

2005



Division of Health Care Services

Recipient Services
Annual Report

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This report is intended for Health Care Services staff.

Executive Summary

Recipient Services is immensely proud of this, our first annual report. Over the past year, we have supported our co-workers in the development of new programs and processes, made enhancements to existing programs and experienced a few setbacks. This report highlights these activities and identifies our goals and objectives for the coming year.

One of our biggest challenges was the implementation of the State Travel Office (STO). We invested significant resources in making this program not only viable, but a considerable success. The State Travel Office is able to make booking arrangements, sometimes within minutes, so that recipients and loved ones continue to access health care. With assistance, the STO has increased their knowledge and skills in medical claiming.

The Lock-in program (the Medicaid program that assists recipients in the management of their medical care) experienced a legal challenge that required current participants be dis-enrolled while managers retooled the program. We used the hiatus to adopt new regulations that added a medical records review prior to placement and we changed the name. The new name, the Care Management program, is a better description of the continuity of care afforded by the program. Once legal reviews are completed, we expect to begin enrolling participants sometime in March or April 2006.

Requests for fair hearings significantly increased this year from 272 in 2004 to 448 in 2005. The increase is due to changes in the Choice waiver level of care and we expect fair hearing requests to remain steady with pending changes to the personal care attendant program. We are seeking legal advice on notices sent to recipients requesting reimbursement for services paid out of pocket.

The Early and Periodic Screening, Diagnosis and Treatment program implemented quarterly meetings with immunization and public health to discuss children's health care issues that require mutual coordination. The program has also analyzed the use of ground transportation and is achieving cost efficiencies by switching agreeable families from taxi to bus travel.

The Recipient Helpline continues to be a valuable asset to recipients and Division of Health Care Services staff alike. The Helpline identifies pressing issues across various programs and it allows us to solve issues before they escalate. This past year the State Travel Office and Medicare Part D have been two of the most urgent issues that the Helpline has managed.

We offer this report as an illustration of the achievements and challenges experienced by the Recipient Services unit, and we conclude with the results of our Strengths, Weaknesses, Opportunities and Threats analysis, goals and objectives.

Sincerely,



Jeri Powers, Manager

Gerry Johnson, Medical
Assistance Administrator II

Sandy Ahlin, Medical
Assistance Administrator III

Mike Huelsman, Health and
Social Services Planner II

Laurie Barter, Medical
Assistance Administrator II

Vision, Mission, Values

Vision

Make a positive difference in the lives of Alaskans through knowledge and commitment to excellence in health care administration.

Mission

We will make a difference by:

Enjoying the privilege of reaching out to meet the needs of others;

Wisely caring for and sharing human, ecological and financial resources held in trust;

Provide and promote access to health care;

Increase awareness of our programs through outreach services.

We value

Equity and fairness in all relationships.



The Gumlikpuk family of Kwethluk.

Implementation of State Travel Office

The Department contracted with USTravel (dba State Travel Office) to begin providing travel services for Medicaid recipients effective January 1, 2005. A short implementation timeline caused a flurry of ramp-up activity in December, 2004, with daily meetings, systems interface sessions for the two contractors and required notices for providers, air carriers, recipients and individual travel agencies.

First Health Services began faxing Prior Authorizations to USTravel the last week in December, 2004, for travel that crossed over into the new year. During that introductory week, activity was brisk yet manageable with USTravel receiving 557 prior authorizations and processing 235 travelers. On January 3, 2005, the State Travel Office's phone system failed to handle the volume of total activity. An interim plan was developed until USTravel could add more phone lines to their system. Agents were stationed at First Health with urgent travel calls forwarded and then triaged to available agents throughout the state. Within a remarkably short period of time, USTravel added additional telecommunications trunk lines, increased the number of agents and centralized operations into their Anchorage headquarters.

As we implemented the State Travel Office, our concern was that no single travel agency could manage the demands of hundreds of daily travelers. Medicaid recipients are used to a responsive system allowing them to travel literally within minutes if needed. None of our fears were realized. Well-child screens¹ have remained steady or have increased slightly, and we have received only 55 complaints (0.23% of all Helpline calls) about the new system.

