THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of
Health and Social Services

OFFICE OF THE COMMISSIONER

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The Honorable Click Bishop
Co-Chair, Senate Finance Committee
State Capitol Room 516
Juneau, AK 99801

The Honorable Bert Stedman
Co-Chair, Senate Finance Committee
State Capitol Room 518
Juneau, AK 99801

Dear Senator Bishop and Senator Stedman:

Please find the answers to questions presented to the Department of Health and Social Services regarding Executive Order 119. Several documents are attached to this letter as back-up documentation to information presented in this letter.

**Senator Hoffman:** ***Please provide a breakdown of AN/AI population in state custody and a breakdown of these cases by region.***

As requested, please find the table below with the following notes:

- The second column is the current percentage of children ages 0-17 in Office of Children's Services (OCS) Children in Out of Home Care (includes Trial Home Visits and other undischarged). Undischarged includes children who were removed from their homes and are on runaway status. It also includes children who were removed from their homes that have an end date for their last Out of Home placement but have not been discharged from Out of Home care yet.

- The third column is the estimated percentage of children ages 0-17 who are AN/AI in each region, based on distributing population statistics for each borough to OCS Regions. This is not a perfect match but is representative.

- Anchorage may be somewhat skewed by children from rural areas being sent there for lack of appropriate foster homes in the region or community in which they reside.

Here is a link to OCS Regions: OCS Region

Here is a link to Alaska Boroughs and Census Areas: https://www.get-direction.com/static-maps.html?id=alaska-county-equivalents-2016&cat=usa-counties

| OCS Region | AN/AI Age 0-17 in OCS Removals 2/21/2021 | AN/AI Age 0-17 Estimated Population 2019 | Ratio of OCS OOH to population |
|---|---|---|---|
| **Anchorage** | 60.9% | 19.1% | 3.2 / 1 |
| **Northern** | 76.1% | 36.6% | 2.1 / 1 |
| **Southcentral** | 51.2% | 18.8% | 2.7 / 1 |
| **Southeast** | 77.4% | 33.5% | 2.3 / 1 |
| **Western** | 100.0% | 92.8% | 1.1 / 1 |
| **Statewide** | 65.5% | 28.0% | 2.3 / 1 |

**Senator von Imhof:** ***How have you engaged with stakeholders?***

On December 22, 2020, Governor Dunleavy announced the effort to re-organize DHSS into two departments – the Department of Health and the Department of Family and Community Services. Attached to this letter is a list of stakeholders that the department has engaged in the discussion of the reorganization of the department.

All of the initial meetings that the department had early on with stakeholders and federal partners have evolved into a dialogue of what the reorganization of the department will mean for constituents and entities served by the department. The department is committed to an ongoing dialogue with all entities. As such, stakeholder engagement is a part of the department's transition plan.

**Senator Stedman:** ***These numbers (budget/position counts) seem big for Alaska, but we are such a small population base. How do other states deal with these services, what governmental/organizational structures do they have in place? Please consider budget, position counts, population served - choose some mid-size states (avoid using a California/New York).***

The consistent thing the department learned while researching other states and talking with commissioners of departments with similar programmatic responsibilities as DHSS, is that there is no single model. Some states have similar responsibilities split over two departments, and other states have the responsibilities split among multiple departments. However, Alaska DHSS is one of the last mega-agencies in the nation.

The department is providing information from the following states: Wyoming, South Dakota, Utah, and Colorado. This information is also provided in a spreadsheet that accompanies this letter. The department can also provide organizational charts for these states if members would like additional information on the divisions, programs, and constituencies served for each of the states' departments.

