy that includes reduction of alcohol and substance abuse.

HEALTH CARE REFORM

Our efforts in this area will depend largely on the results of health care legislation at the national level. However, the department will face the following challenges regardless of those results:

- Development and implementation of a department-wide Quality Management Program incorporating the elements of Program Integrity (fraud detection and audit, with particular emphasis on the Payment Error Rate Measurement project), Quality Assurance (internal controls), and Quality Enhancement (corrective action).
- Identification and implementation of potential solutions to the lack of access to affordable quality health care for Alaskans.
- Identification and implementation of appropriate increases to reimbursement rates for health and social service providers based on results and verifiable costs of service provision.

Medicaid challenges include:

- Development of the Medicaid Management Information System to more effectively use new technology to manage health care in Alaska.
- Development of new comprehensive Medicaid regulations which clarify coverage and payment rules for the program and provide for greater accountability for both the department and health care providers.
- Accurately projecting Medicaid expenses in an environment of rapidly increasing costs and economic uncertainty.

Position Information

The department has over 3,600 positions budgeted under the following three types of work:

Direct Field Workers	
113	Public Health Nurses
290	Social Workers & Children's Service Specialists
313	Eligibility Determination Staff
289	Youth Detention/Treatment Workers
90	Juvenile Probation Officers
256	API Staff
652	Pioneer Homes Staff
2,003	**TOTAL**

Program Support Services	
115	Behavioral Health Programs
150	Senior and Disability Programs
413	Public Health Programs
210	Children's Services
123	Juvenile Programs
10	Facilities Management
372	Benefit Payments/Systems
1,393	**TOTAL**

Administrative/Management Support	
130	Information Technology
141	All Other Centralized Admin/Mgmt
271	**TOTAL**
3,667	**FY11 GRAND TOTAL**

The DHSS FY11 Governor's Request includes 3,667 positions. The details of their budgeted status and geographical location are as follows in the chart below. Select types of employees (i.e. public health nurses, social workers) may be budgeted in one location but provide continual itinerant services to numerous surrounding smaller rural communities.

FY11 Position Summary by Location

Location	Total Full Time	Total Part Time	Total Non Perm	Total Position Counts
Anchorage	1,730	26	43	**1,799**
Aniak	2	0	0	**2**
Barrow	9	0	0	**9**
Bethel	95	0	3	**98**
Cordova	2	0	0	**2**
Craig	6	0	0	**6**
Delta Junction	6	1	0	**7**
Dillingham	10	1	0	**11**
Eagle River	1	0	0	**1**
Fairbanks	360	6	9	**375**
Fort Yukon	0	1	0	**1**
Galena	2	1	0	**3**
Glennallen	3	0	0	**3**
Haines	2	0	0	**2**
Homer	15	1	0	**16**
Juneau	577	25	27	**629**
Kenai	86	1	2	**89**
Ketchikan	116	12	10	**138**
King Salmon	2	0	0	**2**
Kodiak	14	2	0	**16**
Kotzebue	10	0	0	**10**
Mat-Su Area-wide	2	0	0	**2**
McGrath	3	0	0	**3**
Nome	39	0	2	**41**
Palmer	121	15	6	**142**
Petersburg	4	0	0	**4**
Saint Mary's	6	0	0	**6**
Seward	3	0	0	**3**
Sitka	101	0	3	**104**
Tok	2	0	0	**2**
Unalaska	1	0	0	**1**
Valdez	4	1	0	**5**
Wasilla	133	0	0	**133**
Wrangell	2	0	0	**2**
Totals	**3,469**	**93**	**105**	**3,667**

Explanation of FY11 Operating Budget Requests

The Department of Health and Social Services faced tremendous challenges in the last few years to provide a balance between reducing the reliance on state general funds and providing services to vulnerable populations.

Proposed Budget for FY11 Compared to FY10

	FY10 Management Plan	FY11 Governor's Request
General Fund	**$ 832.5 million**	**$ 882.8 million**
Federal Funds	**1,081.5 million**	**1,109.8 million**
Other Funds	**160.8 million**	**154.8 million**
Total	**$ 2,074.8 million**	**$ 2,147.3 million**
Increased Federal Revenue		**28.3 million**
Increased General Fund		**50.3 million**

The proposed budget for FY11 increases general funds by $50,250.9. Significant changes in GF are due to: Medicaid program growth of approximately $36,400.0, increased resources addressing the department's priorities of Vulnerable Alaskans $7,100.0, Substance Abuse $2,800.0, Long-Term Care $800.0, Health & Wellness $1,900.0, and Health Care Reform $500.0.

To assist in understanding the DHSS budget, we have highlighted budget items addressing the five department initiatives. A complete list of budget items for each division is found in its section of the overview.

Vulnerable Alaskans

The state needs to ensure that both children and communities are safe, that developmentally disabled children and adults have access to quality services and supports, and that individuals and families get the kind of financial and vocational supports they need to be contributing members of society. By focusing on family-centered services and through the use of performance-based standards and funding, Alaska can better meet the needs of the most vulnerable citizens and their families.

The following table compares FY10 Management Plan program capacity for Vulnerable Alaskans to that requested for FY11:

	FY10 Management Plan	FY11 Governor's Request	FY11 Governor less FY10 Management Plan
General Fund	$ 403,710.5	$ 416,980.6	$ 13,270.1
Federal Funds	313,875.8	312,573.6	(1,302.2)
Other Funds	73,779.3	74,942.3	1,163.0
Total	**$ 791,365.6**	**$ 804,496.5**	**$ 13,130.9**

Budget requests include:

- Phase 1 of State Medical Examiner's Office reforms - $300.0 GF
- Restoring funding to meet Senior Benefits enrollment and payment projections - $850.0 GF
- Increasing Adult Public Assistance funding due to anticipated enrollment growth - $150.0 GF
- Psychiatric Residency Training at API - $300.0 GF
- Designated Evaluation and Treatment program expansion - $300.0 MHTAAR
- Bring the Kids Home expansion including individualized services, foster parent and parent recruitment training and support, transitional aged youth, expansion of school-based services capacity via grants, and community behavioral health centers outpatient and emergency residential services and training- $1,250.0 GF/MH
- Decreasing unrealizable federal funds (Children's Services Management, Delinquency Prevention) – ($1,250.0) federal
- Replacing unrealizable federal funds with general funds (Front Line Social Workers, Medicaid School Based Admin Claims) - $1,600.0 GF, (1,600.0) federal
- Replacing unrealizable interagency receipts for Medicaid School Based Claims (Children's Services Management, Front Line Social Workers) - $1,120.3 GF, ($1,120.3) Interagency Receipts

Substance Abuse

Substance abuse affects every family and community in Alaska. It is a contributing factor in suicides, crime, unemployment, domestic violence, child abuse, school dropouts, juvenile delinquency, etc. The state needs to prevent, intervene early, and treat and help people recover from substance abuse through public/private partnerships and long-term strategies.

The following table compares FY10 Management Plan program capacity for Substance Abuse to that requested for FY11:

	FY10 Management Plan	FY11 Governor's Request	FY11 Governor less FY10 Management Plan
General Fund	$ 19,909.3	$ 22,732.6	$ 2,823.3
Federal Funds	9,955.3	9,731.8	(223.5)
Other Funds	20,298.1	19,903.2	(394.9)
Total	**$ 50,162.7**	**$ 52,367.6**	**$ 2,204.9**

Budget requests include:

- Specialized Treatment Unit at Clitheroe - $1,200.0 GF
- Detox and treatment capacity as alternatives to protective custody holds - $518.3
- Increased access to Fetal Alcohol Spectrum Disorders (FASD) treatment services in rural Alaska - $228.6 GF/MH
- Increased substance abuse treatment services for pregnant women - $500.0 GF/MH

- Disability justice focus group recommendations including pre-development for sleep off alternatives in targeted communities, Alcohol Safety Action Program (ASAP) therapeutic case management and monitoring treatment, and maintaining treatment capacity for therapeutic court participants with co-occurring disorders - $75.0 GF/MH, 238.0 MHTAAR

Long-Term Care

Seniors represent the fastest growing population in Alaska and it is Alaska's responsibility to determine what kinds of services are wanted for aging parents (and grandparents) to keep them at home in their own communities. The state needs to develop a comprehensive long-term care plan, improve services to those with Alzheimer's disease and related disorders, and promote the expansion of aging and disability resource centers.

The following table compares FY10 Management Plan program capacity for Long-Term Care to that requested for FY11:

	FY10 Management Plan	FY11 Governor's Request	FY11 Governor less FY10 Management Plan
General Fund	$ 170,785.2	$ 184,768.3	$ 13,983.1
Federal Funds	230,990.7	244,587.2	13,596.5
Other Funds	31,526.7	31,439.0	(87.7)
Total	**$ 433,302.6**	**$ 460,794.5**	**$ 27,491.9**

Budget requests include:

- Increased funds for home and community based waiver compliance (split between Long-Term Care and Vulnerable Alaskans) - $500.0 GF Match, $500.0 federal
- Increased capacity for Health Facilities Survey (split between Long-Term Care and Health and Wellness) - $75.0 GF Match, $112.5 federal
- Funds to maintain, improve and design new financial and payment rate systems (split between Long-Term Care and Health and Wellness) - $187.5 GF Match, $187.5 federal
- Funds for traumatic brain injury service coordination (split between Long-Term Care and Vulnerable Alaskans) - $200.0 GF/MH, $150.0 MHTAAR

Health and Wellness

Many Alaskans lead less happy and less productive lives, and many die prematurely each year, because of disability and death caused by tobacco, alcohol abuse, injuries, obesity, diabetes, cancer, heart disease, and sexually transmitted diseases. The economic impact of chronic disease alone in Alaska is staggering: an estimated $600 million is spent annually on direct medical services and $1.9 billion in lost productivity. Most of this is attributable to personal choice involving diet, physical activity and tobacco use - and is preventable. The state and service providers can do a better job of screening, diagnosing and treating these conditions.