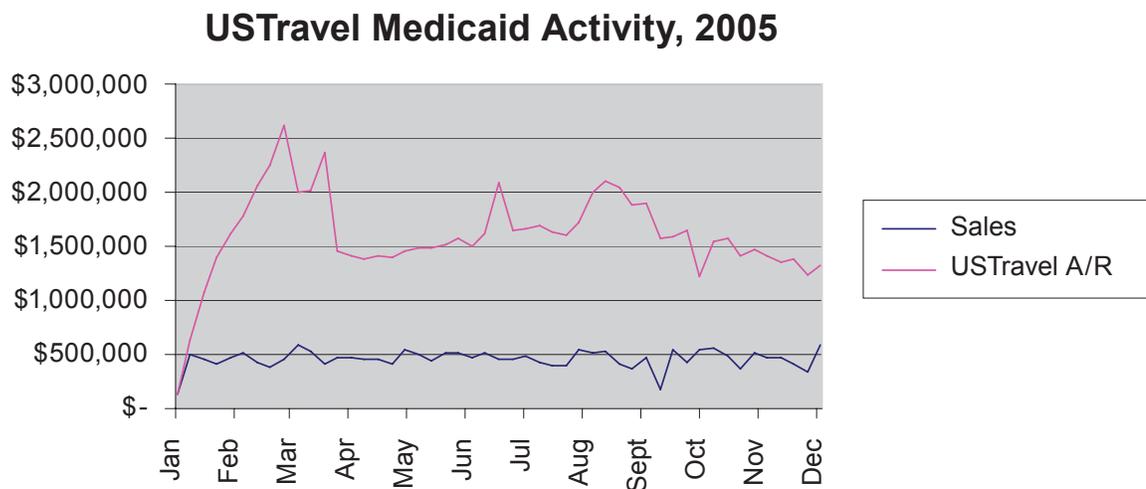
Through weekly meetings and ongoing efforts, we have refined, updated and strengthened our travel systems. Highlights include:

	Activity	Outcome
1-31-05	Changed unit configuration to one unit equals one-way, regardless of the number of legs in the one-way segment	Improved tracking of trips
3-7-05	Activated service code A0170	Better tracking of service fees
4-19-05	Implemented cell phone contact exclusively for urgent travel	Individuals on the organ transplant list have direct contact with an agent
June 05	Implemented ongoing claiming and adjustment oversight	Incremental improvements in claims accuracy
7-29-05	Introduced 9-day lag into billing cycle	Increased time to research and submit clean claims. Denial rate decreased from 5.0% to 2.6%
8-22-05	Submitted Freedom of Choice Waiver to CMS	Better use of cost-effective air carriers once the waiver becomes effective
11-5-05	Added weekend PA staff	Improved customer service
12-5-05	Added new procedure for managing a "used" PA	Reduce denied claims
In process	Provider contracts	Stabilize air fares

¹ Most children living in rural areas travel for a well-child screen.

Implementation of State Travel Office

The following graph summarizes USTravel billing activity over the past year. While sales are relatively consistent at \$450,000 per week, accounts receivable are remarkable for their variability. January through March reflects USTravel's learning curve on medical claiming and use of an inefficient manual data-entry billing system. The sharp decline in receivables the latter part of March represents full implementation of an electronic billing process.



Seeing a gradual increase in receivables April through June, Health Care Services and Department of Administration met with USTravel in July to discuss claiming practices. USTravel responded to our concerns by implementing a variety of quality assurance practices to include better management of incoming prior authorizations, increased staffing in the accounting office and improved billing practices. The “v-notch” in September sales represents the nine day delay before submission of claims with an associated decline in receivables some two weeks later.

Health Care Services contributed by providing support staff to assist in all aspects of claims processing. Laurie Barter met daily and then weekly with accounting staff to assist with claims and adjustments. Due in part to Ms. Barter's efforts, Medicaid has recovered \$98,320 in adjustments and \$214,000 in voided claims.

The State Travel Office is in the process of developing a Remittance Advise database. This database will be an extremely useful tool for the State Travel Office accounting staff to view and research all details of a claim.

Recipient Services participates in weekly accounting meetings with the Department of Administration and USTravel. This has been beneficial in keeping all parties updated about the utilization of the asset account and an opportunity to brainstorm on ways to improve travel and billing processes.

Implementation of State Travel Office

Performance measures were implemented for the State Travel Office in the last quarter of 2005 with results still being compiled. As part of the service performance measure of their contract, customer satisfaction surveys were sent out to recipients and providers. Of the 450 surveys sent out, over 80 have been received for a return rate of about 18 percent. Using a Likert Scale, the State Travel Office has received a 93 percent satisfaction rating from recipients, health aides and parent/family members.

