Mission

To manage health care coverage for Alaskans in need.

Introduction

Health Care Services (HCS) oversees and manages all Medicaid core services including: hospitals; physician services; pharmacy; dental services; transportation; physical, occupational, and speech therapy; laboratory; radiology; durable medical equipment; hospice; and home health care.

Core Services

Provide access and oversight to the full range of appropriate Medicaid health care services. Assure the full range of health care services information is available to our customers.

The division's major goal is to provide support services through management efficiencies and the capitalization of Medicaid financing.

Services Provided

The following units or programs provide services in support of Alaska Medicaid.

Adult Preventative Dental Medicaid Services

Since 2007, the Adult Preventative Medicaid Dental program has provided restorative and preventive dental services that were previously not available to adults. Fiscal limits set by the legislature limit total Adult Preventative Dental program costs, ensuring that program spending remains within the budgeted amount. A separate Medicaid Services component program continues to pay for children's dental services and for adult emergency dental services.

The program offers services for improvement of oral health and reduction in emergency dental services. Covered services include most routine restorative dental services, including exams, cleanings, tooth restoration or extraction, and upper or lower full dentures.

Adult Preventive Dental covered services are limited to $1,150 per person per year. Recently-adopted regulations, however, allow an individual to 'borrow' the upcoming year's limit so that he or she may receive both upper and lower dentures at the same time, as a single year's limit will not cover both.

The program supports the Department's mission to manage health care for eligible Alaskans in need. Providing adult preventive dental services through Medicaid improves and enhances the quality of life for Alaskans with dental problems.

Health Care Services Medicaid

The Medicaid budget is based on projections of the number of eligible Alaskans who will access Medicaid-funded services, estimates of the quantity of services that may be used, and the anticipated changes in the costs of those services. The Department uses both long-term and short-term forecasting models to project Medicaid spending. The short-term model is best for budget development and fiscal note analysis while the long-term model is best for strategic planning.

The change over a long period is generally more smooth and gradual than the annual fluctuations experienced in the short term. Since the budget-preparation cycle requires projections up to 24 months in the future, often before recent policies have been fully implemented and reflected in the baseline spending data, it is premature to know if recent changes in spending are temporary or will last.

The Medicaid Services component funds health care services such as hospitals, physicians, prescription drugs, dental, and transportation. Providing health care services through Medicaid improves the Department's goal of healthy Alaskans living in healthy communities. These programs support the Department's mission to manage health care for eligible Alaskans in need.

Pharmacy and Ancillary Services Unit

This unit manages the following provider types: Pharmacy, Private Duty Nursing, Hearing and Audiology, Home Infusion Therapy, and Respiratory Therapy. The unit manages these providers through policy and regulation development, implementation, and oversight. The unit completes research, analysis, planning, and program implementation for the preceding provider types. The unit ensures services to vulnerable Alaskans are high quality and cost effective. The unit also provides support for the Chronic and Acute Medical Assistance (CAMA) program, the provider-administered drug program, the Department's Program Integrity Unit, the Medicaid Fraud Unit and the Commercial and Fair Business Section of the Department of Law.

This year, the unit implemented a new payment methodology to appropriately reimburse pharmacy providers for dispensing medications and establish a new pricing tool to accurately reimburse providers for medications. The former tool was retired due to federal litigation. The Pharmacy and Ancillary Services unit has several initiatives, enumerated below. These initiatives provide excellent pharmaceutical care through the following:

Preferred Drug List (PDL):
The PDL is a list of medications that contains classes representing Medicaid's first and last choice when prescribing for Medicaid recipients. This list aligns the patient's needs, the physicians' knowledge, and the state's purchasing power. The PDL supports cost efficiency when preferred drugs are prescribed and dispensed. Alaska Medicaid participates in the National Medicaid Pooling Initiative to obtain the best rebates.

Pharmacy and Therapeutics Committee (P&T):
The P&T Committee is a group of Alaskan health care professionals who prescribe or dispense prescription drugs. The committee has statewide representation and includes various physician specialties, pharmacists, dentists, physician assistants, and nurse practitioners. The P&T Committee is responsible for determining which drugs are effective and whether these should/should not be on the PDL.

Drug Utilization Review Committee (DUR): The DUR Committee is responsible for maintaining appropriate use of medications and to prevent inappropriate use and adverse reactions. This program ensures that medications are used safely and appropriately by our Medicaid recipient population. DUR activities are overseen by a committee of licensed Alaskan health care professionals.

Prospective drug utilization review (ProDUR) is performed by all Alaska Medicaid enrolled pharmacists before filling any prescription for a Medicaid recipient. Proprietary software is used to check for potential problems with a Medicaid patient's medication therapy. This immediate review of prescriptions at the time of filling assists pharmacists in determining if the medication is appropriate and will bring to the attention of the pharmacist concerns such as drug-interactions, therapeutic duplications, early refills, pregnancy cautions, and other potential problems.

Medicaid Operations Unit

The Operations Unit performs program management and oversees policy for core Medicaid services, including those delivered at inpatient and outpatient facilities and by physicians and other practitioners. The Operations Unit is also responsible for program management of recipient services, including operation and oversight of a toll-free help line, transportation coordination and prior approval, provider/recipient liaison, provision of case management services, and facilitation of fair hearings.

This unit assures compliance with federal and state Medicaid regulations and related program policies. It provides Medicaid program management for those services performed: (1) at hospitals and ambulatory surgical centers; (2) by end-stage renal disease dialysis clinics, federally qualified health centers and rural health clinics; and, (3) by medical providers including physician services, dental services, transportation and accommodation, physical, occupational, and speech therapies, laboratory, radiology, durable medical equipment, vision services, hospice, and home health care. The unit ensures that positive and productive relationships are maintained with consumers and medical providers. It works directly with various professional health organizations and solicits their input into policy and program development. The unit assists in answering difficult clinical questions from medical providers, service recipients, and the program's fiscal agent.

The unit is responsible for contract management of all fiscal agent activities, and is responsible for oversight and monitoring of the organization contracted to perform both utilization management through the prior authorization of selected inpatient stays and outpatient procedures, and case management services for clients with complex medical conditions. The unit also oversees provider enrollment, education, and outreach efforts.

The unit assists Medicaid recipients and health care providers (acting on behalf of recipients) in appropriately accessing benefits and resolving complaints and grievances. The unit monitors recipient travel under the State Travel Office, manages the statewide Early Prevention, Screening, Diagnosis, and Treatment program, supports the Breast and Cervical Cancer Program, coordinates Fair Hearing requests, represents the agency at Fair Hearings, and monitors the fiscal agent's performance related to recipient services. When necessary, the unit intercedes to resolve recipient and provider disputes regarding eligibility and claims processing.

Accounting and Recovery Unit

The Accounting and Recovery Unit provides financial and collection services to support the Department's Medicaid divisions. The primary responsibilities of the accounting staff include the oversight and management of the accounting interface between the Medicaid Management Information System (MMIS) and the State Accounting System, ensuring weekly check writes are approved, reconciled, and issued. Accounting functions are provided for the Divisions of Health Care Services, Senior and Disabilities Services, Behavioral Health, and the Office of Children's Services.

This unit is also responsible for pended claims related to Third Party Liability (TPL), collection of third party payments, Pay and Chase claims, administration of the Medicare Buy-in Program, and the oversight of the post-payment review and cost-avoidance contractor. Additionally, this

unit administers the Working Disabled Program, the Health Insurance Premium Payment (HIPP) program, the Estate Recovery Program, and works in tandem with the Department of Law on subrogation and trust cases. The cost recovery activities apply to all Departmental Medicaid services.

Chronic and Acute Medical Assistance (CAMA)

The CAMA program provides a limited package of state general fund and only provides health services to those individuals with covered medical conditions who do not qualify for the Medicaid program. Select outpatient and prescription services are available to CAMA recipients with the following covered conditions: terminal illness, chronic diabetes, cancer requiring chemotherapy, chronic seizure disorders, chronic mental illness, and chronic hypertension.

Tribal Unit

The Tribal unit provides program assistance and oversight of Medicaid services for the whole age range from birth to death at or through tribal health care facilities statewide. This includes oversight and liaison work across divisions within the Department. Tribal healthcare delivery is considered a state-wide three-tiered system that is managed through 16 regional health organizations and 17 local health organizations from hospitals to sub regional clinics to village clinic sites.

This unit serves both as a liaison and as a technical assistance resource to each of the Medicaid divisions within the Department to develop, maintain and enhance existing tribal functions (waivers, Behavioral Health, Division of Public Assistance Eligibility Information System (EIS) access, hospital and clinic based services, administrative claiming efforts, settlements, Senior and Disability Services (SDS) and new Long Term Care (LTC) facilities, etc); assists with expansion of tribal refinance efforts through data analysis to promote capacity building in the tribal health care system; maintains successful and proactive working relationships internally and externally; tracks federal and state legislation and regulations pertaining to tribal functions; provides technical assistance to improve revenue generation and billing efficiencies at tribal facilities as well as oversee continuing care agreements, billing manual modifications, training efforts, and other duties related to tribal health care services.

Medicaid Systems and Analysis Unit

This unit bears technical responsibility for the Medicaid Management Information System (MMIS) and related systems. Their purpose is to ensure the integrity of the claims payment system, and to translate Medicaid program business needs into MMIS processing requirements, while operating within the strict confines of all related federal guidelines. They also have responsibility for claims processing analysis and compliance with federal claims processing reporting requirements.

The unit has responsibility for contract monitoring and oversight of all technical components, including the claims processor, the decision support system (DSS), and all interfaces to and from the MMIS and DSS.

Additionally, the unit has responsibility for preparing planning documents to secure federal funding related to the MMIS and fiscal agent services. This includes standard weekly MMIS services as well as federal mandates for changes in standards. The unit coordinates this action with the Department's Grants and Contracts staff.

The unit also provides research and analysis with regard to MMIS processing outcomes, as well as decision support system training and support to the Department's users.

Rate Review

The Office of Rate Review provides quality rate review, accounting and auditing services to support the Department's programs. Rate setting, including compliance and ongoing rate setting systems maintenance tasks, is centralized under this component for all services including Medicaid facilities, Medicaid waivers, Medicaid Continuing Care Agreement settlements, foster care, and child care facilities.

The unit also has responsibility for the State's Certificate of Need (CON) program. The CON program administers State statutes requiring preliminary reviews of large health care projects to ensure the projects are needed and practical additions to the State's health care infrastructure, and to provide a public process for proposed large health care projects.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) is an expansion of the Medicaid program in Alaska. It is managed through the same rules and processes as Medicaid in general. The program, implemented in Alaska in 1999 covers children and teens through age 18; and, is a part of the Denali KidCare program. Services include comprehensive Early Periodic Screening Diagnostic Treatment (EPSDT) services, a children's Medicaid service provision. The program has Federal authorization through 2019, most recently being extended by the Affordable Care Act (ACA) of 2010 that extended CHIP authorization through 2019 and funding through 2015. Under CHIPRA, in 2010, Alaska, Oregon, and West Virginia, were awarded $15,000,000 for a children's quality of care five-year demonstration that encompasses evaluation of 24 children's quality measures and patient-centered medical homes (PCMH), and care coordination models integrating health information technology (HIT).

Child enrollment in Medicaid and CHIP is illustrated in the charts below. The blue line below reflects the number of children funded under CHIP, with Title XXI enhanced federal financial participation (FFP). For example, for every dollar spent on children financed under the CHIP, the federal government contributes $.65 and the state general fund (GF) match is $.35. Children and others enrolled in Medicaid are funded with a lower FFP in that the federal government contributes $.50 and the state GF match is $.50.