The following table compares FY10 Management Plan program capacity for Health and Wellness to that requested for FY11:

	FY10 Management Plan	FY11 Governor's Request	FY11 Governor less FY10 Management Plan
General Fund	$ 234,115.2	$ 253,794.9	$ 19,679.7
Federal Funds	522,589.4	540,313.0	17,723.6
Other Funds	34,523.1	27,823.5	(6,699.6)
Total	**$ 791,227.7**	**$ 821,931.4**	**$ 30,703.7**

Budget requests include:

- Maintaining local control of essential public health services by stabilizing funding to public health nursing grantees - $1,000.0 GF
- Increased receipts for the electronic health record system and the Medicaid management information system projects - $1,257.7 CIP Receipts
- Funds to stabilize the Health Facilities Survey budget (split between Long-Term Care and Health and Wellness) - $260.0 GF

Health Care Reform

Alaska's health care system continues to be fragmented and uncoordinated and doesn't produce expected outcomes. By strategically focusing on care management, reforming Medicaid, creating a Health Care Commission and growing the health care workforce, Alaska's health care system can be transformed.

The following table compares FY10 Management Plan program capacity for Health Care Reform to that requested for FY11:

	FY10 Management Plan	FY11 Governor's Request	FY11 Governor less FY10 Management Plan
General Fund	$ 3,392.8	$ 3,887.5	$ 494.7
Federal Funds	4,071.5	2,588.8	(1,482.7)
Other Funds	657.4	652.2	(5.2)
Total	**$ 8,121.7**	**$ 7,128.5**	**$ (993.2)**

Budget related requests include:

- Continuation funding for the comprehensive integrated mental health plan and the loan repayment program - $317.0 MHTAAR
- Decreased federal receipt authority from expired federal grants - ($1,000.0) federal
- Replacing unrealizable federal receipts for core services - $475.1 GF, ($475.1) federal

Expenditure Category Comparisons

For purposes of historical comparisons we have broken out expenditures into five categories of funding:

Formula Programs
This category includes all programs with specific eligibility standards which guarantee a specific level of benefits for any qualified recipient.

Grants
This category includes the components with major grants to other organizations or major contracts for service delivery, such as Residential Child Care, Energy Assistance Program, Community Health Grants, and various treatment programs.

Program Services
This category includes both administration and delivery of direct services, such as public health nursing and social services, and the program management of entitlements and grants.

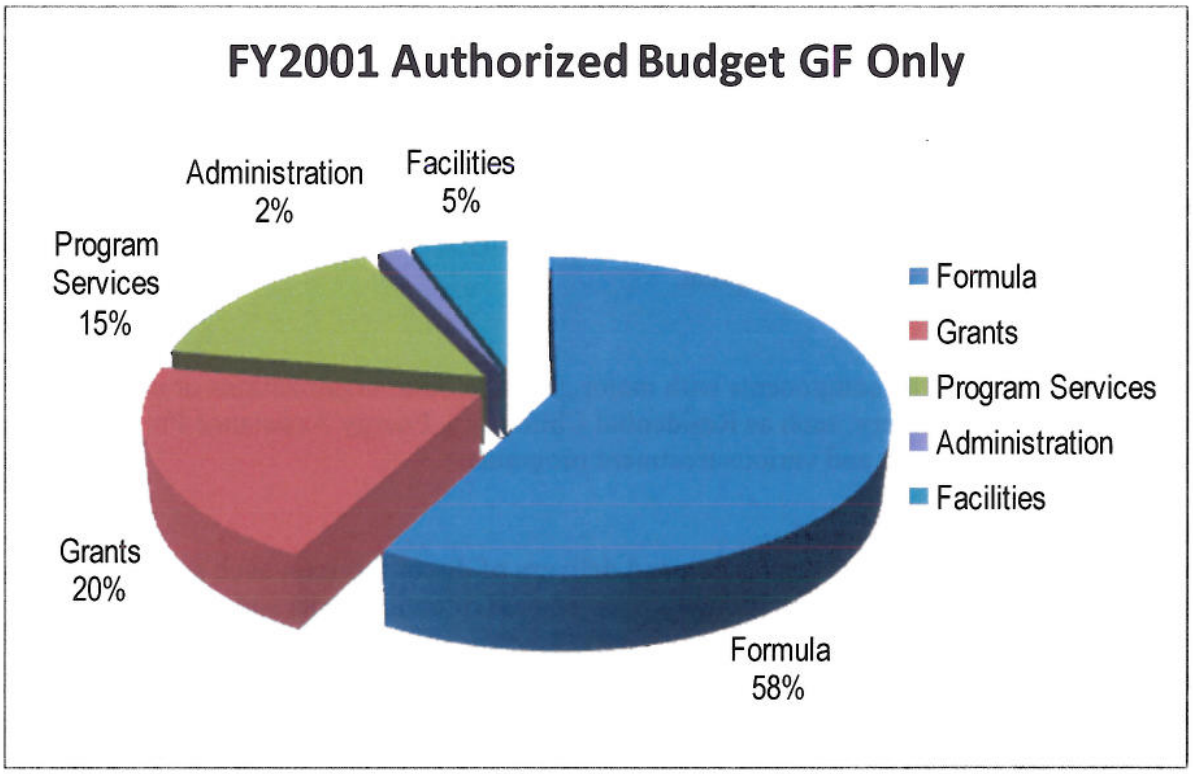
Administration
This category includes departmental administrative oversight and support programs, including the Commissioner's Office, and Administrative Services.

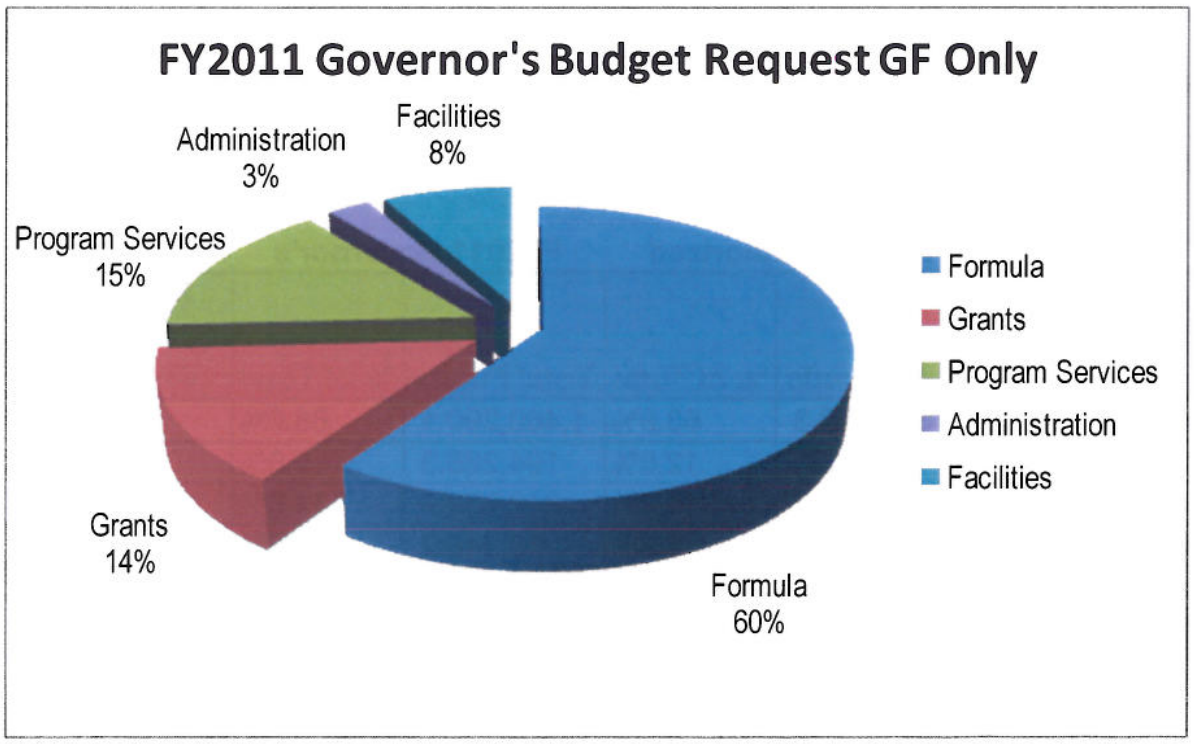
Facilities
The department manages and operates 24-hour facilities and institutions. These include youth correctional facilities, the Alaska Psychiatric Institute, and Pioneer Homes.