The following is a synopsis of first year State Travel Office operations:

	Total Items Received or Processed	Average Cost per Transaction	Sales
PA's Received	75,384		
Travelers Processed	77,989		
Air Transactions Issued	79,188	\$284.14	\$22,500,662
Ferry Transactions Issued	2,039	\$51.56	\$105,138
Transaction Fees	63,664		\$1,353,138
Totals			\$23,958,938

In summary, the benefits of centralized services through the State Travel Office include:

1. Higher level of customer service
2. Improved managerial controls
3. Reduction of provider and recipient misuse of the program
4. Air carriers no longer need to submit medical claims for reimbursement

Contractor Meetings (First Health Services & the State Travel Office)

Because 95 percent of calls received by the prior authorization staff are related to travel, Recipient Services meets biweekly with the prior authorization manager to discuss issues as they occur. These meetings have proven to be a valuable tool to provide additional policy clarification and procedures for the prior authorization staff via flow charts and written guidelines. Open communication, documentation of data and utilization of resources are essential to the continued success of the prior authorization process, and Recipient Services is committed to their success.

In 2005, the prior authorization staff generated 46,779² approved prior authorizations for travel alone.

In efforts to keep the prior authorization data flow and communication open between First Health Services and the State Travel Office, Recipient Services participates in monthly meetings with both contractors. This was implemented in December and, although not long-standing, has been beneficial. The First Health prior authorization manager and the USTravel Medicaid agent manager are the contractor participants.



² Unduplicated

Fair Hearings

During the 2005 calendar year, 448 hearings were requested. We have received 33 decisions with the Agency upheld in 24. The Agency was reversed in six hearings with three mixed decisions. The breakdown by Agency:

	DSDS LOC	DSDS Misc ³	DHCS	Qualis
Hearing Scheduled or awaiting a decision	33	10	7	5
Hearing withdrawn	91	30	15	5
Hearing conceded	156	14	19	13
Hearing abandoned	1	1	1	1
Stayed due to court challenge	7			
Hearing dismissed		4	2	
Agency upheld	19	5	2	0
Agency reversed	1		3	1
Mixed Decision		1	2	
Totals	308	64	51	25
Percent of total hearings	69%	14%	11%	6%

³ Includes Children with Complex Medical Conditions waiver, Mentally Retarded/Developmentally Disabled waiver, Personal Care Attendant, Respite and Covered Services

Lock In Program

- Since 1992 a total of 309 recipients have been placed in the Lock In program. Average placement for each recipient lasted an average of 12 months.
- The total number of recipients active in the Lock In program during 2005 was 133.
- 117 of these recipients were actively participating in the Lock In program during the third quarter of 2005 — which was the final quarter for the Lock in program.
- Alaska Legal Services represented a recipient during a Fair Hearing regarding placement in the Lock in program. Decision was in favor of the recipient.
- Alaska Legal Services proposed a class action lawsuit against the Department regarding the agency's notice and also challenged the regulation that allowed for a presumption that a service had been used at a level that was not medically necessary.
- All Lock In recipients were withdrawn from the program by October 1, 2005, whether or not they had been in the program for 12 months.
- The Lock In program is replaced with the Care Management Program.

Care Management Program

New regulations were drafted and went into effect September 23, 2005, that replaced the existing Lock In regulation.

- An additional step of medical records review has been added to the selection process. A health care professional reviews medical records and determines if the excessive use of services by the selected recipient was medically necessary.
- Notice of placement into the Care Management program now includes the results of the medical review.
- The revised notice has been with Alaska Legal Services since October 3, 2005, with additional requested information provided to them on December 14, 2005.
- The Care Management Program is “on hold” until Alaska Legal Services reviews the notice and communicates its intent regarding the class action lawsuit.
- Recipients have been selected and medical reviews are completed and ready to be sent out when we receive notice that the lawsuit has been dismissed.

Plan

- Ten to 15 recipients will be placed in the Care Management Program each month.
- Comparative usage of medical services will be tracked and reported to the Agency by First Health to include quarterly and yearly use for each recipient. This will include the year prior to placement, during placement and the year after completion of 12 months of eligibility on the Care Management Program.
- Reports mentioned above will track the change of financial burden on Medicaid as services are accessed by Care Management Program participants.
- Anticipate fair hearing requests will significantly decrease due to comprehensive new notice.