Certification and Licensing

The Section of Certification and Licensing's overall responsibility is to protect and reduce the risk to the health, safety, and exploitation of Alaska's most vulnerable citizens being served, and to ensure that there is public confidence in the health care and community service delivery

systems through regulatory, enforcement, and educational activities. This is accomplished by: 1) inspecting adult and children's residential facilities to ensure compliance with state licensing requirements; 2) providing essential technical assistance to residential providers, as needed; 3) receiving and investigating complaints involving resident physical, mental, and sexual abuse, financial exploitation, and safety/sanitation concerns; 4) providing facilities with a notice of violation, when necessary, and taking appropriate action when facilities fail to come into compliance with state or federal law; and 5) ensuring a process wherein all service providers with direct client access must have a background check.

The Adult and Children's Residential Licensing Program is responsible for the inspection, licensure, and investigations of approximately 670 facilities statewide that are required to meet state and federal licensing mandates. Other responsibilities of the program include, providing consultation to licensees, working with other government agencies to compliment licensing functions, and working with individuals, groups, and communities to encourage and support the development of safe and effective residential care homes.

The Background Check Program is responsible for improving the overall safety and security of vulnerable individuals in state licensed and /or certified programs, by providing safeguards against abuse and neglect of individuals receiving direct care services. These functions are accomplished through the implementation of a fingerprint-based criminal history investigation and fitness determination program administered to all staff serving vulnerable populations. Since April 2006, the program has processed over 100,000 applications.

Health Facilities Licensing and Certification

The State Survey Agency is responsible for performing certification functions created by section 1864 of the Social Security Act. Health Facilities Licensing and Certification conducts initial surveys (inspections), periodic resurveys, and complaint surveys for 17 different categories of health providers in the State of Alaska. Surveys are conducted to determine a health provider's compliance with Medicare and/or Medicaid regulatory requirements and to evaluate the health provider's performance and effectiveness in delivering safe and acceptable quality of care. In addition, the State Agency conducts validation surveys of accredited and deemed facilities in order to furnish the U.S. Department of Health and Human Services (DHHS) a monitoring of the validity of surveys conducted by accrediting bodies.

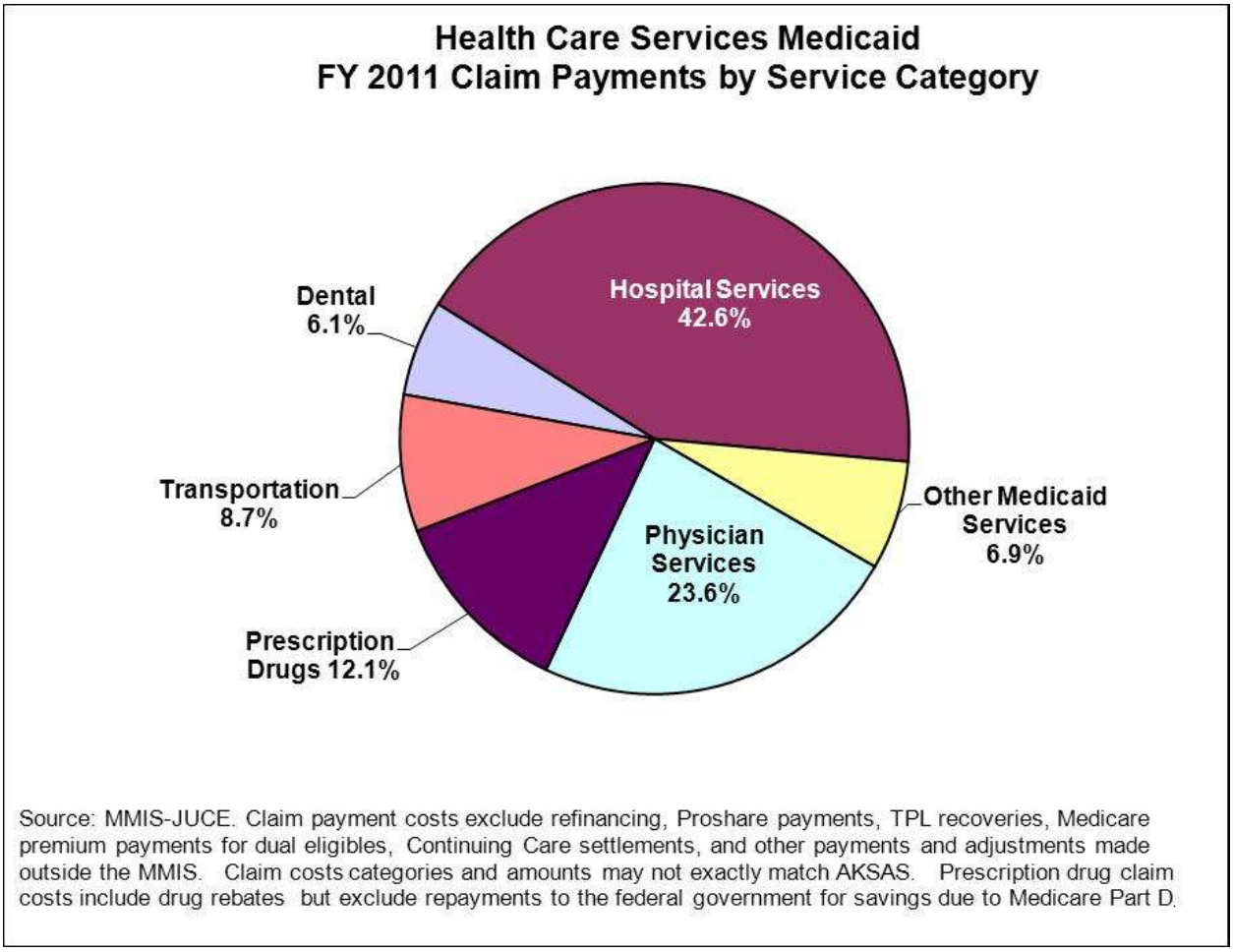
The Health Facilities Licensing and Certification unit conducts periodic educational programs for health facilities; maintains a toll-free telephone hotline to receive complaints; ensures review of Nurse Aide Training and Competency Evaluation Programs; ensures a Nurse Aide Registry is maintained; specifies a specific assessment tool for use in skilled nursing facilities; and maintains pertinent survey, certification and statistical records. The unit's regulatory oversight of health care facilities includes renewing, and if warranted, denying, suspending, or revoking licenses when there is substantial failure to comply with regulatory requirements.

Health Facilities Licensing and Certification, in conjunction with the Centers for Medicare and Medicaid Services and the State's Medicaid Program, promotes efficiency and quality within the health care delivery system.

Health Care Medicaid Services

The Health Care Services (HCS), Medicaid Services component, provides funding for medical assistance services provided for Medicaid enrollees and non-claim payments issued to cover Alaska Medicaid program service costs. In FY2011, approximately 94.4% of the HCS component's expenditures were utilized for direct Medicaid medical services payments. Direct medical assistance services include, but are not limited to, claims for medical services from hospitals, physicians, pharmacies (prescription drugs), dental services, transportation, and a wide range of other preventive and acute care services. Non-claim payments include supplemental payment programs (e.g., Disproportionate Share Hospital, Upper Payment Limit), as well as Medicare premium payments and judgment restitutions.

In FY2011, Health Care Services Medicaid expenditures comprised 54.5% of the total expenditures for all Alaska Medicaid claim payments. Hospital services accounted for the largest share of HCS Medicaid expenditures (42.6%), followed by physician services (23.6%), prescription drugs (12.1%), transportation services (8.7%), other services (6.9%), and dental services (6.1%).



Source: MMIS-JUCE. Claim payment costs exclude refinancing, Proshare payments, TPL recoveries, Medicare premium payments for dual eligibles, Continuing Care settlements, and other payments and adjustments made outside the MMIS. Claim costs categories and amounts may not exactly match AKSAS. Prescription drug claim costs include drug rebates but exclude repayments to the federal government for savings due to Medicare Part D.

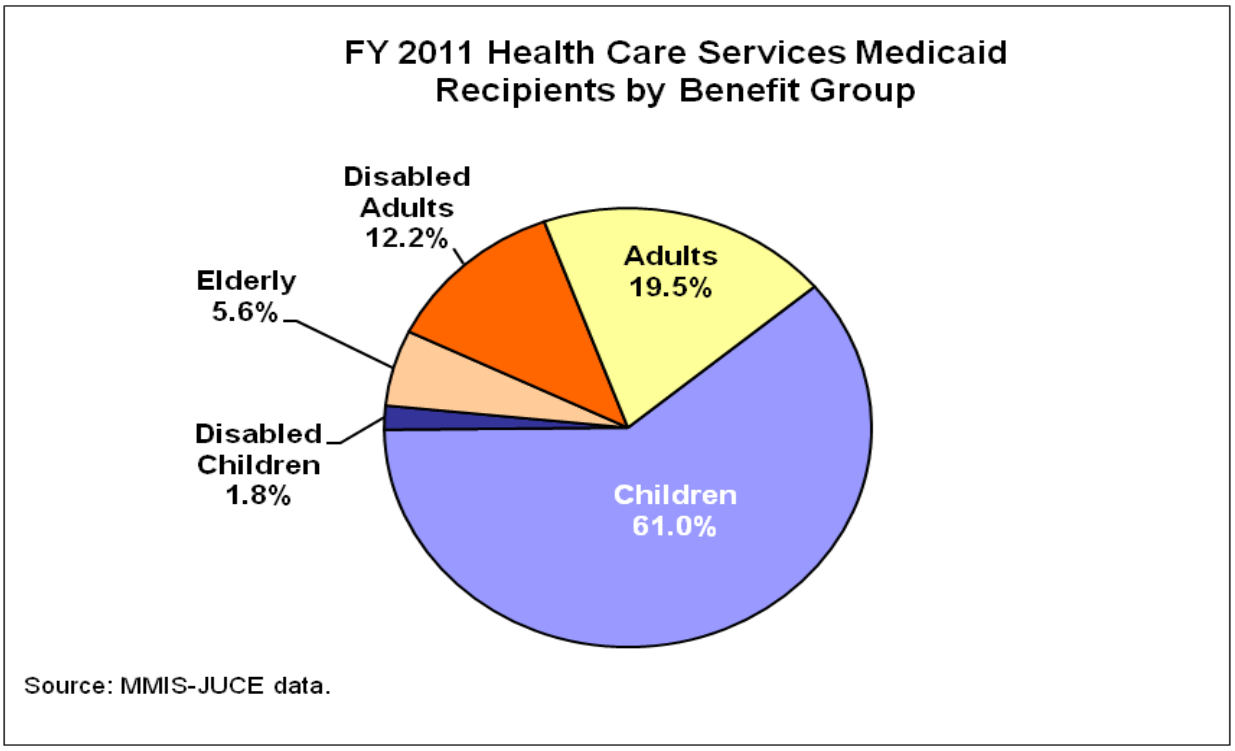
In FY2011, the Alaska Health Care Medicaid Services component supplied medical and related services to 133,773 Alaskans, or 91.9% of all individuals eligible for the Alaska Medicaid program. The total cost of direct medical benefits provided to Medicaid enrollees through Health Care Services (HCS) totaled $726,131.7 million dollars during FY2011. 62.8% of 2011 HCS claim payments provided medical services to children; 31.7% of expenditures provided services for adults; and 5.6% of payments provided medical care for elderly individuals. Approximately 2/3 of Medicaid Medical service expenditures made during FY2011 supported medical care for children and the elderly.

Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Payments (thousands)	CPRPY
Children	61.0%	82,989	41.3%	$299,707.5	$3,611
Disabled Children	1.8%	2,399	4.9%	$35,317.4	$14,722
Elderly	5.6%	7,621	4.0%	$28,959.6	$3,800
Disabled Adults	12.2%	16,618	26.4%	$191,370.0	$11,516
Adults	19.5%	26,508	23.5%	$170,777.2	$6,442
Unduplicated Annual Clients		**133,773**			
Total Medicaid Claim Payments (dollars)				**$726,131,688**	
Average Annual Medicaid Cost per Beneficiary (CPRPY)					**$5,428**

Source: MMIS/JUCE claims paid during FY11. CPRPY is annual cost per beneficiary. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.

The benefit category "disabled Adults" includes disabled persons between 19 and 20 years of age, as well as adults over age 21.

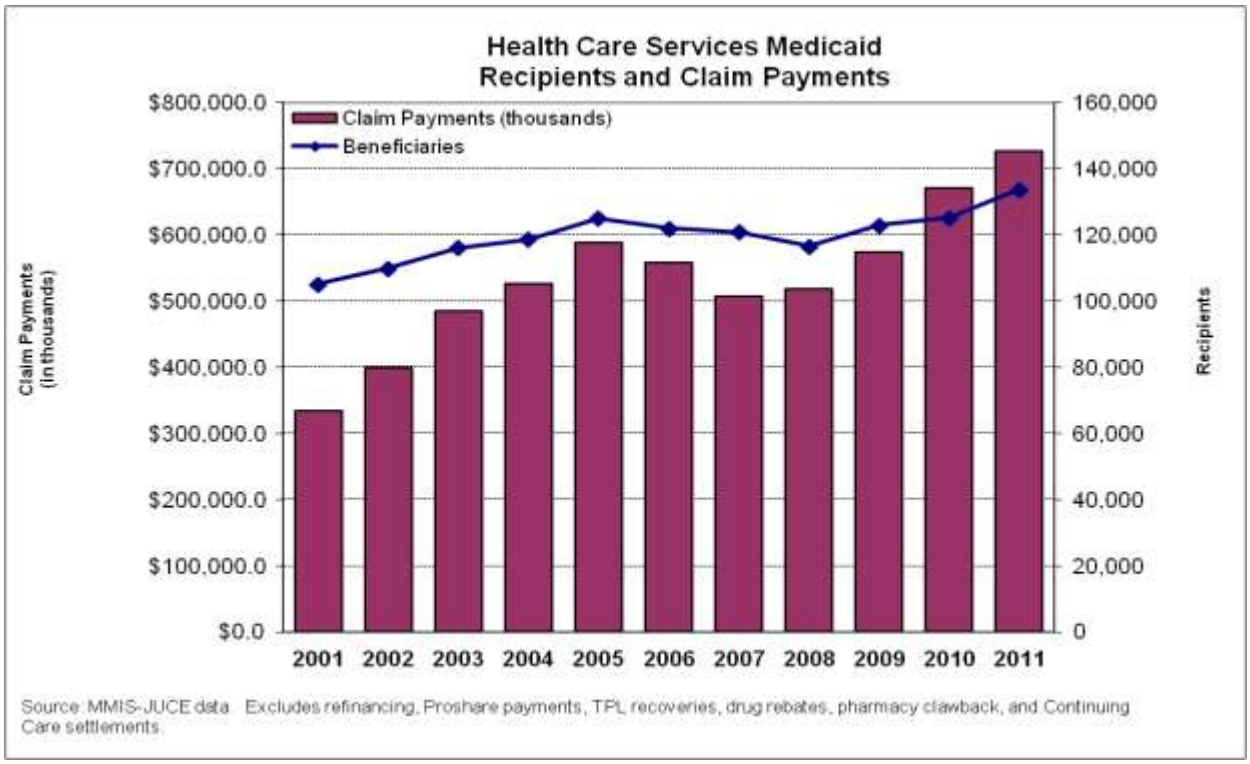
Number of Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2011 (service may have been incurred in a prior year). Grouping is based on status on the date when service was provided. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group categories), but some duplication 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 any time before June 30, 2011. If they later obtained dental services in December 2010, they would also be included in the 13 through 18 age subgroup count if the claim was paid any time before June 30, 2011.



Total medical claim expenditures for Health Care Services Medicaid increased by 7.5% between FY2010 and FY2011, with increased reimbursements for medical services noticeable across several categories of service. This growth in expenditures can be attributed to a combination of increased recipient Medicaid service utilization, as well as, augmented service costs. The number of recipients utilizing HCS Medicaid services in FY2011 increased by 6.8% from FY2010. During this same period, the annual cost per recipient increased 1.2%, from an average cost of $5,366 per participating recipient in FY2010 to $5,430 in FY2011. As noted, increases in medical service costs can in most instances be directly linked to medical service rate changes issued by the Federal Centers for Medicare and Medicaid Services and increased utilization of Medicaid services.

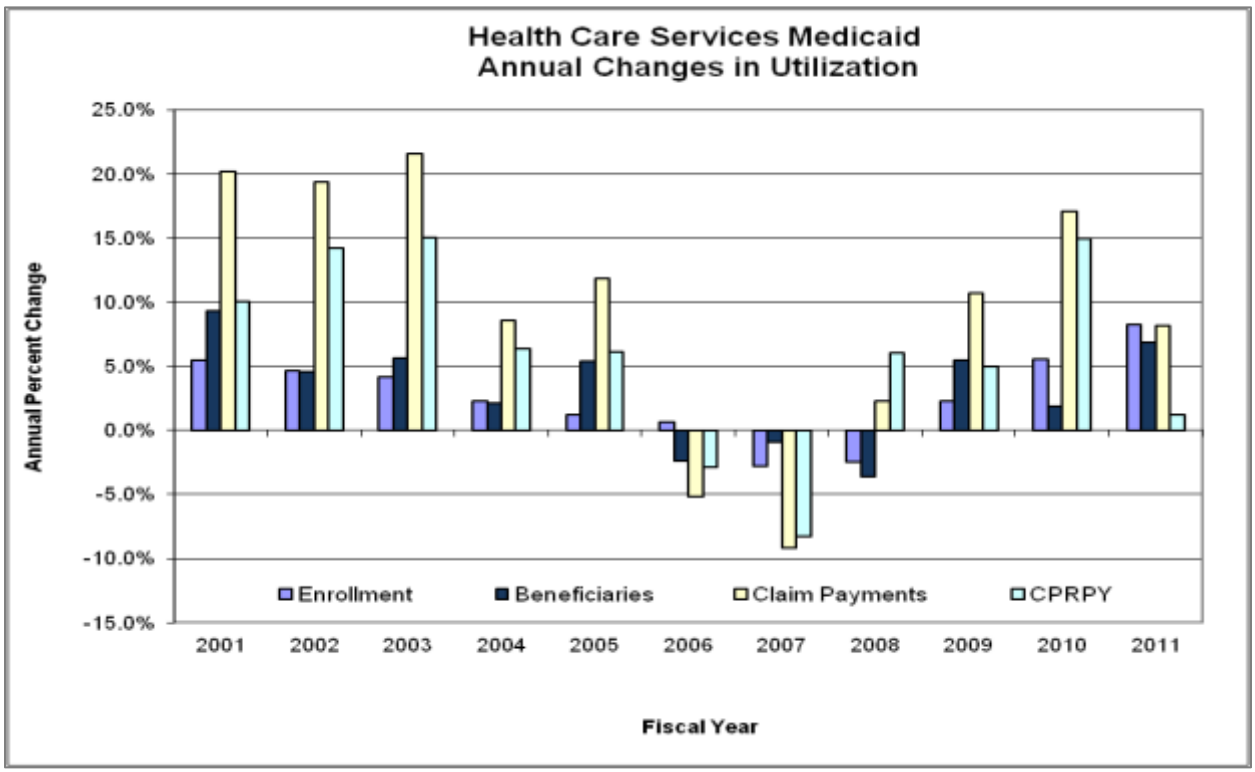
All Medicaid Services*	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	63.4%	85,457	47.0%	$341,098.4	$3,991
21 or Older	36.6%	49,334	53.0%	$385,075.7	$7,805
Unduplicated Annual Clients		**133,733**			
Total Medicaid Claim Payments (thousands)				**$726,174.1**	
Average Annual Medicaid Cost per Recipient (CPRPY)					**$5,428**
Hospital Services	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	55.5%	42,228	46.2%	$140,766.8	$3,333
21 or Older	45.5%	33,875	53.8%	$164,223.4	$4,848
Unduplicated Annual Clients		**75,717**			
Total Medicaid Claim Payments (thousands)				**$304,990.2**	
Average Annual Medicaid Cost per Recipient (CPRPY)					**$4,028**
Physician Services	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	62.4%	70,782	48.9%	$82,815.3	$1,170
21 or Older	37.6%	42,701	51.1%	$86,650.9	$2,029
Unduplicated Annual Clients		**112,855**			
Total Medicaid Claim Payments (thousands)				**$169,466.1**	
Average Annual Medicaid Cost per Recipient (CPRPY)					**$1,502**
Pharmacy	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	60.5%	46,657	30.0%	$25,998.1	$557
21 or Older	39.5%	30,472	70.0%	$60,711.1	$1,992
Unduplicated Annual Clients		**76,718**			
Total Medicaid Claim Payments (thousands)				**$86,709.1**	
Average Annual Medicaid Cost per Recipient (CPRPY)					**$1,130**
Transportation	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	53.7%	15,952	52.3%	$32,486.9	$2,037
21 or Older	46.3%	13,765	47.7%	$29,573.8	$2,148
Unduplicated Annual Clients		**29,609**			
Total Medicaid Claim Payments (thousands)				**$62,060.8**	
Average Annual Medicaid Cost per Recipient (CPRPY)					**$2,096**
Other Medicaid Services	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	49.3%	28,070	48.8%	$24,176.7	$861
21 or Older	50.7%	28,818	51.2%	$25,395.3	$881
Unduplicated Annual Clients		**56,642**			
Total Medicaid Claim Payments (thousands)				**$49,572.0**	
Average Annual Medicaid Cost per Recipient (CPRPY)					**$875**

Source: MMIS-JUCE:
*The recipient counts and payments for All Medicaid Services include all services provided by Health Care Services. The table provides details for some, but not all, of the service categories.