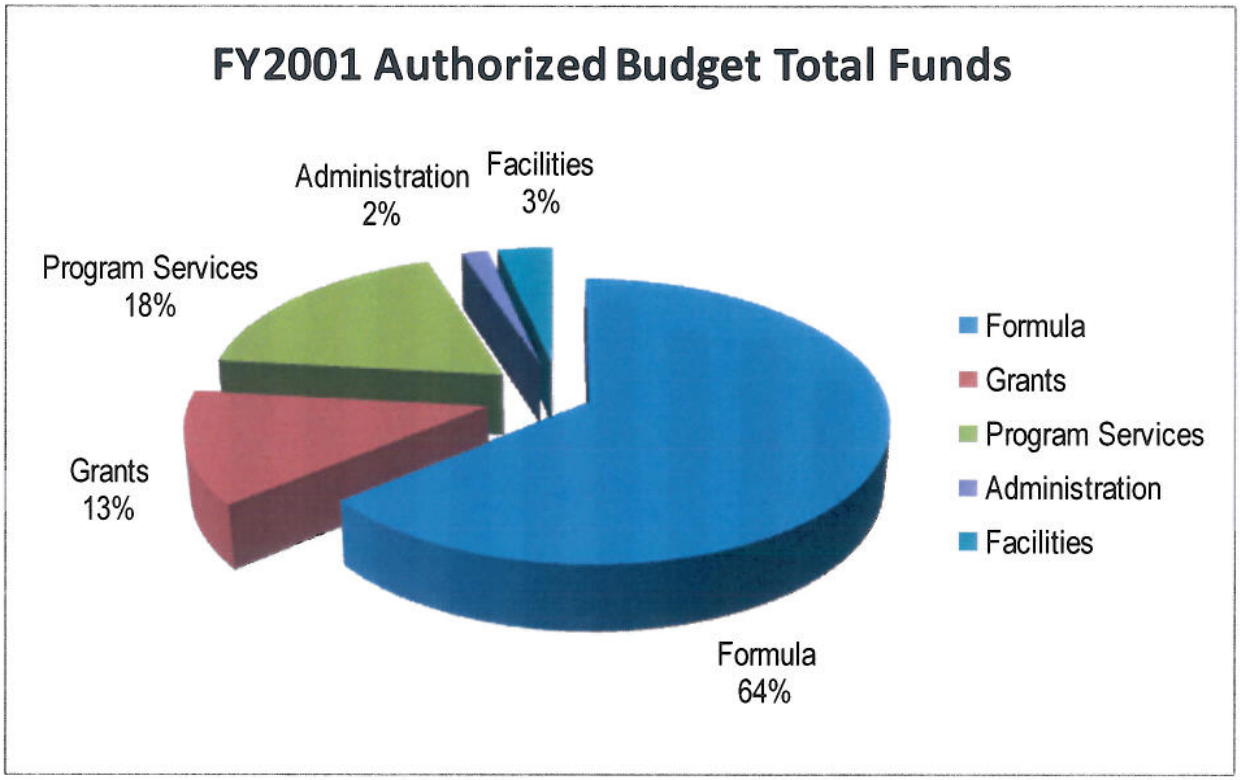
Budget Charts and Graphs

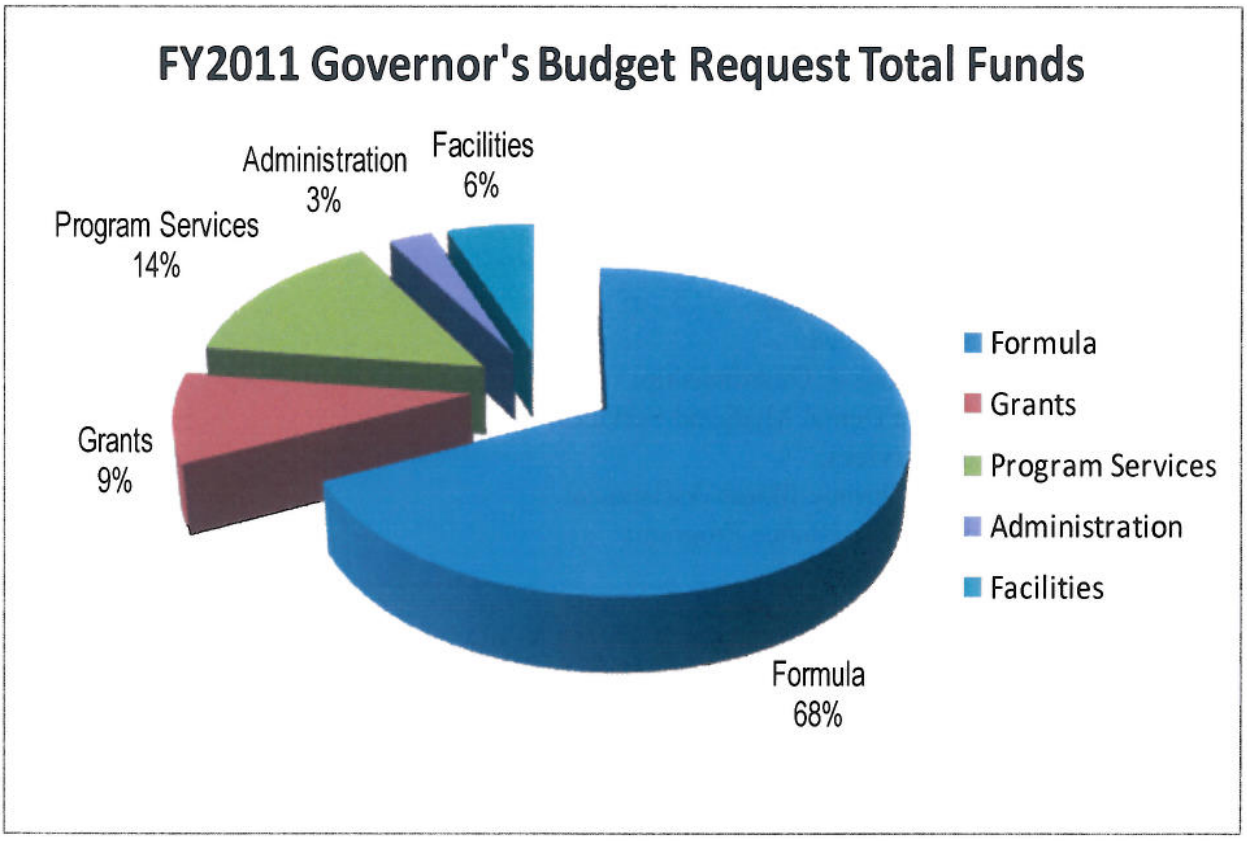
The table below shows the comparison of total funds for FY01 and FY11.

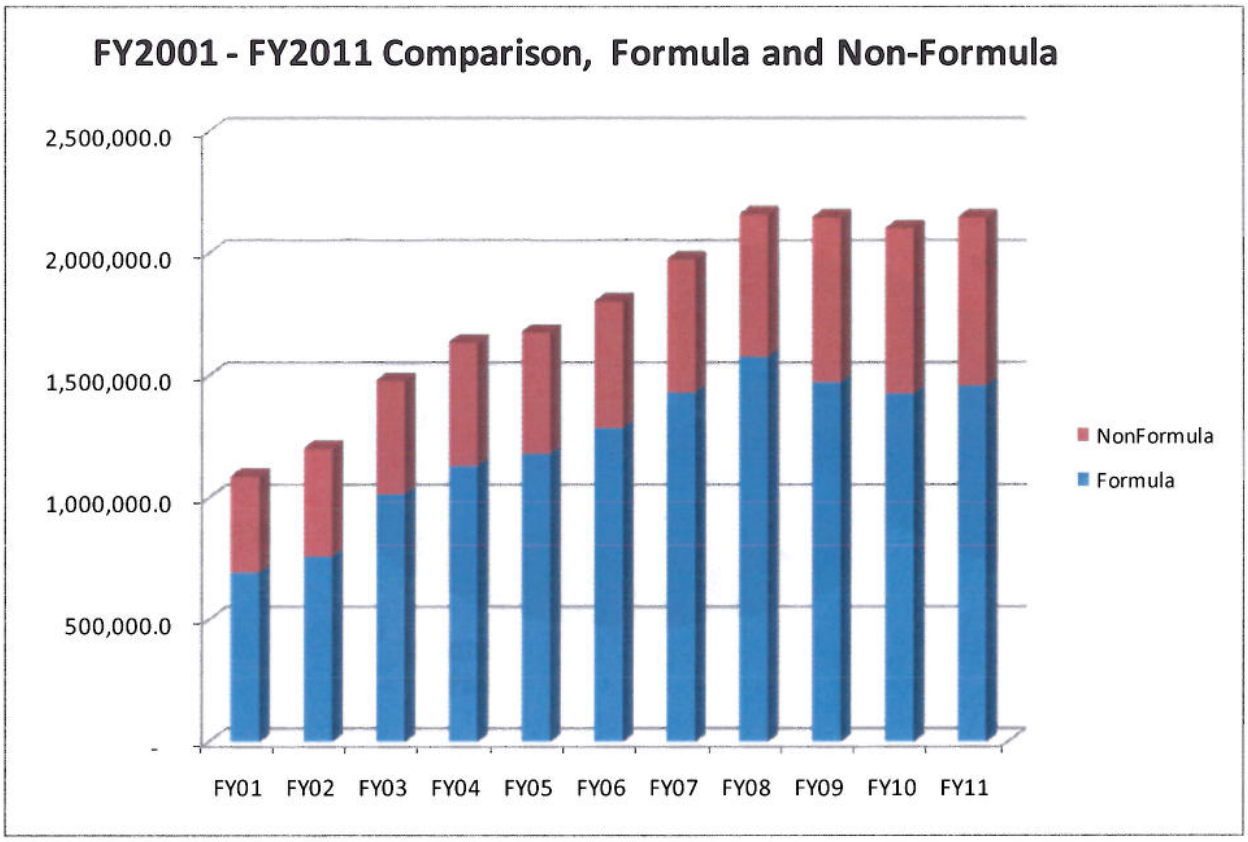
	FY2001 Authorized		FY2011 Governor's		
Category	Total Funds	% of Total	Total Funds	% of Total	2001 to 2010 Change
Formula	696,052.3	63.9%	1,460,290.1	68.0%	109.8%
Grants	139,102.6	12.8%	194,288.3	9.0%	39.7%
Program Services	197,972.2	18.2%	312,732.7	14.6%	58.0%
Administration	17,875.6	1.6%	59,948.2	2.8%	235.4%
Facilities	37,491.4	3.4%	120,059.2	5.6%	220.2%
Total	1,088,494.1		2,147,318.5		97.3%


FY2001 Authorized Budget GF Only
Administration 2%
Facilities 5%
Program Services 15%
Grants 20%
Formula 58%
Formula
Grants
Program Services
Administration
Facilities


FY2011 Governor's Budget Request GF Only
Administration 3%
Facilities 8%
Program Services 15%
Grants 14%
Formula 60%
Formula
Grants
Program Services
Administration
Facilities


FY2001 Authorized Budget Total Funds
Administration 2%
Facilities 3%
Program Services 18%
Grants 13%
Formula 64%
Formula
Grants
Program Services
Administration
Facilities


FY2011 Governor's Budget Request Total Funds
Administration 3%
Facilities 6%
Program Services 14%
Grants 9%
Formula 68%
Formula
Grants
Program Services
Administration
Facilities



Medicaid is the largest formula program in the department, totaling about 84% of the total formula program category in the proposed FY11 budget.