Care Management Program

Challenges

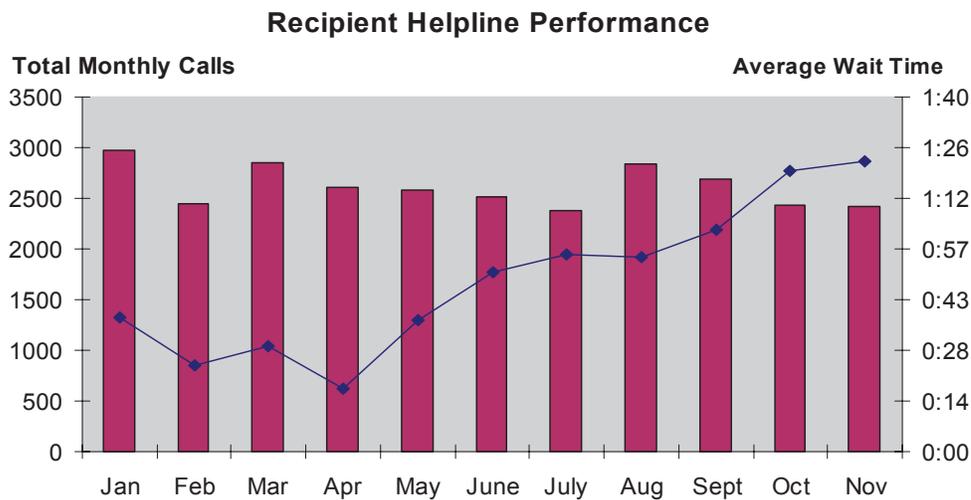
- Providers do not return medical records within the two-week timeframe. Medical necessity reviews for selected recipients are delayed while waiting for providers to send requested records.
- Completing the process of placing a recipient in the Care Management Program has become more time-intensive due to the wait for medical records and the addition of a medical review.
- Recipient Notices are now approximately 14 pages long due to the inclusion of the medical review, thus increasing mailing costs.

Summary

The Care Management Program Staff with First Health have been professional and innovative during this transition from the Lock In program to the Care Management Program. It is the norm for them to go above and beyond what is requested of them by Health Care Services. They act as case managers for the recipient as well as the provider, and perform the duties of a liaison between the two with commendable patience and professionalism. Bimonthly meetings between Health Care Services and First Health Staff have proven to be very helpful and assists in setting realistic goals for this program, which are consistently met and often times exceeded.

Recipient Helpline

The Helpline remains a valuable resource for Medicaid recipients with very few customers expressing dissatisfaction. During 2005, the Helpline experienced a reduction in staff from five to two resulting in increased wait time. On average the Helpline receives about 2,600 calls per month.



The tracking of “Hot Topics” in the Remedy database has been in effect since establishing the Helpline. These topics have included calls concerning the implementation of the State Travel Office as well as the newly implemented Medicare Part D. This tracking provides a guide as to how well the information that is provided to the recipient is received and understood.

Plan

- Implement Quality Assurance process
- Monthly meeting with Helpline staff to review questions and concerns

The Helpline Business Cards have been in great demand this year. The Division of Public Assistance offices have especially found them to be a good asset to provide to recipients at the time of application or review.

Recipient Reimbursement

There were 97 recipient requests for reimbursement for out-of-pocket expenses in 2005.

- Data for 2004 are incomplete; however we estimate a total of 48 reimbursement requests. Reimbursement requests for 2005 have doubled

Plan

- Review reimbursement request process
- Establish parameters for accepting requests for reimbursement when no denial exists
- Review amount that recipient is reimbursed — out-of-pocket vs. Medicaid allowed amount
- Reduce number of fair hearing requests for direct reimbursement to recipient

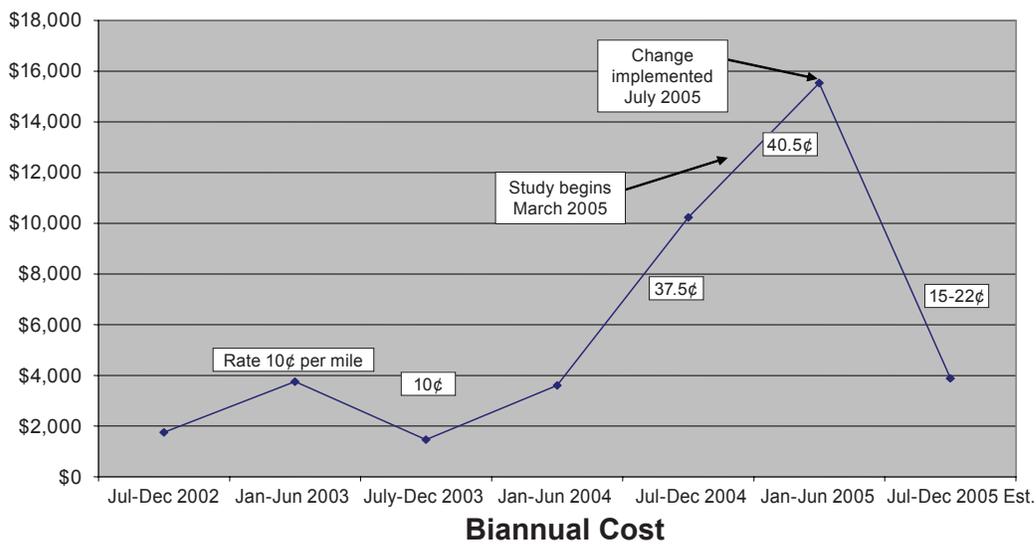
Mileage reimbursement for use of personal automobile