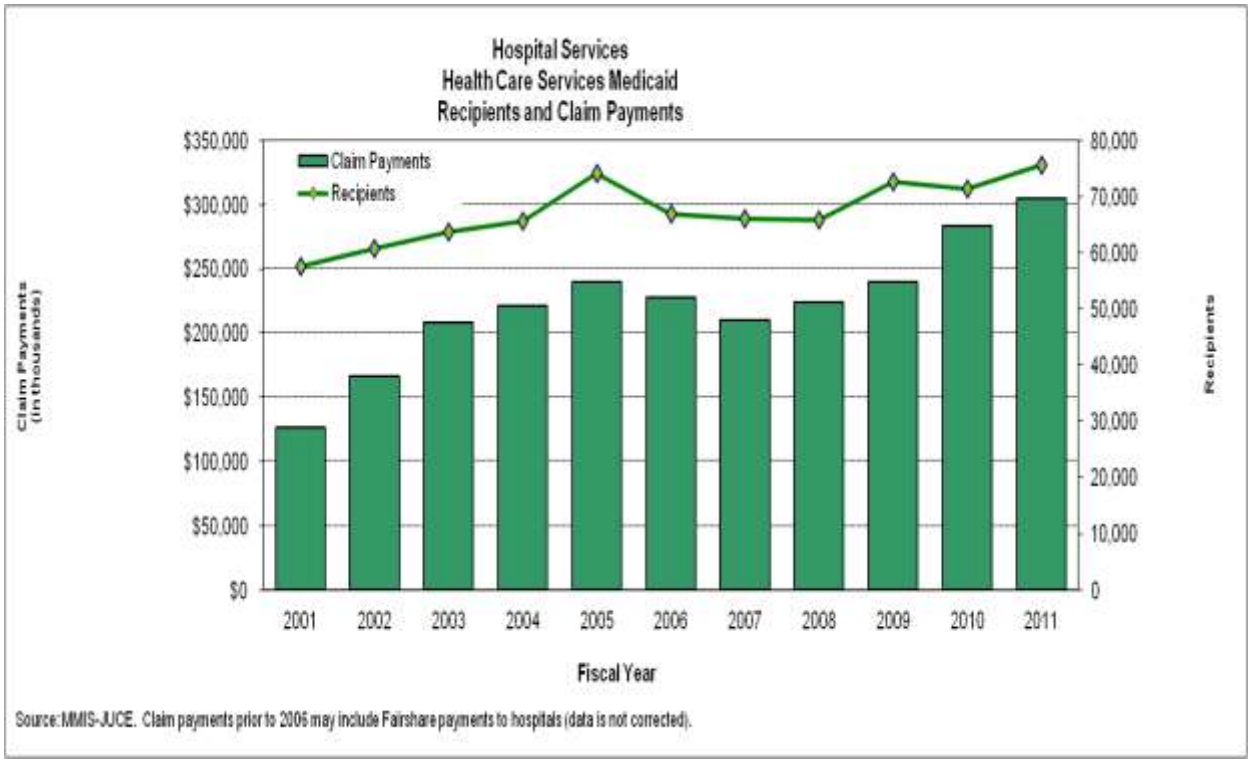
Health Care Medicaid Services Historical Utilization				
SFY	Annual Percent Change			
	Enrollment	Recipients	Claim Payments	Cost per Recipient per Year
2000	15.0%	20.2%	18.1%	-1.7%
2001	5.5%	9.3%	20.2%	10.0%
2002	4.6%	4.5%	19.3%	14.2%
2003	4.2%	5.6%	21.5%	15.0%
2004	2.3%	2.1%	8.6%	6.3%
2005	1.2%	5.4%	11.8%	6.1%
2006	0.7%	-2.4%	-5.2%	-2.9%
2007	-2.8%	-0.9%	-9.2%	-8.3%
2008	-2.5%	-3.6%	2.3%	6.1%
2009	2.2%	5.5%	10.7%	5.0%
2010	5.6%	1.8%	17.1%	15.0%
2011	8.3%	6.9%	8.1%	1.2%

Source: MMIS-JUCE

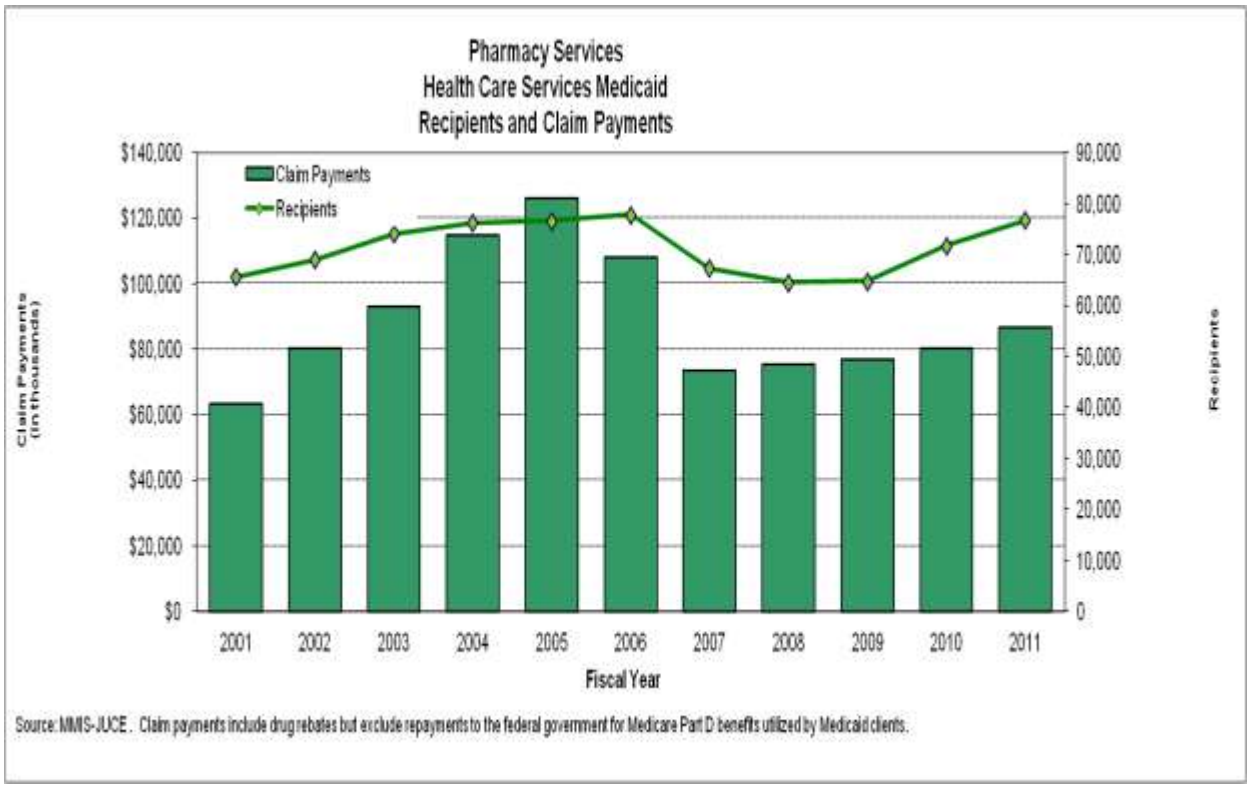


Source: MMIS JUCE

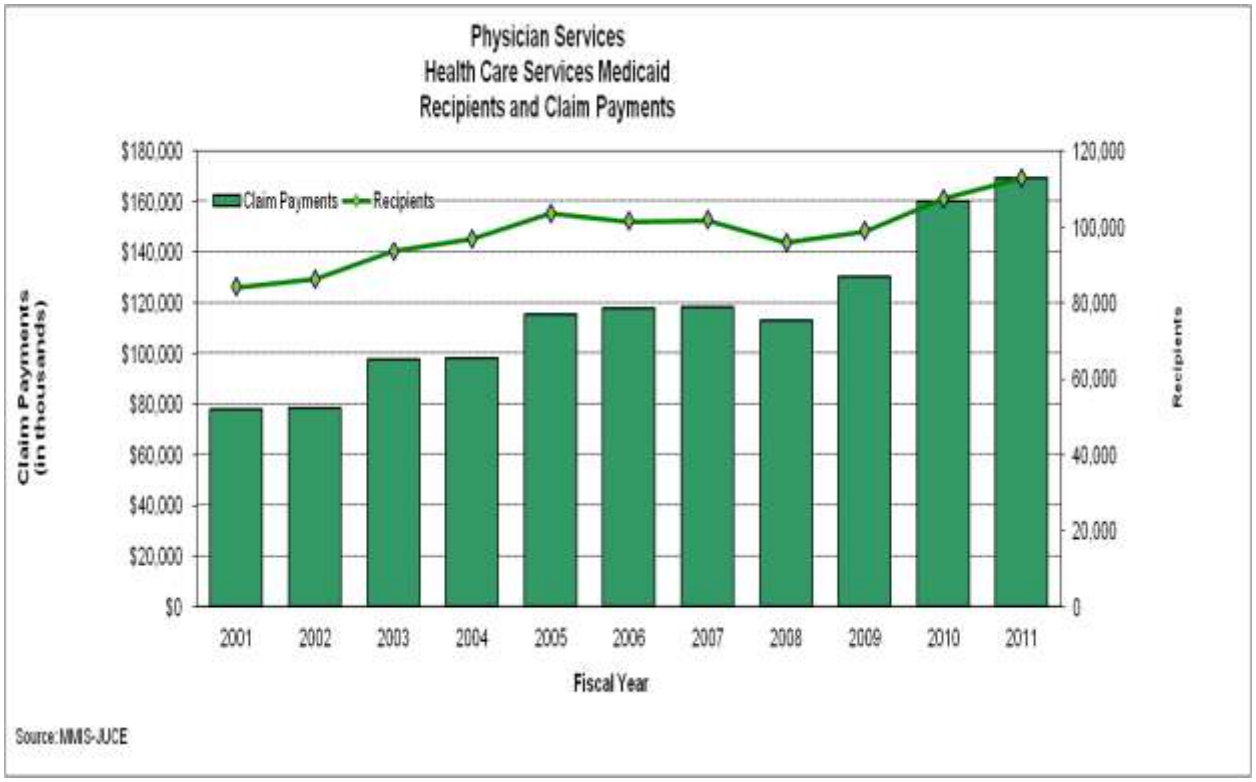
Overall claims expenditures for Medicaid hospital services increased by 7.5% between FY2010 and FY2011. This increase can be attributed to a number of factors, which includes, but is not limited to, increases in recipient enrollment leading to higher levels of service utilization by recipients and increases in service rates. The number of Medicaid recipients utilizing Medicaid hospital services increased by 6.0% between FY2010 and FY2011.