| STATE | POPULATION | DEPARTMENT | FTE | Commisioner | DC Equivalent | CMO/CME | | Budget |
|---|---|---|---|---|---|---|---|---|
| Alaska | 731,545 | | | | | | | |
| | | Department of Health and Social Services | 3401 | 1 | 2 | 1 | | $ 3,483,908,600.00 |
| | | ***Total FTE*** | 3401 | | | | **Total** | **$ 3,483,908,600.00** |
| Wyoming | 578,759 | | | | | | | |
| | | Department of Health | 1,386 | 1 | | | | $ 1,916,589,725.00 |
| | | Department of Family Services | 706 | | | | | $ 306,622,745.00 |
| | | ***Total FTE*** | **2,092** | | | | **Total** | **$ 2,223,212,470.00** |
| South Dakota | 884,659 | | | | | | | |
| | | Department of Health | 465 | 1 | 1 | 1 | | $ 106,289,199.00 |
| | | Department of Social Services | 1562 | 1 | 4 | | | $ 1,065,584,291.00 |
| | | DOC Juvenile Community Corrections | 26 | | | | | $ 15,378,270.00 |
| | | Department of Human Services | 594 | 1 | 1 | | | $ 460,289,340.00 |
| | | ***Total FTE*** | **2,647** | | | | **Total** | **$ 1,647,541,100.00** |
| Utah | 3,205,958 | | | | | | | |
| | | Department of Health | 1,185 | 1 | 2 | 1 | | 5,161,370,900 |
| | | Department of Human Services | 3,381.10 | 1 | 2 | | | 953,050,700 |
| | | ***Total FTE*** | **4,566** | | | | **Total** | **$ 6,114,421,600.00** |
| Colorado | 5,758,736 | | | | | | | |
| | | Department of Public Health & Environmen | 1,382 | 1 | 3 | 1 | | $616,137,812 |
| | | Department of Health Care Policy & Financi | 544.6 | 1 | 3 | | | $10,689,061,864 |
| | | Department of Human Services | 5130 | 1 | 4 | 1 | | $2,344,561,981 |
| | | ***Total FTE*** | **7,057** | | | | **Total** | **$13,649,761,657** |

It should be noted, that an apples-to-apples comparison is difficult to accomplish. There are many factors to consider. In a majority of states, the responsibilities for public health, child welfare, public assistance, and even juvenile justice authorities, are vested in counties, and not the full responsibility of the state.

The above examples provide clarity on standard practices for state department structure. For example, Wyoming, which is smaller in population, budget, and personnel, still has two separate departments to focus their mission sets separately for Health and Family Services. South Dakota (again, with a smaller budget and fewer personnel) has services across four departments, leading to departments with closely aligned missions and authorities. The intent of this administration is to align missions to work more effectively, with the most cost-efficient methods possible.

Department organization is more than a simple comparison of the size of a budget and number of personnel. The ability to work effectively and efficiently is complicated by (1) the number of, and types of, missions an organization faces; and (2) the alignment of federal authorities and funding. As a 'mega-agency', Alaska's DHSS is one of the last remaining states that houses such a variety of disparate missions under one authority.

Some examples of challenges that are created by DHSS' lack of effectiveness include:

1) The mission of Health Care Services (HCS) involves claims processing and regulatory oversight and enforcement. The mission of Office of Children Services (OCS) is to provide direct, 24/7 intervention to protect children. HCS personnel do not physically see, or serve, OCS children directly. Medicaid benefits to children in the OCS system are given by providers. These providers, in turn, are licensed and held accountable by HCS while claims are paid through the billing system operated by HCS. Concerning federal alignment, HCS follows rules, guidance, and funding opportunities provided through the Centers for Medicaid and Medicare Services (CMS) while OCS follows those of the U.S. Department of Health and Human Services (HHS).

2) Similarly, as a contractual agent of CMS, HCS provides quality assurance, regulatory oversight, licensing, and claims processing for all licensed hospitals and assisted living homes, including the Alaska Psychiatric Institute (API) and the Alaska Pioneer Homes (AKPH). HCS does not provide direct services to the individuals in these buildings and acts to enforce quality and regulation and provide claims processing.

3) As a third example, there is almost no overlap between the mission and functionality of the Division of Public Health (DPH) and that of the Division of Juvenile Justice (DJJ). DPH's mission is to improve population health through prevention and emergency response, while DJJ's mission is focused on providing services and legal process to juveniles in the criminal justice system. DJJ runs six (6), 24/7 detention facilities as well as its probation services for community supervision. It is worth noting that youth in DJJ facilities are not eligible for Medicaid. DPH works under the authority and funding programs of the Centers for Disease Control (CDC) while DJJ is under the authority of the Department of Justice (DOJ).