Prior to May 2004, ground transportation was paid at 10 cents per mile. It was decided this rate was too low and was changed to 37 cents per mile, the rate paid for state employees. This in turn was automatically raised to 40.5 cents per mile January 2005.

Starting in March 2005 we began a study of Early and Periodic Screening, Diagnosis and Treatment travel expenditures. As shown in the chart below, mileage reimbursement expenditures per six-month period rose sharply after changing to the state employee rate and peaked in the first half of 2005 at over \$15,000. Between July 2002 and June 2004 the cost of travel ranged from about \$1,500 to \$3,000 per half-year period.

Starting July 2005 we based the mileage rate on the IRS Standard Mileage Rate for vehicle travel for medical purposes. The lower rate, which was regularly adjusted due to increases in gasoline costs, ranged between 15 cents and 22 cents a mile between July and December 2005. Starting January 1, 2006, it is 18 cents per mile. After implementation to the lower rate, the number of trips billed dropped from 174 for January through June 2005 to about 75 for July through December 2005. In addition, as shown in the chart below, the costs also dropped to less than \$4,000 for the last six months of 2005. During the first half of 2005 staff spent a considerable amount of time assuring that travel was medically necessary and not overbilled. Since the change these problems have almost ceased.

Cost of Mileage Reimbursement in Six Month Intervals, July 2002 to December 2005



Encourage use of Anchorage People Mover Bus Passes

The Early and Periodic Screening, Diagnosis and Treatment travel program has begun experimenting with using the Anchorage bus system. In the fall of 2005, it formed a partnership with a social worker at Alaska Native Tribal Health Consortium to provide bus passes to parents. This service assisted the health consortium in reducing the length of hospital stays. We used the opportunity to experiment using bus transportation instead of taxis. Besides using the pass for medical purposes, the parents can use it for other useful purposes. A monthly adult bus pass is usually \$50. However, the Early and Periodic Screening, Diagnosis and Treatment travel program is eligible for a 50 percent discount or \$25 per month for an adult. Half-month passes can be purchased around the 15th of the month for \$12.50. Youth passes are half the cost of adult passes.

All of the parents with hospitalized children accepted the offer. We also offered the pass to a single parent who travels by taxi weekly with her child for speech therapy. She was our first refusal saying “it wouldn’t work.” We found this to be reasonable as she has four children under the age of four years, including a baby, making bus travel difficult, especially in the winter. We compared the costs of bus travel to estimated taxi travel for participating parents and this is summarized in the table below:

Recipient	Issue	Purpose	Desired Impact	Bus Pass Cost	Est. Cab Costs
1	Pre-mature twins	Teach mother to care for children and enable continuation of breastfeeding. The babies stayed in the hospital after mother was discharged.	Earlier discharge from hospital, reduce future medical costs through breastfeeding.	\$25 for two weeks	\$350 for 10 days cab fare
2	Fragile child	Teach mother of hospitalized child how to maintain medical equipment at home	Earlier discharge from hospital.	\$25 for two weeks	\$125 for 5 days cab fare
3	Pre-mature child	Teach mother to care for fragile child and enable continuation of breastfeeding. The baby stayed in the hospital after mother was discharged.	Earlier discharge from hospital, reduce future medical costs through breastfeeding.	\$37 for 6 weeks	\$1,125 for 42 days cab fare
4	Fragile child	Teach both parents how to care for hospitalized child at home and to operate medical equipment.	Earlier discharge from hospital	\$50 for 1 month for 2 parents	\$750 for 30 days cab fare
Total				\$137	\$2,350

EPSDT (Early and Periodic Screening, Diagnosis and Treatment Program)

Our next step will be to experiment with an offer to all Anchorage area parents needing Early and Periodic Screening, Diagnosis and Treatment travel assistance giving them the option of:

- A bus pass for the balance of the month, or
- Taxi authorization

Those not choosing the bus pass will be asked the reason. Documentation will be kept of the option selected and the reason for not choosing a bus pass.