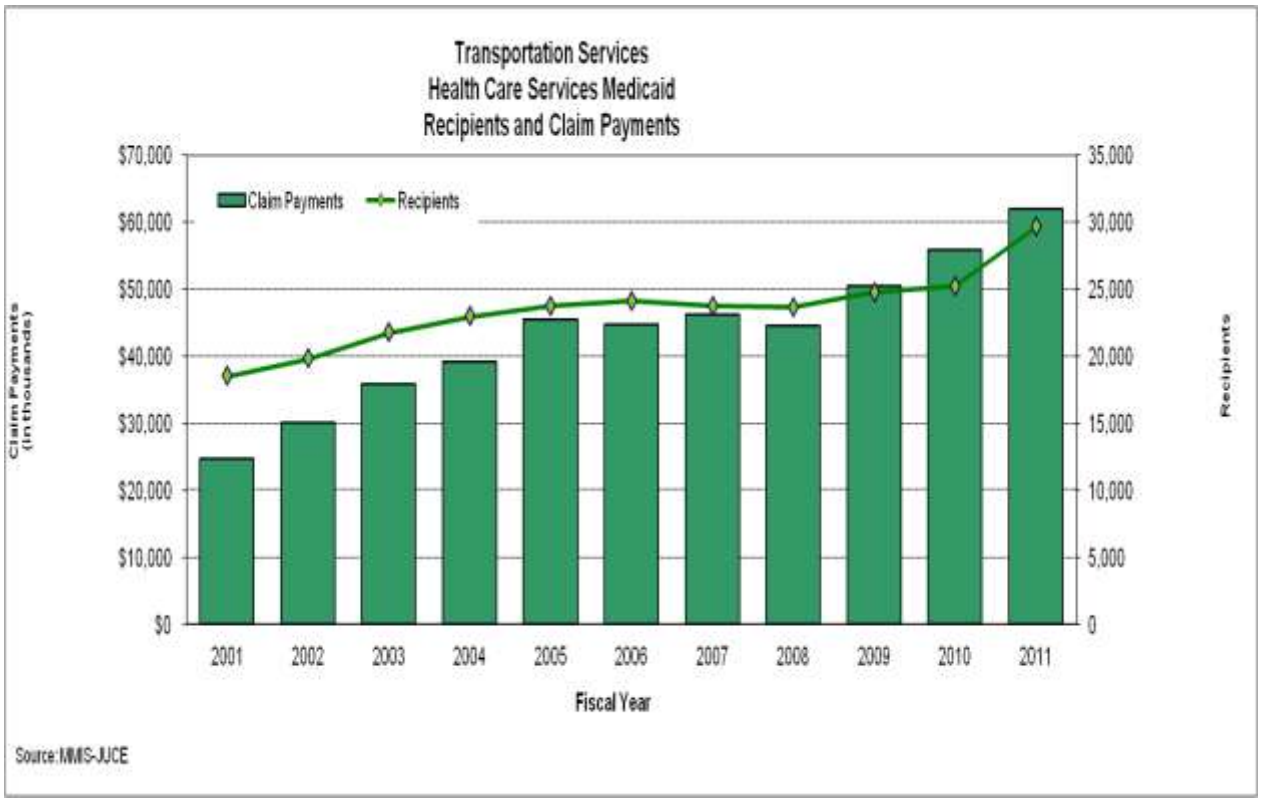
Pharmacy claim payments increased by 8.2% from FY2010 to FY2011. While pharmacy expenditures fell substantially during FY2006 and FY2007, due to the addition of Medicare Part D prescription drug coverage, there has been an increase in expenditures from that period forward. The number of Medicaid recipients receiving prescription drugs increased by 6.9% between FY2010 and FY2011, while the annual average cost per recipient rose by .6% during this period.



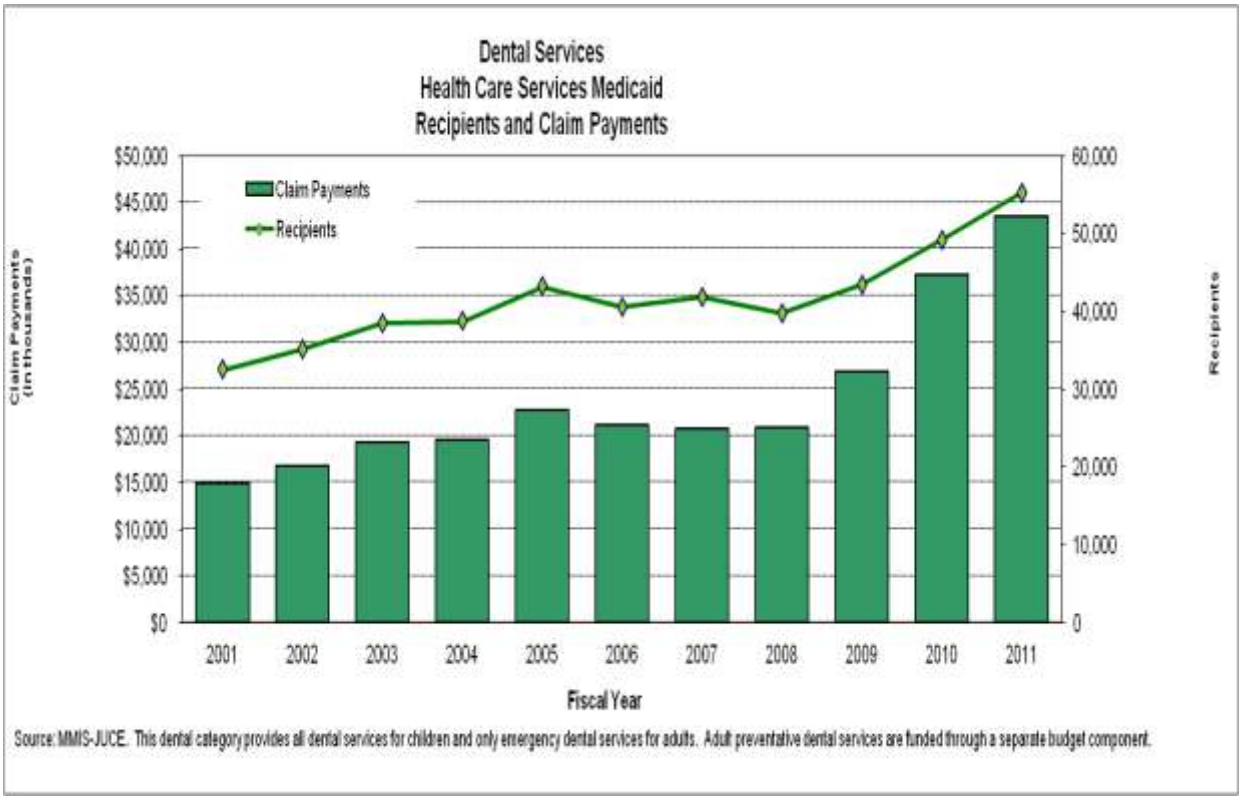
Claims payments for Medicaid physician services saw an increase of 5.8% between FY2010 and FY2011. The number of Medicaid recipients utilizing physician services during this period increased by 5.1%, while the average expenditure per recipient increased by $11.00, or .7%.



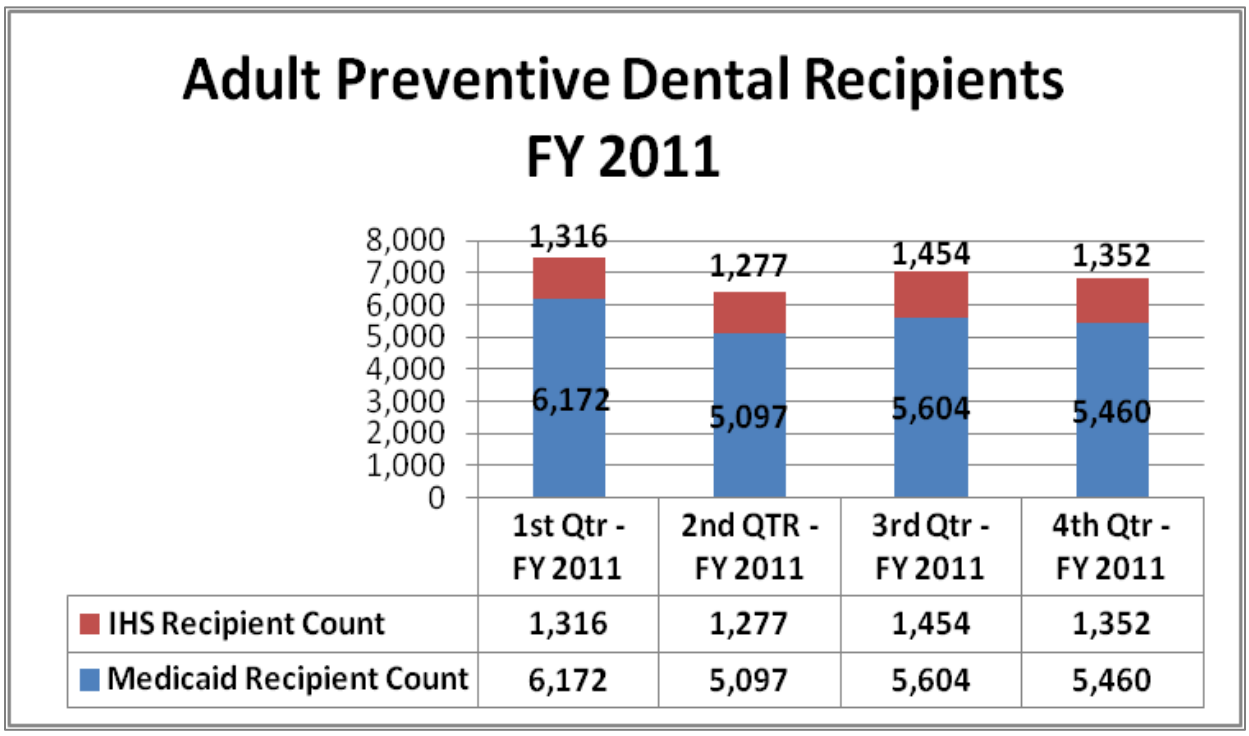
Expenditures for Medicaid transportation services grew by 11.2% between FY2010 and FY2011, due in large part to increased reimbursement rates and increased service utilization. The number of Medicaid recipients utilizing Medicaid transportation services increased by 17.5%, while the average cost per recipient decreased by 5.3%, from $2,214 in FY2010 to $2,096 in FY2011.



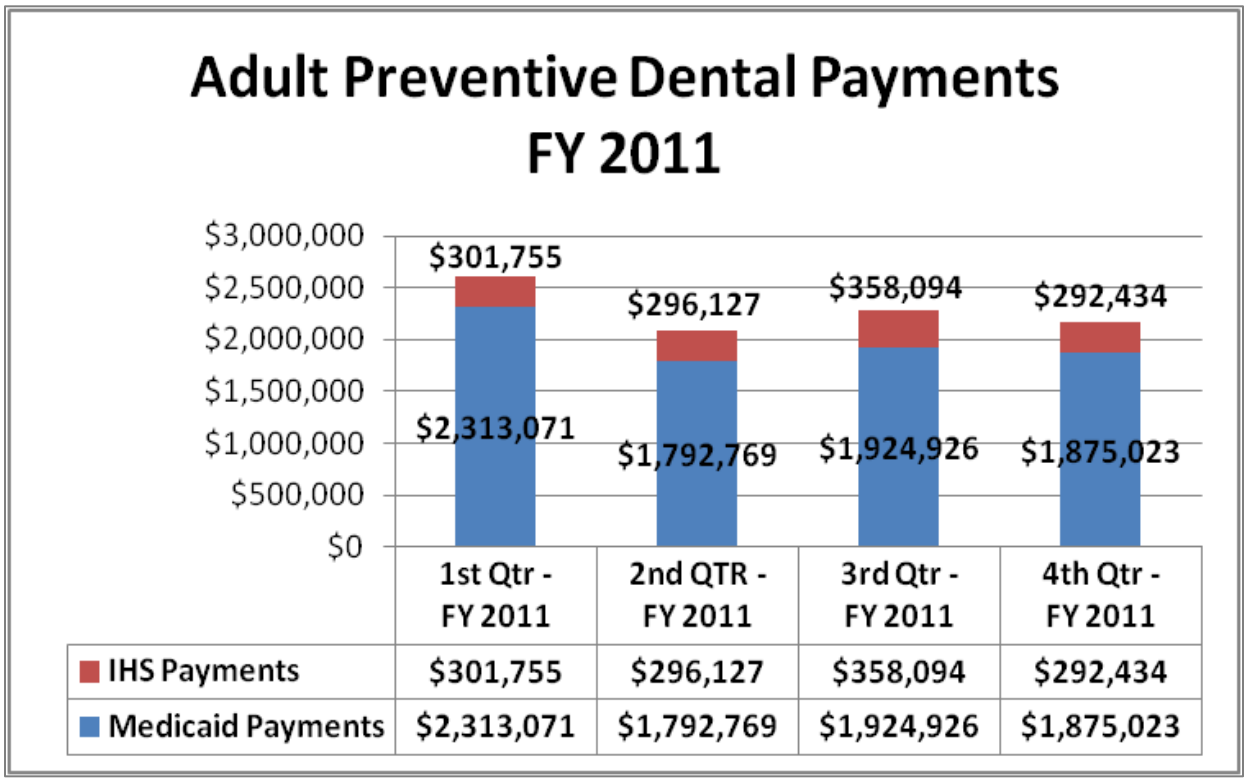
Total Medicaid expenditures for dental services increased by 16.8% between FY2010 and FY2011, while the number of Medicaid recipients utilizing dental services increased by 12.3%. The average cost per recipient increased by $34, or 4.1%, between FY2010 and FY2011.
(Note: Dental services discussed here do not include Medicaid adult preventative dental services.)