Formula programs in the Department of Health and Social Services are:

- Behavioral Health Medicaid Services;
- Children's Medicaid Services;
- Foster Care Base Rate;
- Foster Care Augmented Rate;
- Foster Care Special Need;
- Subsidized Adoptions & Guardianship;
- Adult Preventative Dental Medicaid Services;
- HCS Medicaid Services;
- Catastrophic and Chronic Illness Assistance;
- Alaska Temporary Assistance Program;
- Adult Public Assistance;
- Child Care Benefits;
- General Relief Assistance;
- Tribal Assistance Program;
- Senior Benefits Payment Program;
- Permanent Fund Dividend Hold Harmless; and
- Senior and Disabilities Medicaid Services.

Medicaid

Introduction

This section provides a department-wide review of the Medicaid program. Additional detailed descriptions of programs and budget changes, as well as more in-depth statistical analyses, are found in later chapters of the Budget Overview covering the four divisions that oversee direct service delivery: Behavioral Health, Children's Services, Health Care Services (including Adult Preventative Dental Medicaid), and Senior and Disabilities Services.

Program Overview

Medicaid is an entitlement program created in 1965 by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. People qualify for Medicaid by meeting federal income and asset standards and by fitting into specified eligibility categories. It covers aged, blind, or disabled persons and single parent families. In addition, Medicaid expanded coverage in 1998 through the Children's Health Insurance Program (CHIP) to children and pregnant women whose income is too high to qualify for regular Medicaid, but too low to afford private health insurance. CHIP enrollment is administered through the Denali KidCare office.

Four main divisions manage benefits: Health Care Services, Behavioral Health Services, Senior and Disabilities Services, and Office of Children's Services. Medicaid administrative activities support the service delivery of every division within the Department of Health and Social Services, as well as six other departments within the state government (Departments of Administration, Corrections, Education and Early Development, Law, Labor and Workforce Development, and the Court System).

Medicaid Benefit Programs by Results Delivery Unit

Behavioral Health	Mental health, substance abuse, residential psychiatric treatment centers, and inpatient psychiatric facilities
Children's Services	Behavioral rehabilitation
Health Care Services	Hospitals, physician services, pharmacy, transportation, dental, vision, physical/occupational/speech therapy, chiropractic, medical equipment, home health, hospice, laboratory, X-ray, state-only Medicaid, premium assistance, third-party recoveries, supplemental hospital payments, Medicaid administrative management, and routine restorative dental services including exams, cleanings, tooth restoration or extraction, and upper or lower full dentures
Senior and Disabilities Services	Nursing homes, personal care, and four home and community based waiver programs

Funding Overview

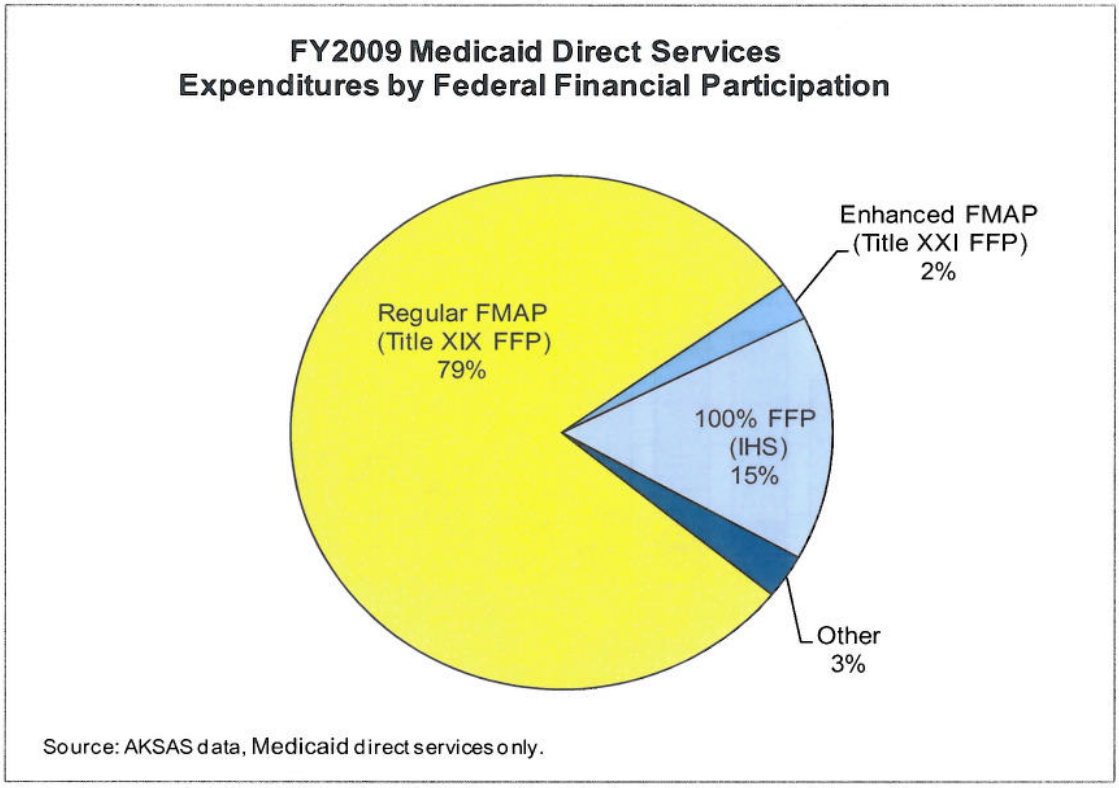
As a joint federal-state program, the federal and state governments share the cost of Medicaid. Federal financial participation rates are set at the federal level, and are largely outside of state control. The State's portion of Medicaid Service costs differs according to the recipient's Medicaid eligibility 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 the Federal Medical Assistance Percentage, or FMAP.

The FMAP is based on a three-year average of per capita personal income, ranked among states. While each state has its own FMAP, it can be no lower than 50%. Although the majority of benefits are reimbursed at the regular FMAP rate, certain subgroups have higher reimbursement rates (e.g., qualified Indian Health Services claims are reimbursed 100%). Where possible, the state contains costs by taking advantage of higher reimbursement rates.

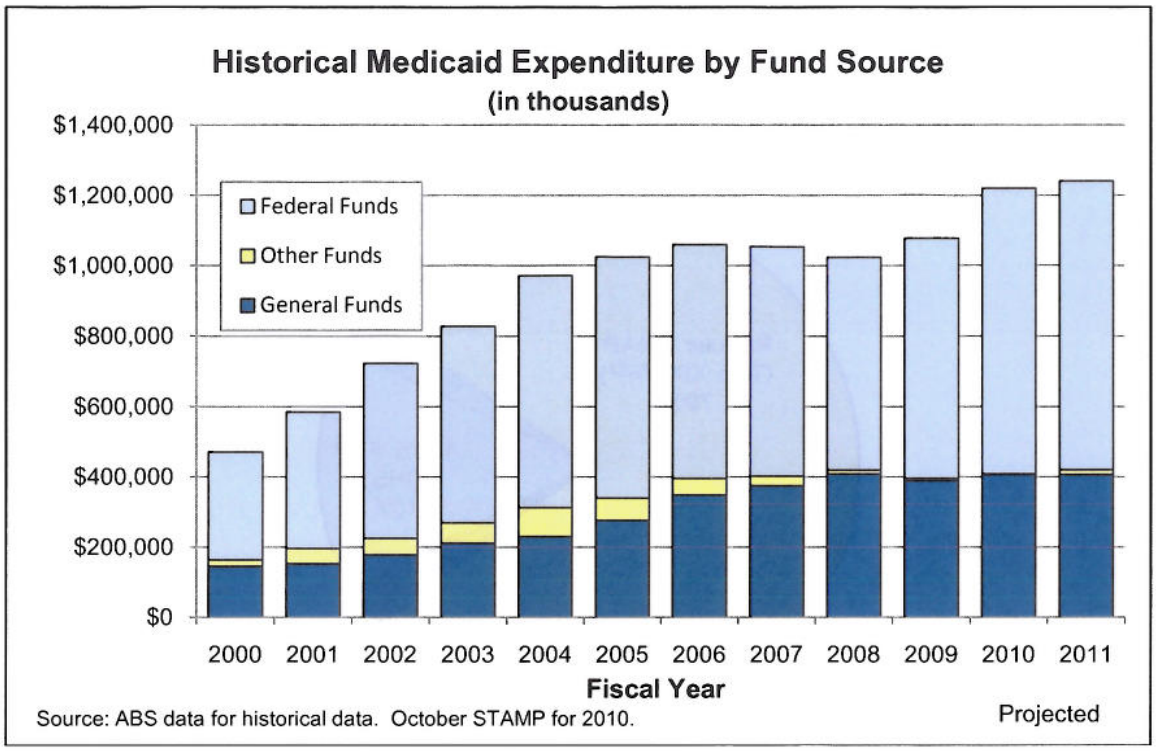
Federal Medical Assistance Percentages for Claim Payments

	Federal Fiscal Year Statutory Rate		State Fiscal Year Average Rate	
Year	Regular FMAP	Enhanced FMAP	Regular FMAP	Enhanced FMAP
Before 1998	50.00	n/a	50.00	n/a
1998	59.80	71.86	57.35	71.86
1999	59.80	71.86	59.80	71.86
2000	59.80	71.86	59.80	71.86
2001	60.13	72.09	60.05	72.03
2002	57.38	70.17	58.07	70.65
2003 Q1-Q2	58.27	70.79	58.79	71.15
2003 Q3-Q4	61.22	72.85		
2004 Q1-Q3	61.34	72.94	61.31	72.92
2004 Q4	58.39	70.87		
2005	57.58	70.31	57.78	70.45
2006	57.58	70.31	57.58	70.31
2007	57.58	70.31	57.58	70.31
2008	52.48	66.74	53.76	67.63
2009 Q1-Q2	58.68	65.37	57.74	65.71
2009 Q3-Q4	61.12	65.37		
2010 Q1-Q4	61.12	66.00	61.12	65.84
2011 Q1	61.12	65.00	55.56	65.25
2011 Q2-Q4	50.00	65.00		

Source: Medicaid Budget Group and Centers for Medicare and Medicaid Services.
The FMAP prior to 1998 w as 50%. The enhanced FMAP started in 1998.