Enhanced Outreach Efforts

Recipient Services presently sends federally required informing letters to parents whose children are not current on their well-child visits, have not used services for a year, or who are new to the program. The letter is unattractive and bureaucratic. Also included is a newsletter with broadly targeted information for a wide range of ages and developmental stages.

In a Lower 48 study, parents of Medicaid families participated in focus groups about informing letters. They were asked what the letters should look like and said:

- Please only send notices once a year.
- Recognize we care about our kids and can make the right decisions, if you give us the information.
- We would appreciate a reminder, if it is age appropriate and concise.
- Help us understand what to talk to the doctor about.
- Give us a bright postcard we can put on the fridge.

Using this information we are developing a new approach and design by:

- Drafting 20 separate concise letters containing age specific recommendations based on Bright Futures guidelines;
- Personalizing the text with the child's name and local contact information;
- Print it on brightly colored card-like designed stationary;
- Incorporate birthday images into the design to serve as a reminder to schedule preventative appointments at least annually;
- Mail it soon after the child's birth and just before birthdays.

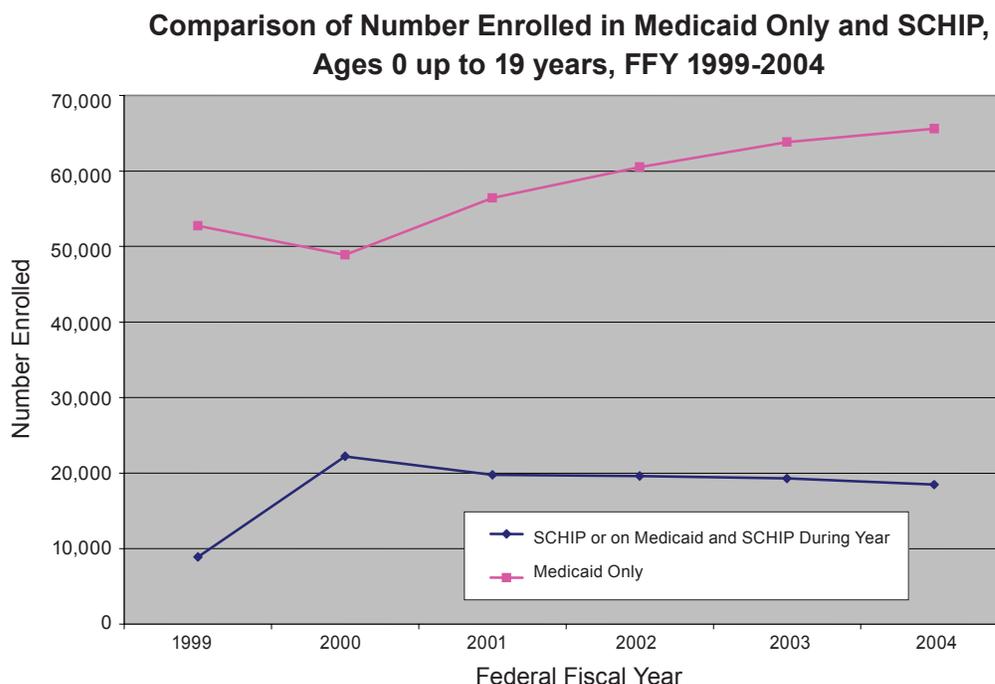
EPSDT (Early and Periodic Screening, Diagnosis and Treatment Program)

We are in the process of organizing the transition. Major areas to be addressed include:

- Issuing three printing-related bids; continue the present printing and mailing effort during the transition; printing of the card stock; and printing the individualized text and mailing the newly designed notice;
- Finding a way to tease out of the current Medicaid Management Information System the needed information;
- Developing designs for the cards;
- Coordinating with and informing a wide range of partners including native health corporations, pediatricians, public health nurses, dentists and others in the health community.

Brief Description of Early and Periodic Screening, Diagnosis and Treatment Program Using Federal Fiscal Year 2004 Data

The total number of Early and Periodic Screening, Diagnosis and Treatment enrolled children continues to increase while the number of children enrolled in Denali KidCare slowly decreases.