The Adult Preventative Medicaid Dental program was established with the passage of House Bill 105 in FY2006. Its implementation in April 2007 began a three-year trial period for the program. House Bill 26 (passed into law during the 2009 session) repealed the sunset clause in the original bill, and reauthorized the program to continue beyond June 30, 2009. The preauthorization requirement and annual cap per individual remains the same ($1,150 per year). The total program costs are subject to fiscal limits set by the legislature, ensuring that total program spending remains within the budgeted amount. (A separate Medicaid Services component program continues to pay for children's dental services and for adult emergency dental services.)

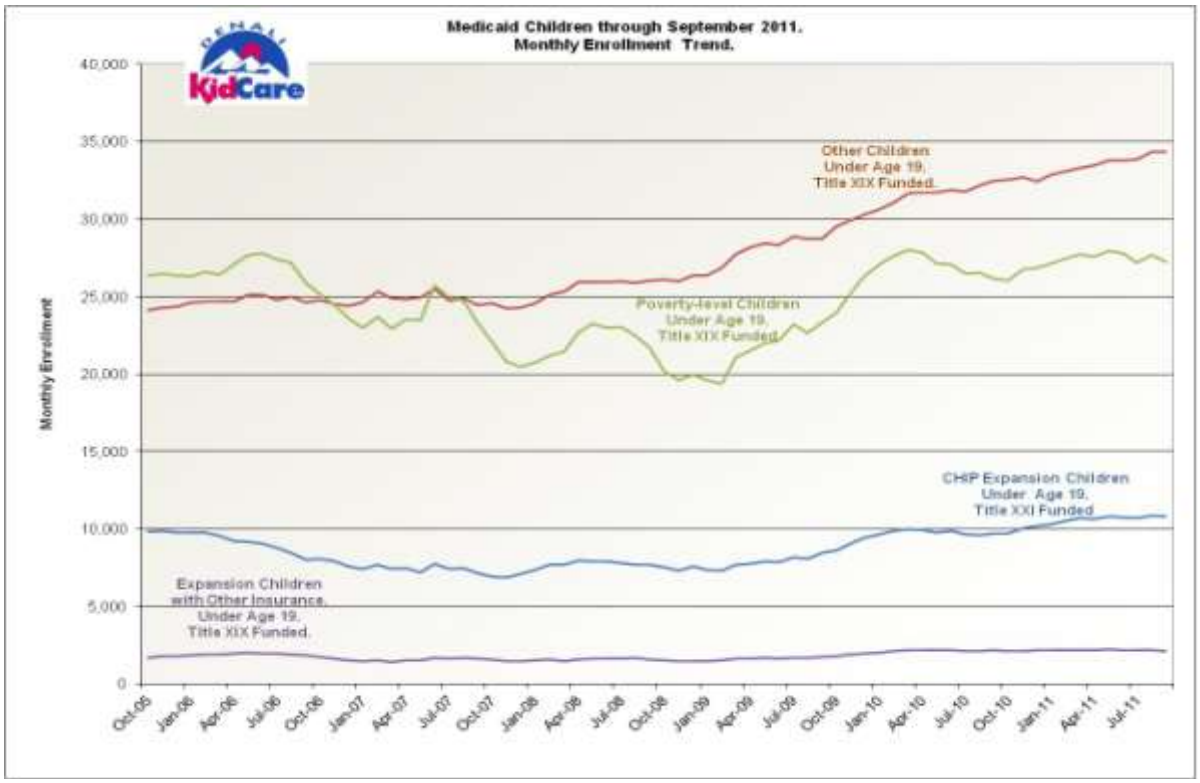


Source: STARS Data Download/AKSAS Authorization Report

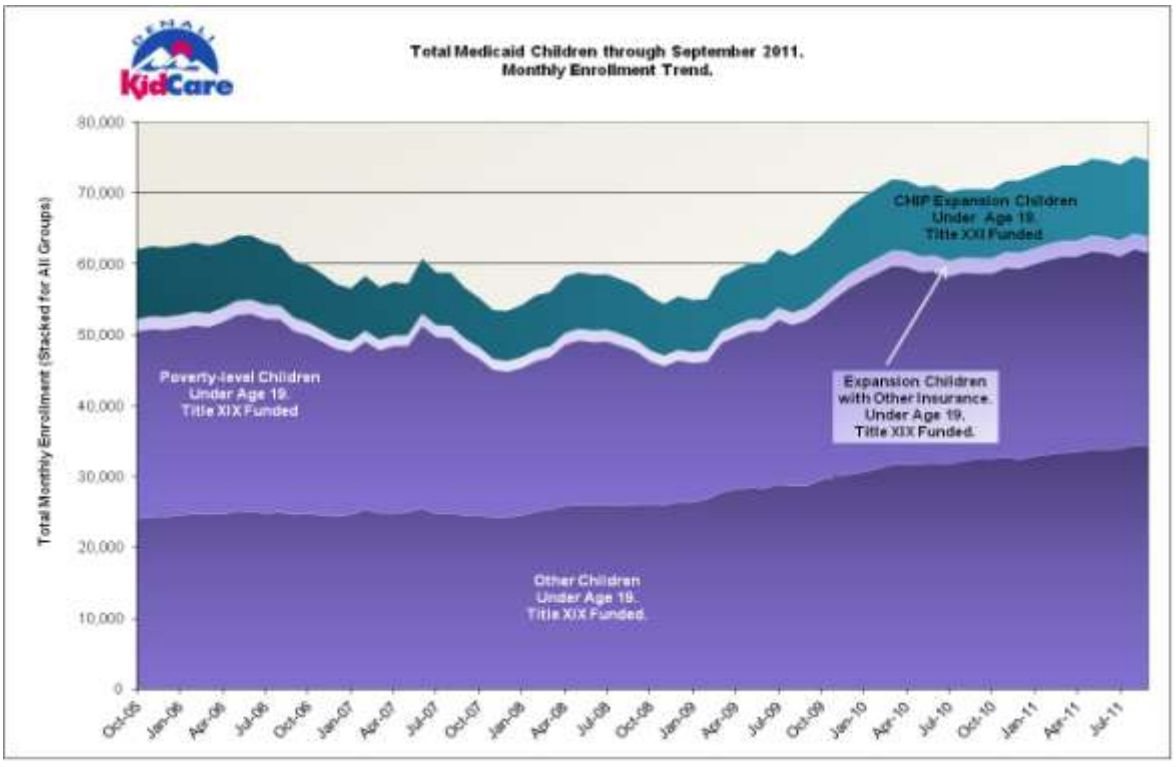


Source: STARS Data Download/AKSAS Authorization Report

Child enrollment in Medicaid/CHIP represents more than 2/3 of total Medicaid enrollment.



The teal green bar below reflects the number of children funded under CHIP with Title XXI enhanced funding. As of September 30, 2011, there were more than 70,000 children enrolled in Medicaid and the CHIP expansion.



FY 2011 DIVISION LEVEL SUMMARY: Health Care Services Medicaid	HEALTH CARE SERVICES MEDICAID CLAIMS (DIRECT SERVICES ONLY)				
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR
	Percent of Category	Annual Count	Percent of Category	Annual Total	
Medicaid, Division Annual Totals		**133,773**		**$726,131,688**	**$5,428**
Gender					
Female	56.3%	75,283	58.9%	$427,678,628	$5,681
Male	43.7%	58,523	41.1%	$298,453,060	$5,100
Unknown	0.0%	0	0.0%	$0	$0
Race					
Alaska Native	38.4%	51,695	42.4%	$307,582,851	$5,950
American Indian	1.6%	2,126	1.6%	$11,623,191	$5,467
Asian	6.4%	8,675	5.3%	$38,522,751	$4,441
Pacific Islander	3.3%	4,496	2.7%	$19,862,476	$4,418
Black	5.5%	7,434	4.7%	$34,218,449	$4,603
Hispanic	3.6%	4,828	2.7%	$19,346,476	$4,007
White	38.6%	51,977	38.3%	$278,398,651	$5,356
Unknown	2.6%	3,445	2.3%	$16,576,843	$4,812
Native	40.1%	53,801	44.0%	$319,206,043	$5,933
Non-Native	59.9%	80,374	56.0%	$406,925,645	$5,063
Age					
under 1	8.6%	12,504	13.2%	$96,116,714	$7,687
1 through 12	36.8%	53,630	19.4%	$140,847,150	$2,626
13 through 18	15.4%	22,483	10.8%	$78,398,041	$3,487
19 through 20	3.7%	5,354	3.5%	$25,736,540	$4,807
21 through 30	10.9%	15,877	14.8%	$107,728,335	$6,785
31 through 54	14.2%	20,641	23.9%	$173,192,984	$8,391
55 through 64	4.1%	6,032	9.6%	$69,387,243	$11,503
65 through 84	5.3%	7,697	4.3%	$31,288,721	$4,065
85 or older	0.9%	1,338	0.5%	$3,435,960	$2,568
Benefit Group					
Children	61.0%	82,989	41.3%	$299,707,538	$3,611
Adults	19.5%	26,508	23.5%	$170,777,159	$6,442
Disabled Children	1.8%	2,399	4.9%	$35,317,438	$14,722
Disabled Adults	12.2%	16,618	26.4%	$191,369,991	$11,516
Elderly	5.6%	7,621	4.0%	$28,959,562	$3,800
Location (DHSS Region)					
Anchorage/Mat-Su	48.8%	67295	62.2%	$345,047,432	$5,127
SouthCentral	13.3%	18285	17.5%	$97,040,220	$5,307
Northern	12.3%	16974	14.8%	$81,976,157	$4,830
Western	15.2%	20927	21.9%	$121,625,588	$5,812
SouthEast	9.2%	12673	13.2%	$73,309,324	$5,785
Out of State or Unknown	1.3%	1759	1.3%	$7,132,968	$4,055

Notes to HCS Medicaid Claims Table:

Payment amounts are net of all claims paid during the fiscal year. 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. Payment amounts may not tie exactly to amounts in AKSAS or ABS.
Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2010 (service may have been incurred in a prior year).
Grouping is based on status on the date the benefit was obtained (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 duplication may occur between subgroup counts. For example, if a 12 year old child with a September birth date 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 2009, they would also be included in the 13 through 18 age subgroup count if the claim was paid any time before June 30, 2010.
Location is based on residence of the recipient or enrollee, not the location where service was provided.
Division, Percent of Department Medicaid for all 4 divisions may exceed 100%.

Source: MMIS/JUCE.