The department has successfully minimized the need for additional state general funds while still meeting its mission. Although costs have grown yearly federal dollars have covered the majority of the increases. The department accomplished this by taking full advantage of enhanced match rates and federal refinancing programs. Due to additional FMAP support provided through ARRA funding, state matching funds required in 2009 for the entire Medicaid program dropped to 36%, from 40% in FY08. State funding is projected to be about 33% of the total program costs in both 2010 and 2011.



One of the refinancing measures the Department has implemented is to increase the proportion of Medicaid services eligible for Indian Health Service 100% federal reimbursement. For every dollar shifted to the tribal system from regular FMAP in FFY09, the State saved 40 cents in state matching funds. The department continues to work with tribal health corporations to maximize the benefits of this refinancing program.

Cost containment is an important method of holding down increases in Medicaid expenditures. Strategies to control costs have been successful as demonstrated by the slowing rate of growth in Alaska's Medicaid costs. Growth has been controlled through 2009—mitigating increases in population and payment rates. This trend is not expected to continue in 2010 and 2011 due to enrollment and utilization increases driven by the current general economic climate, as well as provider service rate increases.

Medicaid Expenditures by Fund Source
(in thousands)

Fiscal Year	General Funds	Federal Funds	Other Funds	Total Funds
1991	$80,094	$91,990	$1,796	$173,880
1992	$93,582	$105,740	$934	$200,256
1993	$103,447	$119,602	$708	$223,757
1994	$123,553	$142,729	$1,401	$267,684
1995	$127,125	$149,589	$1,792	$278,506
1996	$138,013	$167,280	$3,105	$308,398
1997	$141,517	$183,355	$6,568	$331,440
1998	$125,542	$231,330	$5,476	$362,347
1999	$131,523	$261,316	$2,851	$395,690
2000	$145,515	$307,508	$17,686	$470,709
2001	$152,791	$387,432	$43,671	$583,894
2002	$177,701	$497,428	$46,926	$722,054
2003	$211,077	$558,581	$58,460	$828,117
2004	$230,119	$658,741	$82,631	$971,491
2005	$276,089	$685,474	$63,355	$1,024,918
2006	$348,648	$664,722	$46,507	$1,059,877
2007	$374,492	$651,908	$26,976	$1,053,376
2008	$408,250	$604,348	$11,189	$1,023,788
2009	$389,089	$682,271	$6,123	$1,077,483
2010 *	$405,964	$811,587	$9,462	$1,227,012
2011 **	$408,700	$820,417	$12,939	$1,242,056

Source: Medicaid Budget Group using Alaska Budget System data and STAMP forecast. FY09 and earlier are actual expenditures.
*Projection as of October 2009. **Governor's Budget.

Annual Statistical Summary of Medicaid Services Provided in FY09

The statistics summarized in this section are for the entire Medicaid program. There are additional detailed Medicaid statistics in the division sections for Health Care Services, Behavioral Health Services, and Senior and Disabilities Services.

In FY09, one in five Alaskans was enrolled in the state's Medicaid program. After slowing for several years, the annual change in enrollment (enrollment growth) increased by 2% in FY09. The number of persons receiving Medicaid benefits (beneficiaries) also increased in FY09, by over five percent.

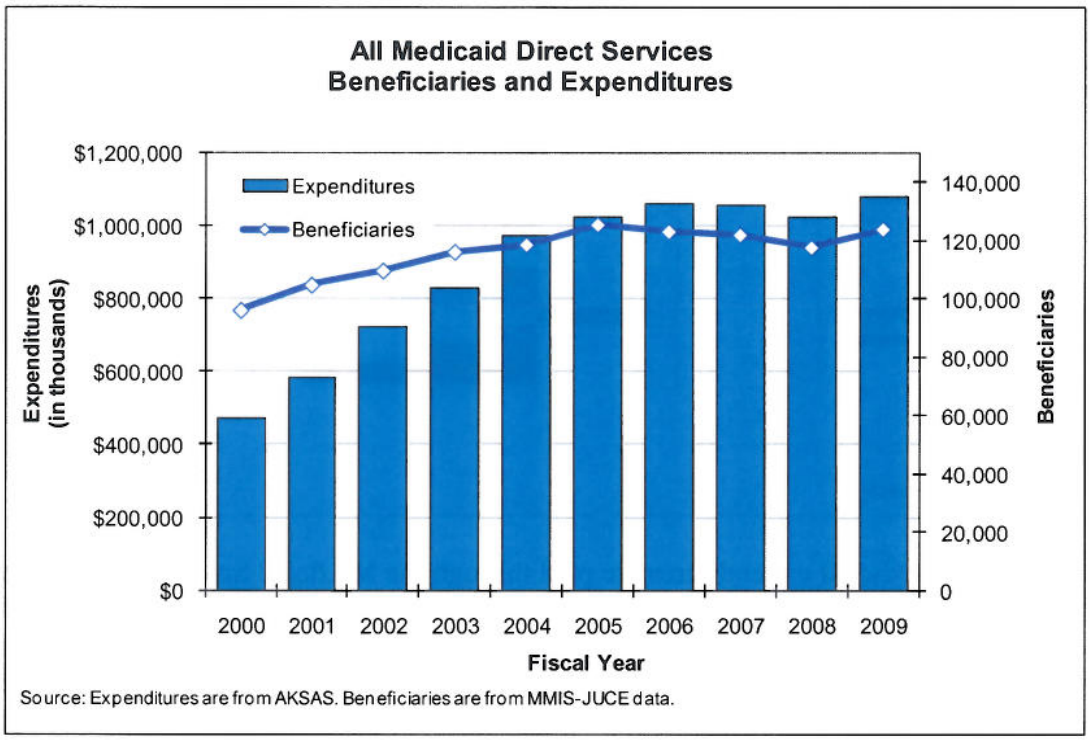
The majority, but not all, of enrollees receive benefits in a fiscal year. The ratio of enrollees to beneficiaries is called the participation rate. The participation rate has increased steadily from 87% in FY00 to 97% in FY09. The participation rate for FY09 is up by 3% from the 94% participation rate in FY08.

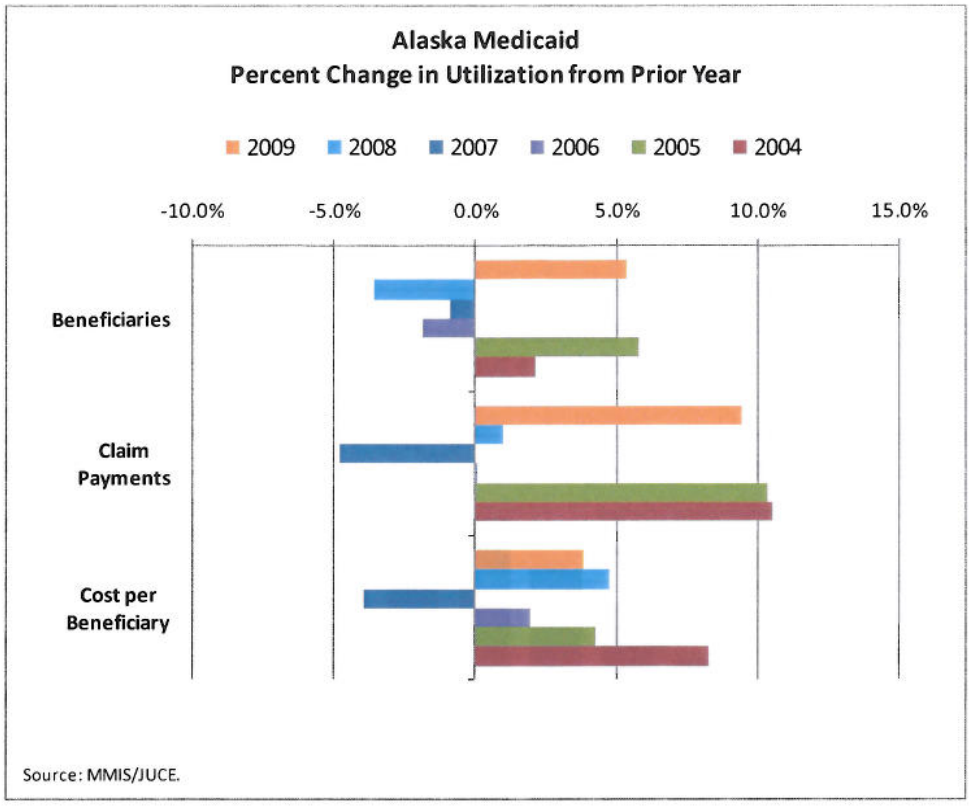
Participation in Medicaid

Fiscal Year	Alaska Population	Medicaid Enrollment	Medicaid Beneficiaries	Percent of Population Enrolled in Medicaid	Percent of Enrollees Receiving Benefits
2000	627,533	110,219	96,033	18%	87%
2001	632,091	116,226	104,730	18%	90%
2002	640,522	121,582	109,571	19%	90%
2003	647,773	126,632	116,008	20%	92%
2004	657,314	129,528	118,466	20%	91%
2005	664,060	131,136	125,318	20%	96%
2006	670,958	131,996	122,978	20%	93%
2007	676,987	128,295	121,864	19%	95%
2008	679,720	125,138	117,472	18%	94%
2009 *	691,354	127,944	123,791	19%	97%