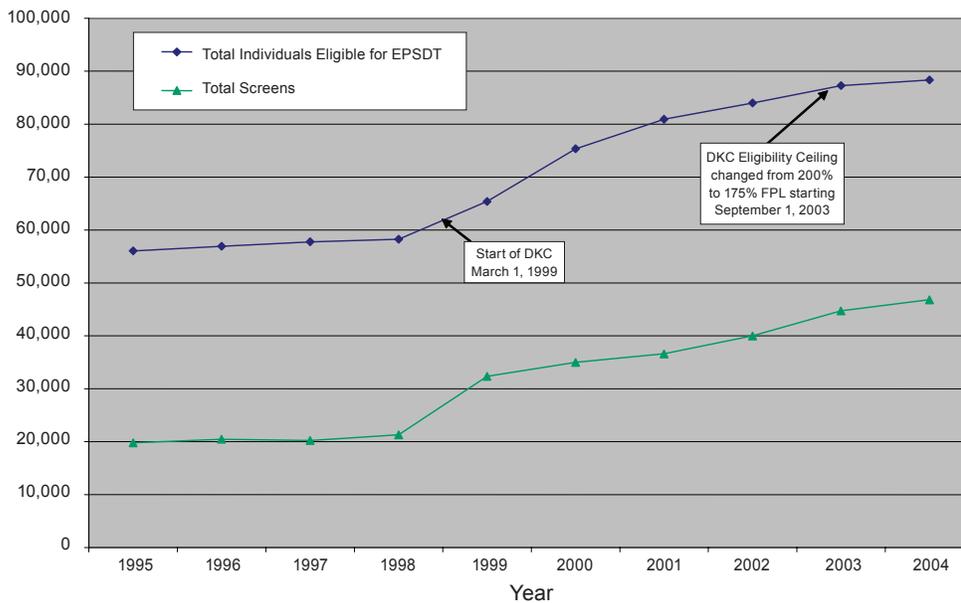
The number of eligible Early and Periodic Screening, Diagnosis and Treatment children increased by 1.2 percent in Federal Fiscal Year 2004. This increase is similar to pre Denali KidCare years and appears to be based on population growth.

EPSDT (Early and Periodic Screening, Diagnosis and Treatment Program)

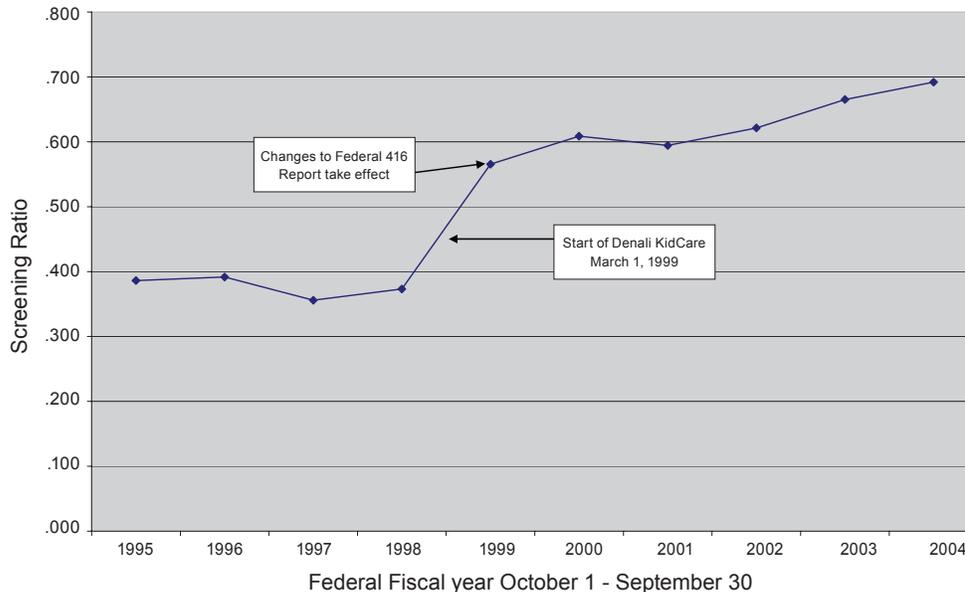
In Federal Fiscal Year 2004 the number of Early and Periodic Screening, Diagnosis and Treatment screens increased by 4.7 percent, a welcome but modest increase. The five-year average is 7.7 percent. The higher average five-year rate is probably due to the implementation of Denali KidCare.

Because our number of screens increased more than the increase in number of eligible children, our screening ratio improved slightly from 0.665 in FFY03 to 0.692 in Federal Fiscal Year 2004. Our screening ratio has improved four years straight with Federal Fiscal Year 2004 being the highest rate in recent history. This suggests that the Medicaid/ Denali KidCare health system is continuing to increase the rate of preventative health care for children.