List of Primary Programs and Statutory Responsibilities

AS 47.07	Medical Assistance for Needy Persons
AS 47.08	Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions
AS 47.25	Public Assistance
AS 47.30	Mental Health
Title 42	CFR Part 400 to End
Title XVIII	Medicare
Title XIX	Medicaid
Title XXI	Children's Health Insurance Program
7 AAC 43	Medical Assistance
7 AAC 48	Chronic and Acute Medical Assistance
7 AAC 100	Medicaid Assistance Eligibility
7 AAC 105-160	Medicaid Coverage and Payment
20 AAC 40	Mental Health Trust Authority

Division of Health Care Services

Budget Overview Table

Health Care Services	FY2012	FY2013 Gov	12 to 13 Change
Unrestricted General Funds	$11,710.8	$12,113.3	$402.5
Designated General Funds	1,836.7	1,909.6	72.9
Federal Funds	14,887.4	12,676.8	-2,210.6
Other Funds	5,751.1	5,554.7	-196.4
Total	**$34,186.0**	**$32,254.4**	**($1,931.6)**

Budget Requests/Adjustments

Medical Assistance Administration

Interagency Receipt Authorization Reduction: ($250.0) Total – ($250.0) I/A

Health Care Services requests a reduction of $250.0 in its interagency (I/A) receipts authorization. The division has determined that I/A funding requested in the FY2012 budget is not required in the FY2013 budget.

Federal Receipt Authorization Reduction: ($2,000.0) Total – ($2,000.0) Federal

Health Care Services (HCS) requests the decrement of $2,000.0 of excess federal authorization from the Medical Assistance Administration component. This excess federal authorization has been in the HCS budget for a number of years without any expectation of actual federal receipts collection. The authorization was originally placed in the budget to meet improvements to the legacy Medicaid Management Information System (MMIS) mandates issued by the Centers for Medicare and Medicaid Services (CMS). The amount listed above is no longer needed because the legacy MMIS mandates are less than originally anticipated.

Rate Review

Rate Settings and Acuity Measurement Systems: $640.0 Total - $320.0 Federal/$320.0 GF

Behavioral Health Outpatient Rate Setting and Acuity Measurement System
$100.0 ($50.0 Federal/$50.0 GF)

The Department believes it is necessary to update rate setting methodologies for outpatient behavioral health services. Work in other areas of the Department has shown that well-documented rate setting methodologies consistent with state and federal laws and regulations are invaluable in avoiding federal findings, and ensuring access to quality care for Medicaid recipients. After many meetings with providers and much review of formal public comments, the need for a robust acuity measurement system is obvious for rate setting and claims payment purposes as well as for Behavioral Health program administration.

Home Health Rate Setting and Acuity Measurement System
$100.0 ($50.0 Federal/$50.0 GF)

The Department has recently been informed that federal state plan reviewers find the current state plan requirements for home health services, in particular the rate setting methodology, unacceptable.

The Department proposes to hire experienced consultants as necessary to design and implement a rate setting system for Medicaid home health services in Alaska. The design would include a relationship to costs and related adjustments to Medicaid payment rates for various acuity levels.

Home and Community Based Services Acuity Measurement System
$300.0 ($150.0 Federal/$150.0 GF)

The Department over the last 2-3 years has worked to establish a new rate setting system for home and community based services. After many meetings with providers and much review of formal public comments, the need for a robust acuity measurement system is obvious for rate setting and claims payment purposes, as well as for the Division of Senior and Disability Services (DSDS) program administration. Without an accurate measurement of acuity, long term cost containment in rate setting would be compromised, access to services could eventually deteriorate for Medicaid clients, accurate trends in the condition of Medicaid clients and related impacts of policy decisions could not be measured, and provider concerns about the fairness of payment rates cannot be addressed completely.

Tribal Dental and Behavioral Health Encounter Rate Settlement Calculations
$140.0 ($70.0 Federal/$70.0 GF)

The Department has adopted encounter rate based payment methodologies for tribal behavioral health and dental payments. Since these new payment methodologies have not been incorporated into the Medicaid Management Information System (MMIS), the Department's Information Technology section is designing and operating systems necessary to reprocess fee for service claims into the appropriate encounter format.

Challenges

Adult Preventative Dental Medicaid Services

The Adult Preventive Medicaid Dental program was reauthorized in FY2009 when the three-year sunset provision was repealed.

The key to the continued success of the adult preventive Medicaid dental program is adequate provider capacity, both private dental participation in the Medicaid program and dental access through tribal and community health center dental programs. DHSS continues to work with the Alaska Dental Society to encourage more participation of private dentists in the Medicaid program. Other measures taken to increase provider participation include significant fee schedule increases in three of the four previous years, as well as new regulations to implement a mechanism for annually reviewing and adjusting dental reimbursement rates based on changes in the U.S. Department of Labor, Consumer Price Index.

.*Medicaid Services*

Health Care Services (HCS) continues to seek new ways to provide affordable access to quality health care services to eligible Alaskans. Ensuring there are sufficient numbers of enrolled providers, particularly in rural areas, continues to be a challenge.

The primary strategy to maintain adequate provider enrollment is to offer reimbursement rates that maintain pace with the rising cost of providing health care. During the past two years, rates paid to dentists, hospitals, nursing homes, ambulatory surgery centers, and other providers have been increased.

Adjustment of rates for physician, advanced nurse practitioner, chiropractic, direct-entry midwife, and other professional services that are subject to Resource Based Relative Value Scale (RBRVS) payment methodology has been problematic, as current regulations do not provide an objective means by which to make fee schedule adjustments. HCS is working to resolve this problem by proposing new regulations that will adjust RBRVS fee schedules in accordance with the U.S. Department of Labor's Consumer Price Index. The new regulations will propose to make all future adjustments effective July 1 of each year. In addition to providing objectivity to rate setting, rate adjustments will correspond with the state fiscal year for budgeting purposes. This change will allow adequate time for staff to review RBRVS changes published by CMS and effective January 1 of each year.

HCS is also exploring brokerage services and other means to expand ground transportation services, while simultaneously developing a sound payment methodology for taxi and other ground transportation providers.

HCS will need to adopt regulations and develop benefit packages for the projected 25,000 – 30,000 additional adults who will qualify for Medicaid in 2014 as a result of the Patient Protection and Affordable Care Act. It is speculated that many of the new enrollees may have chronic medical and/or behavioral health challenges. In addition, HCS will need to accommodate the resulting increase in claims, prior authorizations, and other claims-related activities.

Medicaid Pharmacy

The Department will begin work on a new dispensing fee survey in FY2012 to examine the current pharmacy payment methodology and evaluate whether future changes are needed to adequately and accurately reimburse pharmacy providers and ensure access to pharmacy services for Medicaid recipients. The pharmacy program will also implement the new pharmacy point-of-sale claims transaction standard mandated by HIPAA 5010 during FY2012. Implementation will present challenges for pharmacy providers, as they will have to update their claims processing software to submit claims compliant with the new transaction standard by January 1, 2012. Alaska Medicaid is prohibited from paying any pharmacy claims that do not comply with the new standard after December 31.

Tribal Medicaid

The Tribal unit of the Division of Health Care Services is required to draft, submit and gain approval on a Tribal consultation process that details the steps taken to inform Tribal Health organizations of changes to Medicaid State Plan Amendments (SPA) that affect American Indian/Alaska Native (AI/AN) beneficiaries.

The challenge in crafting this document is to meet the requirements CMS specifies for consultation without necessarily gaining consensus of all Tribal Health organizations. The goal is to ensure both parties are successful in defining and achieving consultation and gaining approval of SPAs that affect the whole Medicaid beneficiary base, which includes the AI/AN population. The other change that continues to be considered is cost-based reimbursement for Community Health Aide Practitioners (CHAP's) and the inclusion of behavioral health aides (BHAs) in the CHAP service delivery model. This effort follows the reimbursement request process through CMS, as was done for tribal dental and behavioral health services. The cost-based reimbursement of CHAP's, and inclusion of BHAs in the CHAP model, would provide improved financial stability allowing tribes to expand infrastructure and scope of CHAP/BHA services.

The more Medicaid services CHAP/BHA's provide in village-based tribal health care facilities, the more state general funds Alaska saves by insuring the federal government meets its trust responsibility to native recipients. The challenge this model creates is tension between tribal and non-tribal providers. The non-tribal providers continue to see this as the creation of a dual services delivery system. However, a separate rate would be closer to the actual costs of delivering services offered at Tribal facilities. Additionally, local access to health care reduces the cost of Medicaid clients traveling to receive similar care elsewhere in the state.

Chronic and Acute Medical Assistance (CAMA)

Health Care Services strives to stay within CAMA's limited budget while providing prescription drugs and outpatient care for approximately 600 recipients each month. CAMA funding is 100 percent GF.

Health Facilities Licensing and Certification

The ability to meet CMS survey-related mandates is dependent upon having qualified registered nurse surveyors. Due to a rigorous training and travel schedule, retention of staff is challenging. There is a 1-2 year orientation period and additional training is required for each facility type. Surveyors spend approximately 6 months of the year conducting surveys, with the majority being out-of-town.

The unit is conducting additional training surveys in an effort to meet the training needs of new surveyors. In addition, the unit implemented an internal quality assurance process to identify specific training needs. The State Agency is also exploring the implementation of a consultative, collaborative technical assistance program to promote regulatory compliance and improve nursing home care practices. Meeting these challenges can enhance safe and adequate quality of care, meet CMS mandates, and avoid serious delays in licensing and/or certifying new providers.

Medical Assistance Administration

Medicaid Management Information System (MMIS) Development Project

Federal law requires all states participating in the Medicaid program to operate an automated claims processing system that must be certified by the federal government. In FY2008 the State successfully bid and awarded a contract to Affiliated Computer Services (ACS). The contract includes: design, development and implementation (DDI) of a new claims payment system; a claims data warehouse information system; and operations of the new MMIS for five years.

The new MMIS, known as Alaska Medicaid Health Enterprise, is described by ACS as a sophisticated, web-enabled solution for administering all Medicaid programs. It was scheduled to be available to providers and recipients who participate in the Medicaid programs in FY2011. ACS has informed the Department that delivery of the source code for the Enterprise product will be delayed; therefore, Alaska Medicaid Health Enterprise will be delayed.

The MMIS DDI project team has received a complete, stable version of the Enterprise source code, and continues to build out the Alaska specific requirements. Alaska Medicaid Health Enterprise is expected to be available to state staff, providers, and members in 2012. The MMIS DDI project team continues to analyze and develop services that can be implemented before Alaska Medicaid Health Enterprise is fully operational, such as ePrescribe, Smart Non-Emergency Transportation (NEMT), and the early deployment of the data warehouse.

DHSS will be prepared to receive and send Health Insurance Portability and Accountability Act (HIPAA) X12N 5010 transactions and code sets by the mandated effective date of January 1, 2012 with the current legacy MMIS system. Alaska Medicaid Health Enterprise will be fully compliant with the 5010 transaction set at system go live.

Rate Review

Rate Review will complete implementation of acuity-based rate setting systems for behavioral health and senior services that will make rate adjustments based on the characteristics of individual clients and their needs. This item poses a challenge to HCS because once the acuity rate systems are designed for Medicaid Waiver and Behavioral Health services, full implementation, which will involve significant problem solving and working with providers on details of implementation, will proceed during this year.

The unit will also work to incorporate tribal behavioral health and dental encounter payment processes into the Department's Medicaid Management Information System (MMIS). This item poses a challenge to HCS because after years of processing tribal dental and behavioral health payments for services through specially designed data processing applications, the Department will shift this complex logic to an updated MMIS, with prior year adjustments, that can process those payments as part of claims processing.