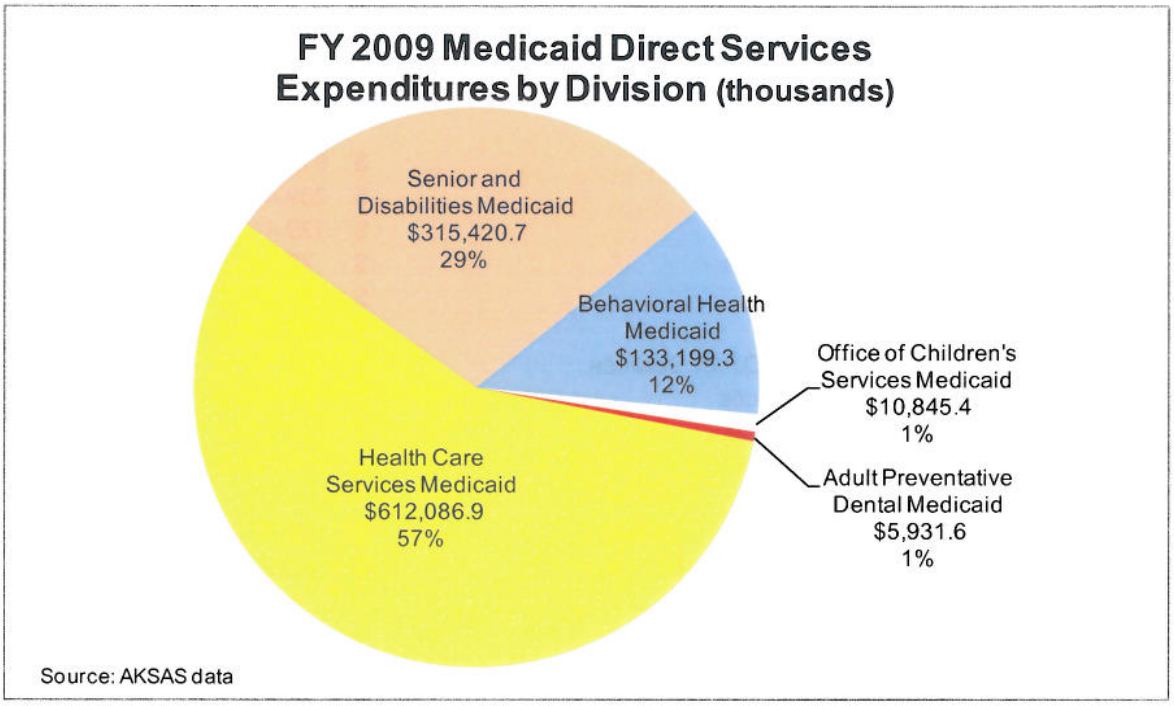
Source: Medicaid Budget Group (MMIS/JUCE) and AK Dept. of Labor and Workforce Development.
*Population is projected.
Enrollment and beneficiaries are unduplicated counts of individuals in each fiscal year.

The total cost of Medicaid direct and indirect services grew by 5% between FY08 and FY09. Costs for direct services (claims paid in FY09) increased by about 9% and the cost of direct services per beneficiary increased by almost 4%. The increase in expenditures from FY08 to FY09 was largely the result of increased enrollment due to the general economic climate and rate increases for some Medicaid services.





The majority of Medicaid expenditures are paid through the Medicaid Services component in the Division of Health Care Services, which funded 57% of the total costs for Medicaid direct services in FY09. The Senior and Disabilities Medicaid Services component provided long-term and home-based care services that accounted for 29% of total Medicaid direct services costs. The remaining 14% of expenditures were paid through the Behavioral Health Medicaid Services budget component (12%), Children's Medicaid Services budget component (1%) and Adult Preventive Dental Medicaid budget component (1%) in the Division of Behavioral Health, Office of Children's Services, and Division of Health Care Services, respectively.


FY 2009 Medicaid Direct Services Expenditures by Division (thousands)
Senior and Disabilities Medicaid $315,420.7 29%
Behavioral Health Medicaid $133,199.3 12%
Office of Children's Services Medicaid $10,845.4 1%
Adult Preventative Dental Medicaid $5,931.6 1%
Health Care Services Medicaid $612,086.9 57%
Source: AKSAS data

Medicaid Direct Services Expenditures by Division, FY09
(in thousands)

Total Medicaid Direct Services	$1,077,483.2
Health Care Services Medicaid	$ 612,086.9
Hospital Services	$ 239,407.3
Physician Services	$ 129,412.7
Pharmacy Services	$ 72,136.2
Dental Services	$ 33,673.7
Transportation	$ 50,445.7
Other Medicaid Direct Services	$ 45,561.9
Non-MMIS Services	$ 40,335.9
Medicaid Financing	$ 557.7
Medicaid (State-only)	$ 555.8
Adult Preventative Dental Medicaid	$ 5,931.6
Adult Preventative Dental	$ 5,931.6
Senior & Disabilities Medicaid	$ 315,420.7
Personal Care Services	$ 76,847.2
Nursing Homes	$ 80,515.6
Adults with Disabilities Waiver	$ 24,756.7
Children with Complex Medical Conditions	$ 9,909.1
Mental Retardation / Developmental Disabilities	$ 84,862.8
Older Alaskans Waiver	$ 38,280.3
Other Services	$ 249.1
Behavioral Health Medicaid	$ 133,199.3
Residential Psychiatric Treatment Centers	$ 44,263.4
Inpatient Psychiatric Hospitals	$ 16,897.2
General Mental Health Services	$ 72,038.8
Office of Children's Services Medicaid	$ 10,845.4
Behavioral Rehabilitation Services	$ 8,088.8
Behavioral Rehabilitation Services - BTKH	$ 2,756.6

Source: Medicaid Budget Group using AKSAS and ABS data.

Many beneficiaries receive services which are budgeted in more than one component since individuals, once enrolled, can receive any services for which they are eligible. For example, a beneficiary receiving mental health counseling paid from Behavioral Health Medicaid Services' budget can also get a flu shot paid from Health Care Services' Medicaid budget.

99% of all persons with paid claims for Medicaid services during FY09 received some benefits funded through Health Care Services Medicaid,
10% received benefits through Behavioral Health Medicaid Services,
6% received benefits provided by Senior and Disabilities Medicaid Services,
1% received benefits provided by Office of Children's Services Medicaid, and
1% received benefits provided by Adult Preventative Dental Medicaid.

FY 2009 DEPARTMENT LEVEL SUMMARY	MEDICAID CLAIMS AND ENROLLMENT							
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR	ENROLLMENT		COST per ENROLLEE per YEAR
	Percent of Category	Annual Count	Percent of Category	Annual Total		Percent of Category	Annual Count	
Medicaid, Department Annual Totals		**123,791**		**$1,032,427,408**	**$8,340**		**127,944**	**$8,069**
Gender								
Female	56.8%	70,312	56.8%	$586,064,938	$8,335	54.9%	70,218	$8,346
Male	43.2%	53,520	43.2%	$446,362,470	$8,340	45.1%	57,777	$7,726
Unknown	0.0%	1	0.0%	$0	$0	0.0%		
Race								
Alaska Native	37.5%	46,770	37.3%	$385,325,840	$8,239	36.9%	47,671	$8,083
American Indian	1.6%	1,953	1.5%	$15,003,114	$7,682	1.6%	2,025	$7,409
Asian	6.0%	7,521	5.3%	$54,308,904	$7,221	6.9%	8,868	$6,124
Pacific Islander	3.1%	3,893	2.2%	$22,489,057	$5,777	3.2%	4,158	$5,409
Black	5.7%	7,065	4.4%	$45,637,560	$6,460	5.6%	7,178	$6,358
Hispanic	3.7%	4,600	2.3%	$23,911,655	$5,198	3.6%	4,709	$5,078
White	39.6%	49,447	44.1%	$455,384,278	$9,210	39.3%	50,812	$8,962
Unknown	2.8%	3,471	2.9%	$30,366,999	$8,749	2.9%	3,716	$8,172
Native	39.0%	48,800	38.8%	$400,432,447	$8,206	38.7%	49,667	$8,062
Non-Native	61.0%	76,460	61.3%	$633,390,430	$8,284	61.3%	78,661	$8,052
Age								
under 1	9.9%	13,535	8.8%	$90,946,051	$6,719	8.4%	11,526	$7,891
1 through 12	35.8%	48,871	15.1%	$155,930,592	$3,191	38.7%	53,021	$2,941
13 through 18	16.2%	22,166	15.3%	$157,753,758	$7,117	17.1%	23,428	$6,734
19 through 20	3.4%	4,587	2.5%	$25,670,113	$5,596	2.9%	4,033	$6,365
21 through 30	10.7%	14,617	11.6%	$119,362,590	$8,166	9.7%	13,288	$8,983
31 through 54	13.7%	18,763	21.4%	$221,011,251	$11,779	13.2%	18,109	$12,204
55 through 64	3.8%	5,233	8.7%	$89,436,641	$17,091	3.6%	5,000	$17,887
65 through 84	5.4%	7,364	12.1%	$125,223,393	$17,005	5.4%	7,444	$16,822
85 or older	1.0%	1,359	4.6%	$47,093,019	$34,653	0.9%	1,294	$36,393
Benefit Group								
Children	61.4%	77,627	34.7%	$357,946,514	$4,611	63.8%	82,516	$4,338
Adults	18.8%	23,812	12.3%	$127,202,503	$5,342	17.0%	21,959	$5,793
Disabled Children	1.9%	2,399	5.5%	$57,146,913	$23,821	1.7%	2,215	$25,800
Disabled Adults	12.0%	15,214	32.6%	$336,494,020	$22,117	11.8%	15,255	$22,058
Elderly	5.9%	7,416	14.9%	$153,637,458	$20,717	5.8%	7,467	$20,576

Payment amounts are net of all claims paid during the fiscal year. Because amounts do not reflect payments for Medicaid services made outside of the Medicaid Management Information System (MMIS) such as lump sum payments, recoveries, or accounting adjustments, dollar amounts may not tie exactly to amounts in the state accounting system.