These are just a few of the many examples of divisions with highly disparate missions and federal authorities, which are currently housed under one department.

**Senator von Imhof:** ***Does the Mental Health Trust Authority support this proposal?***

The Alaska Mental Health Trust Authority has reviewed Executive Order 119 and has consulted with the Department of Law and confirmed that the Trust does not believe that the proposed reorganization of DHSS will impact the settlement that created the Trust. Further, the Trust supports any changes that will help the State meet its responsibilities to Trust beneficiaries. The Trust has been actively engaged in dialogue with the department and this will continue through the duration of the process.

**Senator Bishop:** ***What is Value Based Care vs. Fee for Service?***

**What is "Fee-for-Service" in Medicaid:**
Medicaid-enrolled and qualified providers receive compensation for each allowable procedure, test, and treatment performed on a Medicaid-eligible patient. The employment of a fee-for-service model in Medicaid does not preclude the use of a value-based care model.

Categories of value-based payments under Fee for Service:

- Fee for Service – link to quality & value (e.g., advanced payment methodologies, incentive payment structures)
- Foundational payments for infrastructure & operations (e.g., care coordination fees and payments for health information technology investments)
- Pay for reporting (e.g., bonuses for reporting data or penalties for not reporting data)
- Pay for performance (e.g., bonuses for quality performance)
    - Alternate payment methodologies (APMs) built on a fee-for-service architecture (e.g., primary care case management, primary care medical homes)
    - APMs with shared savings with upside risk only (if savings are achieved, providers receive a percentage of the savings)
    - APMs with shared savings and upside and downside risk (e.g., episode-based payments for procedures and comprehensive payments)

**What is "Value-based Care" in Medicaid**:

- Compensate providers for the quality of care – measured by pre-designated patient outcomes.
- Providers are rewarded for effectively managing the health of individuals and populations.
- Requires and relies upon a team-oriented approach to patient care, coordinating care across the continuum, and collaborating with a patient's other providers to deliver the best health outcomes possible.

- Value-based payment (VBP) mechanisms (alternate payment methodologies) are critical to holding a provider accountable for the costs and quality of care provided under value-based care initiatives.
- Different alternate payment methodologies (APMs) carry varying levels of risk for the provider in terms of meeting care goals and controlling costs
    - APMs with shared savings with upside risk only (if savings are achieved, providers receive a percentage of the savings)
    - APMs with shared savings and upside and downside risk (If savings are achieved, providers receive a percentage, but if costs increase, providers absorb a portion of those losses)
    - APMs with full risk (providers are accountable for cost and quality, if savings or losses occur, they bear significant financial risk for those outcomes).
- Examples of full risk population-based value-based payment models –
    - Condition-specific population-based payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
    - Comprehensive population-based payment (e.g., global budgets or full/percent of premium payments)
    - Integrated finance and delivery system (e.g., global budgets or full/percent of premium payments in integrated systems)

**Senator Wielechowski and Senator Olson:** ***Page 57, line 17 – "reasonable corporal discipline" – what does this mean?***

This question is addressed in the Department of Law memo that was sent to the Senate Finance Committee on March 1, 2021.

**Senator Stedman:** ***If you need help, why don't you just request 13 new positions to support the Commissioner's Office in the current structure? What is the cost-benefit analysis for creating an entire new department?***

In the second session of the 31st Alaska State Legislature, the department did propose the addition of a Deputy Commissioner position and support staff. Ultimately, this request was not approved, although an executive support position was approved. The department leadership took a step back and reflected on the feedback from the ten divisions that support the operations, programs and services that the department provides on a daily basis to Alaskans. When evaluating how similar services are structured and delivered in other states, and looking at organizational design and leadership theory, it was evident that the most important aspects for successful program and management improvements are tied to two concepts: span of control and alignment of operations.