Certification and Licensing

Advanced technology is critical in order to better utilize staff time and enhance data production for both the Background Check and Licensing programs. The Assisted Living Program is currently working on a request for proposal for case management software. Licensing staff have never had a program database, which has reduced their ability to obtain basic licensing identification information, requiring staff to utilize valuable time pulling hard copy information. A database will also serve as a tracking mechanism for licensing inspections, violations, investigations and other essential information needed to ensure the health, safety and welfare of those that reside in assisted living homes.

This coupled with a dramatic increase in the number of licensing complaints and complaints that involve health-related concerns, has also been a challenge. The future plan for the program is to reassess licensing positions, as they are vacated, with the anticipation of having the medical and/or geriatric expertise to sufficiently work with providers in adapting to a higher level of need resident population.

The Background Check Program will also work toward enhancing their database in an effort to streamline processes. With an antiquated database, the program has unintentionally caused delays in providing timely background checks, impacting the ability for applicants to go to work. With funding from a competitive grant from the Centers for Medicare and Medicaid Services, emphasis is being placed on replacing the current database with a new and improved program. In addition, plans are in place to expand the use of live scan machines, statewide, in order to capture fingerprints electronically that can be transmitted straight to the Department of Public Safety (DPS); thus, elevating the need for paper copies that may need to be mailed to the DPS which in turn causes further delay. The goal is to provide background checks in a seamless, expeditious way to encourage the marketability of jobs in the health care service provider industry.

Other Challenges

In FY2013, Health Care Services will be leading departmental efforts to keep the Medicaid program fully compliant with the federal mandate to implement a new version of the code sets used for reporting diagnoses and inpatient hospital surgical procedures. This is the International Classification of Diseases version 10 (ICD-10) mandate. The ICD-10 project requires significant work efforts to analyze and convert to a new code set for all current program rules that use diagnosis criteria. The implementation date for this mandate is October 1, 2013. Project work efforts commenced in FY2011 and are ongoing in FY2012.

Also in FY2013, Health Care Services will be developing solutions to respond to a federal mandate relating to insurance plan IDs. This is the National Plan ID mandate. This mandate is an outgrowth of the 1996 federal HIPAA legislation; it establishes national identification numbers for health plans. Federal Medicaid rules require that services for clients with both private insurance and Medicaid coverage be first processed by the private insurance payer before consideration for payment by Medicaid. The electronic exchange of this payment information will need to incorporate the National Plan IDs.

In addition to these items, Health Care Services will be managing the project to re-enroll all Medicaid providers. This project will begin in FY2012 and continue in FY2013 leading up to the implementation of the replacement of MMIS.

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 an increase in IHS billings, the target strategy of increasing IHS billings by 5% was realized, with an increase of approximately 7% from FY2010 to FY2011.
In addition, the division far exceeded the target of a 2% increase in GF recovery. Recovered GF increased by approximately 28.7% in FY2011 when compared to FY2010.
*Note: The large increase in recovered GF during FY2011 can be attributed to an expanded focus on estate recoveries during this period. THIS INCREASE IN RECOVERED GF MAY NOT BE NOTICED IN FUTURE FUNDING CYCLES.
Source: FY2011 AKSAS Authorization Report/ FY2011 TPL/Recovery Quarterly Payment Reports

Health Care Services Actuals - Other Funds (by percentage)

Fiscal Year	% Federal	% General	% Other
FY 2011	51.1%	40.1%	8.8%
FY 2010	69.2%	30.0%	0.8%
FY 2009	58.8%	34.7%	6.5%
FY 2008	64.6%	32.3%	3.1%
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%	0.8%

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).

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 increased from FY2010 to FY2011. Total IHS expenditures were $206.0 million in FY2011, compared to $192.7 million in FY2010, an increase of approximately 7% in FY2011. The increase in IHS participation is attributable to a number of factors, but the two projects which contributed the most to the increase were the updating of race codes in EIS to insure a higher percentage of IHS eligible claims were billed accordingly, and the addition of three new IHS facilities during FY2011.
(Source: 2011 AKSAS Authorization Report, Tribal Health Team)

Health Care Services IHS Participation (in millions)

Fiscal Year	Total Exp	IHS	% of Total	% Increase
FY 2011	$726.1	$206.0	28%	7%
FY 2010	$671.5	$192.7	29%	21%
FY 2009	$573.4	$159.3	28%	9%
FY 2008	$517.9	$146.3	28%	9%
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 Services (IHS) expenditures increased from FY2010 to FY2011 by $13.3 million. The increase can be attributed to a higher percentage of IHS claim filings, increased utilization of IHS facilities, the addition of three new IHS medical

facilities, and the updating of EIS eligibility records to insure correct race codes have been applied to recipients to correct billing irregularities.

IHS facilities are reimbursed for Medicaid services at a 100% federal participation, whereas non-IHS facility patient costs require a state match of GF funds 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) recipients going to non-tribal facilities. Certain tribal entities with 638 statuses receive 100% FMAP for service delivery to AI/recipients, thus assisting the state with maximizing federal reimbursement through Centers for Medicare and Medicaid Services.

In addition, the Department completes periodic data matches between IHS and the MMIS to ensure that AI/AN recipients are appropriately coded in the Eligibility Information System (EIS) as noted in Status #1.

This allows DHSS to capture 100% FMAP vs. the standard match for non-native recipients. Once AI/AN recipients are connected to a tribal healthcare delivery system that is eligible to bill Medicaid, recipients can access additional service areas as required. Depending on the door recipients enter, (for example: behavioral health, rural health clinic, or dental services facility), 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 services the long-term system can provide.

A2: Strategy - Expand fund recovery efforts.

Target #1: Increase funds recovered by 2%.
Status #1: The division exceeded the 2% target for increasing GF recovery during FY2011. The division experienced an increase in recovered funds of approximately 29.7% in comparison to FY2010.
*Note: Increases in recovered GF during FY2011 can be directly attributed to an expanded focus by the Third Party Liability (TPL) Unit on subrogation, AG restitution/subrogation, drug rebates, Miller Trust recoveries, and increased oversight of health services utilization.
The large increases in recovered GF may not be attainable in future funding cycles.
Source: TPL/Recovery Quarterly Recoupment Reports

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

Year	Drug Rebates	TPL	Total	% Change
2011	37.8	54.2	92.0	30%
2010	28.9	42.0	70.9	107%
2009	24.0	10.2	34.2	14%
2008	21.6	8.4	30.0	0%
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 increased by 29.7% between FY2010 and FY2011. The increase in recoveries experienced during FY2011 can be attributed to a number of factors, the majority of which are listed above in Status #1.

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: The definition of enrolled provider has changed in FY2011 as the Department makes a concerted push towards group enrollment, statutory requirements for enrollment of PCAs as rendering providers, and similar changes in enrollment requirement statutes. This being said, there were 11,642 eligible Medicaid providers enrolled during FY2010. This number has increased (due to the reasons mentioned above) to 16,441 eligible Medicaid providers in FY2011. This represents an increase of 41.2% in eligible providers.
Note: The comparison between FY2010 and FY2011 is for informational purposes only. A more accurate comparison of providers will be shown between FY2011 and FY2012 due to re-enrollment under the new statute parameters listed above.
(Source: MARS MR-O-02-M Medical Assistance Program Status)

Number of Providers Enrolled in Medicaid

Year	Applications Received	Applications Denied	Applications Approved	Providers Inactivated	Enrolled Providers
2011	3,600 +30.43%	185 +6.94%	2,942 +6.59	1,213 -20.46%	16,441 +41.22%
2010	2,760 +11.74%	173 +35.16%	2,760 +12.75%	1,525 +53.73%	11,642 +13.53%
2009	2,470 -0.36%	128 +19.63%	2,448 +24.77%	992 -47.12%	10,255 +15.01%
2008	2,479 -0.24%	107 -61.09%	1962 -2.87%	1,876 +22.14%	8,917 -25.16%
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

Methodology: source: Affiliated Computer Systems, Provider Enrollment Subsystem FY2011.

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 Medicaid 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 discontinuing their enrollment.

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 contributing factor to provider participation and enrollment figures 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 targeted at increasing provider enrollment or participation.

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 witnessed a decrease of approximately 3 days in adjudication time from receipt of a claim to final adjudication, decreasing from 11 days in FY2010 to 8 days in FY2011. This represents a decrease in adjudication time of approximately 27%. The time required for claim processing depends largely on the method of claim submission, the type of claim submitted, and the day of the week the submission occurred. For example, a point-of-sale pharmacy claim submitted on Monday may only take one day to process, whereas an inpatient hospital claim may take several days for processing due to a pending claim resolution, requests for additional documentation, etc. At this time, it can be safely assumed that an average processing time of 6 days from entry to adjudication for all claims would be the maximum efficiency attainable with the necessary constraints noted above.

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

Fiscal Year	Medicaid Claims	Average Days	Days Changed
FY 2011	8,961,689	8	-3
FY 2010	8,215,221	11	-4
FY 2009	7,509,326	15	4
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: Source: MARS MR-0-08-T. No national average available.

Analysis of results and challenges: Average days to pay between FY2010 and FY2011 decreased from 11 days to 8 days.

There may be several reasons for the continuing decrease in claims processing times, though the most prominent of these would be the continuing Medicaid claims processing familiarization occurring with ACS staff members. As the contractor employees acquire experience, the ability to supply accurate provider helpdesk information, and provide the necessary provider outreach and training, a decrease in processing times would be the expected result, and is noticeable in the above comparison. There are other behind-the-scenes factors which may also contribute to the decrease, such as electronic claim submissions, clear and concise medical coding instructions, etc. It is the coordination of all these factors that are having a positive impact on claims processing times outlined in the above table.

B2: Strategy - Improve payment efficiency.

Target #1: Increase the percentage of adjudicated claims paid with no provider errors.
Status #1: The percentage of claims paid without error remained at 75% between FY2010 to FY2011.

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

Year	Medicaid Claims Paid	% No Errors	% Change
2011	7,284,060	75%	0
2010	6,648,011	75%	-4%
2009	5,858,223	79%	-2%
2008	5,550,357	81%	9%
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. This measurer is updated quarterly.
2. 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 ensure timely claims payments. ACS, 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.

At this time, it is not possible to predict the effect changes in claims billing procedures implemented with the change to ICD-10, in tandem with implemented billing processes necessary to support the Affordable Care Act will have on the provider claims billing, and payment of claims without errors. Large amounts of provider outreach and clarification of coding questions have been underway by both the fiscal agent and the Department in an attempt to raise the percentage of claims adjudicated without error. However, it can be stated with a fair amount of certainty that a percentage of 80% of claims adjudicated without error would be the highest threshold attainable.

FY2013 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2013 Governor's Request for Health Care Services General and Other Funds (Increase, Decrease and OTI Items Only)					
Item	UGF	DGF	Federal	Other	Total
Delete Unrealizable Authorization	$ -	$ -	$ (2,000.0)	$ -	$ (2,000.0)
Unrealized Authority	$ -	$ -	$ -	$ (250.0)	$ (250.0)
Authority for Collection of Civil Money Penalties for Protection of Nursing Home Residents	$ -	$ 60.0	$ -	$ -	$ 60.0
Rate Settings and Acuity Measurement Systems	$ 320.0	$ -	$ 320.0	$ -	$ 640.0
Reverse American Recovery and Reinvestment Act (ARRA) Funding Sec 33(d) CH3 FSSLA2011 P92 L8-12 (HB108)	$ -	$ -	$ (625.4)	$ -	$ (625.4)
Health Care Services Total	***$ 320.0***	***$ 60.0***	***$ (2,305.4)***	***$ (250.0)***	***$ (2,175.4)***