Enrollment: Number of persons eligibile for Medicaid and enrolled for at least 1 month during state fiscal year 2009. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age,and benefit group categories). Some duplications may occur between subgroup counts. For example, an infant with a September birthdate would count in the under 1 age subgroup based on enrollment activity between July and September but would also be counted in the 1 through 12 age subgroup based on enrollment activity between October and June.

Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2009 (service may have been incurred in a prior year). Grouping is based on status on the date when benefit (service) was provided. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group categories). Some duplications may occur between subgroup counts. For example, if a 12 year old child with a September birthdate obtained vision services in August, they would be included in the 1 through 12 age group fiscal year count if that claim was processed for payment anytime before June 30, 2009. If they obtained dental services again in December 2008, they would also be included in the 13 through 18 age subgroup count if the claim was paid anytime before June 30, 2009.

Participation: The cost per recipient (the cost per peson actually accessing care) and the cost per enrollee differ due to the percentage of persons eligible and enrolled during the year that also accessed benefits (participation). Participation is typically over 90%. Because claims data is summarized here based on the claims processing cycle rather than on the claim date of service, the recipient count includes some persons that were enrolled and

Explanation of FY11 Medicaid Operating Budget Requests

For FY11, the department request for Medicaid services includes a $34.7 million increase in General Funds, a $32.8 million increase in Federal funds, and a $3.9 million decrease in Other Funds. Enhanced federal participation authorized through the ARRA legislation is projected to continue at current levels through FY11.

		FY10 Mgmt Plan	FY11 Proposed	10 to 11 Change
Total All Medicaid Services	General Funds	$371,805.2	$406,500.0	$34,694.8
	Federal Funds	$787,605.5	$820,417.1	$32,811.6
	Other Funds	$17,041.4	$13,138.9	-$3,902.5
	Total	**$1,176,452.1**	**$1,240,056.0**	**$63,603.9**
Behavioral Health Medicaid Services	General Funds	$49,540.9	$54,974.1	$5,433.2
	Federal Funds	$90,771.4	$95,373.5	$4,602.1
	Other Funds	$2,217.5	$2,217.5	$0.0
	Total	$142,529.8	$152,565.1	$10,035.3
Children's Medicaid Services	General Funds	$7,139.0	$5,396.5	-$1,742.5
	Federal Funds	$8,914.3	$8,165.9	-$748.4
	Other Funds	$0.0	$0.0	$0.0
	Total	$16,053.3	$13,562.4	-$2,490.9
Adult Preventative Dental Medicaid Services	General Funds	$2,416.8	$2,873.2	$456.4
	Federal Funds	$4,871.6	$5,319.6	$448.0
	Other Funds	$0.0	$0.0	$0.0
	Total	$7,288.4	$8,192.8	$904.4
Health Care Medicaid Services	General Funds	$182,938.4	$198,268.6	$15,330.2
	Federal Funds	$460,689.2	$476,055.8	$15,366.6
	Other Funds	$11,071.7	$7,169.2	-$3,902.5
	Total	$654,699.3	$681,493.6	$26,794.3
Senior and Disabilities Medicaid Services	General Funds	$129,770.1	$144,987.6	$15,217.5
	Federal Funds	$222,359.0	$235,502.3	$13,143.3
	Other Funds	$3,752.2	$3,752.2	$0.0
	Total	$355,881.3	$384,242.1	$28,360.8

Source: Medicaid Budget Group Using Alaska Budget System data.

	General Funds	Federal Funds	Other Funds	Total
Total All Change Records for Medicaid Services	**$34,694.8**	**$32,811.6**	**($3,902.5)**	**$63,603.9**

Transfers to Other Components and Reduction of Excess Authority (OCS, HCS)

($3,742.5) ($2,748.4) ($4,000.0) ($10,490.9)

The department can adjust its authorization this year to reflect the current state of the Medicaid program and the services provided. This includes a decrease in interagency receipts authority related to the discontinued ProShare program, the transfer of GF and Federal funds to Public Health Nursing for Medicaid administrative claiming, the removal of excess federal authority from OCS, and the transfer of non-Medicaid eligible costs to Residential Child Care.

Medicaid Growth (DBH, HCS, SDS)

$36,203.5 $35,407.5 $0.0 $71,611.0

One in five Alaskans is enrolled in Medicaid in any given year. In an average week, 25,500 Alaskans receive some level of medical care that costs the Medicaid program $17-25 million in benefit payments made to 2,100 health care providers. The Medicaid budget is based on the projections of the number of eligible Alaskans who will access Medicaid funded services, the estimates of the quantity of services that may be used, and the anticipated changes in the costs of those services.

Enhance Medicaid Dental Prevention Benefits (HCS)

$200.0 $0.0 $0.0 $200.0

This increment will support the department's continuing efforts to provide dental care for non-Medicaid covered services. These services include: dentures, crowns, cleanings, routine dental exams, and other preventive services. Outreach to the dental provider community, as well as an increase in dental reimbursement rates in both FY09 and FY10, has resulted in increased participation by dental providers. In addition, both overall costs and the total number of individuals served have increased. The number of beneficiaries utilizing dental services saw an increase during FY09 of 9.3%, and the annual average cost per beneficiary rose by 17.5%.

Improve Medicaid Tobacco Cessation Services (HCS)

$0.0 $152.5 $97.5 $250.0

This increment will be used to modify the Medicaid tobacco cessation service coverage so that Medicaid-covered services are more effectively coordinated with the efforts of the Tobacco Quit Line, the American Lung Association, and tribal efforts. This funding will also be used to assist public education and to partner with other advocacy groups to deter young kids from starting to smoke or chew tobacco products. While quantifiable and standardized measures are still in the discussion phase and have to be agreed upon, they could include reduced Medicaid payments addressing secondary conditions associated with smoking as well as the reduced effects of maternal smoking on newborns.

Transfer General Fund from Alaska Pioneer Homes for Medicaid Match Payment (SDS)

$2,033.8	**$0.0**	**$0.0**	**$2,033.8**

The division currently receives GF match related to Residential Assisted Living Medicaid Waiver receipts as inter-agency receipts through reimbursable service agreements with the Alaska Pioneers Home division. Transferring the GF match to the Senior and Disabilities Medicaid Services component will increase efficiency and reduce paperwork by placing the general fund in the budget of the division responsible for making the match payment.

Vulnerable Populations

- Preliminary data for 2008 indicates an Alaska suicide death rate of 24.6 suicides for all ages per 100,000 population. This rate is more than double the stated target of 10.6.
- The target to decrease the rate of substantiated allegations of child maltreatment in Alaska was not met in FY09, as there was a 1.6% increase in the rate of maltreatment per 1,000 children from FY08 to FY09.

Substance Abuse

Substance abuse affects every family and community in Alaska. Through public/private partnerships and departmental strategies DHSS will help to prevent, intervene, treat and assist recovery from substance abuse among Alaskans. Key indicators are being developed.

Long-Term Care

- In FY09, the medication error rate decreased to .13% comparing favorably with the target medication error rate of less than one percent.
- In FY09, the rate of Pioneer Homes resident falls resulting in a major injury (sentinel event injury rate) was 2.7%, exceeding the 2% target rate, but in line with past performance on this measure.

Health and Wellness

- In 2007, 70% of two year olds were fully immunized, which was below the 80% target rate, but slightly above the 67% in FY06. Alaska ranked 45th in the country for fully immunized two year olds.
- In 2007, 90% of persons with tuberculosis (TB) completed adequate treatment; this was in line with prior year performance. This was below the target rate of 95% primarily due to some difficult cases.
- The 2007 death rate caused by unintentional injuries was 57.3 per 100,000 population, above the 50/100,000 target and representing a nearly 10% increase from the 2006 rate. The rate dropped by 12% from 2002 to 2006.
- The adult obesity rate was 27.9% in 2008, below the 28.2% in 2007. However, this was higher than the 26.6% national average and did not meet the 18% target rate.
- The post-neonatal death rate for 2008 was 3.0 per 1,000 live births, above the target of 2.3 per 1,000 live births, but below the rate of 3.3 per 1,000 in 2007.
- There has been a 51% decline in youth smoking over 12 years, bringing the 2007 prevalence rate of 18% within 1 percentage point of the 17% target.

Health Care Reform

- From FY08 to FY09 the Division of Health Care Services realized an increase in GF recovery of 14%, exceeding the 2% target increase.
- Indian Health Services (IHS) Medicaid participation increased by 9% in expenditures from FY08 to FY09. This exceeded the 5% target increase.