Total Early and Periodic Screening, Diagnosis and Treatment Screens Statewide, 1995-2004



Early and Periodic Screening, Diagnosis and Treatment Screening Ratio All Ages, 1995-2004



Miscellaneous Activity

- Health Care Services was awarded a \$35,000 transportation planning and coordination grant. No activity has yet occurred under this grant and we are requesting to subcontract the actual study and report.
- School Based Services added Behavioral Health interventions to the array of services. Jeri Powers provided on-site training to the Yukon-Kuskowim School District on School Based Services and presented to the Special Education Directors at their annual conference.
- Jeri Powers and Laurie Barter attended the Department of Transportation annual Coordinated Transportation Conference.
- Office of Program Review submitted the Freedom of Choice Waiver late last fall 2005. We anticipate implementation on March 1, 2006.
- Sandy Ahlin is coordinating the updating of the Recipient Handbook.
- Provided onsite training for accommodation provider Ramada Ltd Hotel of Anchorage. Ramada encountered many claims that were not submitted to Medicaid or submitted improperly without follow up. Meetings were also set up with First Health and Ramada in order to review these claims and provide help in the resubmission process and/or appeal process.
- Eligibility Information System training is provided to First Health staff on an ongoing basis. Throughout the year Sandy Ahlin has provided Eligibility Information System training to the Prior Authorization, Provider Inquiry, as well as new Helpline staff. Follow-up training is planned to help all users maintain proficiency.
- First Health Provider Inquiry, First level appeals, Helpline and Claim Resolution continue to send eligibility issues that are pended and questions to Sandy Ahlin on a daily basis. These are resolved by contacting the appropriate Eligibility Technician or their supervisor as well as updating the Eligibility Information System. This contact with the eligibility technicians has been beneficial as a tool to also educate Division of Public Assistance workers as to how their actions regarding eligibility screens within the Eligibility Information System affects the recipients' appropriate receipt of Medicaid benefits. Division of Public Assistance caseworkers continue to request meetings with a Health Care Services representative in order to better understand how Medicaid uses the information they provide to us in the Eligibility Information System. Caseworkers are generally pleased to know where to refer the recipient for issues involving Medicaid benefits, covered services and calls from pharmacies and providers. Helpline business cards and Recipient Handbooks continue to be distributed to DPA locations

Strengths, Weaknesses, Opportunities, Threats

Members of Recipient Services met throughout December 2005 and January 2006 to engage in a standard Strengths, Weaknesses, Opportunities and Threats analysis. We developed and prioritized the following objectives and strategies for implementation during 2006:

1. Provide good customer service to all stakeholders and encourage and support their doing the same with Health Care Services.

Recipient Services believes our most valuable commodity is customer service. We will measure our performance against this standard by:

- Keeping our promises
- Returning phone call and e-mail inquiries on the same day or next business day
- Being factually accurate in our information and explanations

2. Continue frequent (biweekly or more often) meetings with contractors on critical topics.

- Weekly meetings with the State Travel Office on operations and accounting issues
- Weekly meetings with the State Travel Office accounting staff on specific prior authorization and claiming issues
- Biweekly meetings with First Health supervisors regarding prior authorization, Helpline, and Care Management program issues
- Monthly meetings with First Health prior authorization and State Travel Office Manager on interface issues

3. Establish a routine of monthly staff meetings and quarterly reports.

- Staff meetings are scheduled on the third Thursday of the month.
- Quarterly staff reports are due to the manager by 10 business days following the end of a quarter.

4. Have a vision on current issues, develop an agenda and communicate our vision.

- Be knowledgeable on health care trends both nationally and locally.
- Research proposals and understand possible impacts of program initiatives.
- Present analysis of issues at appropriate meetings.

Strengths, Weaknesses, Opportunities, Threats

5. Maintain and expand our knowledge of current law, regulations, Medicaid plan and federal requirements.
 - Alternate review and presentation during staff meetings of proposed changes to regulations.
 - Research specific program areas as the department rewrites Chapter 43.

6. Perform an analysis of variance on the Lock-in program
 - Have requested the necessary data from First Health

7. Build social capital with division partners and contractors.
 - Share analyses, opportunities and burdens with our partners
 - Dispel folklore when possible

8. Be mindful of the challenges we accept and those that we decline.
 - We will prudently allocate our human resources to issues

9. Shift some ground transportation from taxi to bus.
 - Follow the Florida example: When they shifted a small percentage of travelers to bus travel they saved several million dollars in transportation costs.



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