With the reorganization of DHSS into two departments – a department that currently serves hundreds of thousands of Alaskans on a daily basis and has the largest budget – there will be a cabinet level position for each department.

The Commissioner for the Department of Health (DOH) will have focus and oversight on health care services, payment, and public health, as well as more time to work with all stakeholders to improve and implement innovation for the single largest budget item in the state, Medicaid.

The Department of Family and Community Services (DFCS) will have an aligned focus on supporting and improving our child welfare system and our facilities that serve Alaskans around the clock.

The mission of the two departments is different, for example, the Medicaid divisions in DOH, which are Division of Behavioral Health, Health Care Services (HCS) and Senior and Disability Services, provide regulatory oversight, claims processing, facility licensing and the enforcement of Medicaid and state regulations – they do not provide direct care services.

In comparison, DFCS divisions provide 24/7 care for specific populations and are a direct care provider. For example, API and the Alaska Pioneer Homes provide care for patients and elders, and when eligible, can bill Medicaid for the services provided – in much the same way that hospitals and clinics work. In turn, HCS processes those claims to Medicaid, the same as they would for any other provider in the state.

The commissioners of each of these departments requires a different skill set and the bandwidth to fully support the operations of each department. The Alaskans that we serve deserve this attention. By narrowing the span of control, by aligning the divisions and focusing on long term system improvements and stakeholder engagement, this will allow us the opportunity to work better for Alaskans. The leadership of each department will be able to focus on work processes, maximizing efficiencies, incorporating innovative ideas, with the mission of improving outcomes for the Alaskans that we serve.

**Senator Stedman:** ***What is the cost of the 13 people – salary, benefit package. What # of these people are classified, what # of them are exempt?***

Of the 13 new positions, four of the positions are exempt and the rest of the positions are classified. The cost of salaries for new positions in both departments is $1,136.0; the cost of benefits for new positions in both departments is $654.3. The total cost for salaries and benefits for the 13 new positions in both departments is $1,790.3.

| **Cost of Salary and Benefits for New Positions** | | | |
|---|---|---|---|
| **Department** | **Salary** | **Benefits** | **Total** |
| DOH | $446.9 | $265.3 | $712.2 |
| DFCS | $689.1 | $389.0 | $1,078.1 |
| **Total** | **$1,136.0** | **$654.3** | **$1,790.3** |

**Senator Hoffman:** ***The reduction of 139 positions – where are these positions located? The 13 new positions associated with reorganization – where will these be located?***

| **Division** | **Positions Added/ (Deleted)** | **Total** | **Location** |
|---|---|---|---|
| Alaska Psychiatric Institute | (5) | (5) | Anchorage |
| Juvenile Justice | (8) | (13) | Anchorage (4), Dillingham (1), Nome (1), Valdez (1), Fairbanks (1) |
| Public Assistance | (116) | (129) | Anchorage (13), Wasilla (4), Fairbanks (2), Juneau (1), remainder through attrition so location currently unknown |
| Public Health | 1 | (128) | Anchorage |
| Support Services | (24) | (152) | Positions transferred to Dept. of Administration per AO 304 and AO 305 |
| Support Services | 13 | (139) | Anchorage and Juneau |
| | **Total** | **(139)** | |

**Senator Wielechowski:** ***Please explain why the Pioneer Homes are no longer considered health care facilities? (Section 2 of Executive Order 119)***

This question is addressed in the Department of Law memo sent to the Senate Finance Committee on March 1, 2021.

**Senator Stedman:** ***Will splitting into two departments have a fundamental impact on the audited financial statements – meaning will this result in less findings related to DHSS?***

Smaller departments will allow for improved oversight, process improvements, and greater control over programmatic and financial activity resulting in fewer audit findings.

Thank you for your consideration of this information. We look forward to the Senate Finance Committee's consideration of Executive Order 119.

Sincerely,

Adam Crum
Commissioner

CC: Miles Baker, Legislative Director, Office of the Governor
Neil Steininger, Director, Office of Management & Budget

Attachments: Stakeholder Engagement
State Organizational Structures – Health and Social Services Structures