Bring the Kids Home (BTKH)

What is Bring the Kids Home (BTKH)? From 1998-2004, out-of-state placements of children with severe emotional disturbances in residential psychiatric treatment centers (RPTC) grew by nearly 800% with no expectation that this trend would change without intervention. The Alaska Mental Health Trust Authority and DHSS organized a stakeholder group to plan, fund, implement and monitor the BTKH initiative. The goal was to develop an in-state system to serve children as close to home as possible and with the family guiding care. Significant progress has been made and FY10 was selected as the target date to end the BTKH initiative, assuming sufficient resources and adequate progress.

How much Progress Has Been Made? Use of out-of-state RPTCs has decreased greatly: admissions are down by 85.4% from 752 to 110 from the high year, FY04. Total yearly recipients are down by 57.6% from 749 to 318.

Use of in-state RPTC has increased: in-state recipients represented only 22.4% of the total RPTC population during FY04 (216 youth) but were 54.3% for FY09 (378 youth). There has been a steady decline in recidivism to RPTC: the recidivism rate dropped from 20% in FY04 to 4% in FY09.

Medicaid expenditures for out-of-state RPTC decreased by 51.3% between FY06 and FY09 ($40 M to $19.48 M). In-state RPTC Medicaid expenditures increased by 739% from FY98 to FY09 ($2.82 M - $20.87M).

What is Working? General funds, MHTAAR and Medicaid have been invested into in-state care. RPTC beds increased from 123 to 186 and lower level beds (residential treatment and therapeutic group/foster homes) went from 530 to 776. These new beds serve youth diverted from out-of-state.

Community behavioral health start-up grants have expanded non-residential services. Examples include sub-acute crisis stabilization, school supports, best practices for children with co-occurring disorders, and expanding mental health Medicaid access to new communities and new providers.

In addition, resource facilitation mechanisms have been established: State staff identify in-state resources and negotiate system gaps while contractors provide gate keeping, peer navigation and coordination. These services help to divert and step children down from residential and RPTC care.

An Individualized Service Agreement (ISA) flexible funding pool was established to pay for services to stabilize a child in the community which are not available through Medicaid, insurance, grants, etc. As ISA use has expanded, RPTC placements have dramatically decreased.

What are the Remaining Priorities? The state needs a system that can serve children with behavioral health problems and their families in communities across Alaska. In order to achieve this, we are *expanding successful strategies* statewide, *addressing funding gaps* and *shifting funding* to programs that reach children and families earlier and prevent severe disturbances.

Expanding Successful Strategies:
BTKH community behavioral health grants are developing in-state capacity to serve children with intensive needs and their families. During FY09 BTKH grantees accepted 41 children from out-of-state RPTC, diverted 129 from out-of-state RPTC and accepted 219 from more restrictive in-state care. However, some communities/regions have not applied for or received BTKH grants yet and have limited behavioral health capacity (Nome, Barrow, Valdez, Petersburg, Wrangell, Aleutians, Pribilofs, etc). Also, some BTKH projects are in a pilot phase and need to be expanded (family therapy, wraparound, etc).

During FY10, DHSS developed training modules and technical assistance targeting behavioral health services to increase revenues and reverse the trend of low billing and reimbursement: between FFY07 and FFY08 tribal Medicaid payments for mental health and substance abuse services decreased by 10.27%. Expansion of tribal behavioral health services will allow increased access to culturally competent care while capturing 100% federal match for services through tribal health organizations. The FY11 budget contains increments for this effort.

Another priority is to improve DHSS capacity to provide technical assistance and training. FY10 MHTAAR funds supported DBH to provide training to providers to expand family therapy services and to improve outcomes. The FY11 budget maintains the MHTAAR funding level for this effort.

Addressing funding gaps:
While ISAs are an effective strategy to divert youth from residential care, 27 eligible providers are not yet using ISA. Also, youth with a primary substance use disorder do not yet have access to ISA. For FY09 less than 1% of ISA recipients were subsequently admitted to an RPTC (5 out of 506). Additional funding is included in the FY11 budget to expand ISA use.

Youth with behavioral disorders transitioning to adulthood encounter service gaps and show poor outcomes: involvement with justice systems, mental health and substance abuse problems, unplanned pregnancy and homelessness. Covenant House Alaska reports that, of 627 youth who completed a FY09 intake assessment, 80% were mental health beneficiaries (501 youth). Within their Crisis Center, 34% of the youth reported a history of residential mental health treatment (65 youth). The FY11 budget contains increments for this effort.

Peer navigation services are limited in Anchorage, Mat-Su, Fairbanks, Juneau and Kotzebue, and are very sparse elsewhere. Peer navigation provides support, parenting classes, and resource facilitation. For FY08 and FY09, over 90% of the youth served who were at risk of out-of-home placement were able to remain in their own communities. Peer navigation can only be partially funded via Medicaid. The FY11 budget maintains the MHTAAR funding level for this effort.

Shifting funding to intervene earlier:
Alaskan stakeholders have identified service gaps for young children with behavioral health problems and their families: few clinicians are qualified to work with young children and early learning settings often expel children with behavioral challenges. The "Adverse Childhood Experiences Study" (which can be found at www.cdc.gov/NCCDPHP/ACE/index.htm) found that children exposed to traumatic experiences were more likely to engage in substance abuse, promiscuity, and suicide attempts and to experience mental illness, heart disease, cancer, and stroke.

Three BTKH projects are aimed at reducing traumatic experiences and intervening earlier. One project provides mental health consultation for young children in early care settings. A second provides a mental health clinician to work with professionals serving young children. Each will reduce the number and impact of traumatic events that impact children's development. A new FY11 project will provide foster parent and parent training and intensive family preservation. Intervening earlier can reduce the need to take children into custody and thus reduce trauma and costs. All three of these projects need FY11 funding to expand beyond the pilot phase and impact families statewide.

BTKH graphs are included in the chapter for the Division of Behavioral Health.

Families First

Families First is a service delivery strategy to increase collaborative services for families who are accessing services from multiple Health and Social Services providers. Families First facilitators are located in Kenai, Sitka, Anchorage, Wasilla, Nome and Fairbanks. These staff are responsible for coordination of efforts within their regions. DHSS offices of Public Assistance, Children's Services, Behavioral Health and Juvenile Justice are partners in Families First and share an abundance of families concurrently accessing many or all of our services. By working as a team, these partners give families a better opportunity to achieve their goal of becoming self-sufficient.

DHSS developed the Families First service delivery strategy to provide collaborative, community-based services, supports, and resources to families to help them become self-sufficient. Employment is the focus of this family-centered approach, and it relies on the creative and efficient use of family, community, and multi-agency resources. In addition to promoting the best possible outcomes for families, these services create opportunities for service providers to work together and work efficiently by making the best use of private and public resources. Many families who will benefit from this approach have complexities in their lives that make it difficult for them to compete in a labor market driven work search.

This approach focuses on solutions to help families be successful. Families frequently find themselves being "shuffled" among and between multiple government, private and non-profit community agencies. Families often report that they have difficulties meeting the expectations of multiple agencies from whom they receive services. This puts families in a difficult situation, because when they can't meet the expectations of an agency, they could very well lose their assistance.

Addressing this problem shines the light on a key aspect of Families First: teams made up of staff from multiple agencies gather in a collaborative meeting with the family to get a holistic view of their needs. The team approach includes learning about the family's daily lives to learn their needs, complexities, strengths and skills. The family is involved in all conversations and decision making. An important facet of this approach is that families engage in this process more strongly when their voice is heard and respected. Gathering this initial information is an important part of creating a family profile, which helps lay the ground work for delivering services and is the beginning of a plan for self-sufficiency.

National studies show that implementing wrap-around services has increased positive outcomes for families. By developing collaborative interdisciplinary service teams to help families identify critical issues and to create plans or strategies to mitigate challenges, families are able to make incremental advances towards self-sufficiency and improved family stability.

The Office of Children's Services' Family-to-Family program exemplifies this course of action as a core program component as the family and natural supports along with agency staff are involved in placement decisions for their children. The use of a coordinated team approach will establish reasonable performance expectations for families.

The primary purpose of Families First is to help families become self-sufficient. DHSS Families First uses "customized employment," a proven employment model for people with significant

disabilities. Customized employment is a blend of services designed to increase employment options for individuals with significant barriers to employment. The process discovers the strengths, skills, needs and interests of the job seeker. The team works with the job seeker to identify potential work sites. The team's Job Developer works with the management at the identified work site to determine if there are unmet needs to which the job seeker can contribute for a mutually beneficial outcome. The parties work together to negotiate a new job description. The goal of this "customization" is a meaningful employment relationship where both parties get their needs met. The model has been successfully implemented in Alaska by the Department of Labor and Workforce Development as part of a national initiative to promote employment for people with disabilities.

Alaska is moving forward to expand the Families First approach, and is hosting Families First trainings across the state for government, non-profit and community partners starting January 2010.

FY11 Capital Project Requests

Capital		FY11 Capital Funding Request (In thousands)			
DHSS Initiatives/ Divisions	***Project Titles***	***GF***	***Fed***	***Other***	***Total***
Vulnerable Alaskans					
Juvenile Justice	Johnson Youth Center Renovation and Remodel to Meet Safety and Security Needs -Phase I	9,880.0			9,880.0
Pioneer Homes	Pioneer Home Deferred Maintenance, Renovation, Repair and Equipment	4,000.0			4,000.0
Department Support Services	Non-Pioneer Home Deferred Maintenance, Renovation, Repairs and Equipment	3,000.0	20.0		3,020.0
	*Mental Health Deferred Maintenance and Accessibility Improvements	500.0			500.0
	*Mental Health Home Modifications and Upgrades to Retain Housing	500.0		550.0	1,050.0
	*Mental Health Housing – Pre-development, Anchorage Assets Building	500.0			500.0
Capital Budget Totals		**18,380.0**	**20.0**	**550.0**	***18,950.0***

These projects are included in the mental health bill.