Alaska Department of Health & Social Services Performance Review

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EXECUTIVE SUMMARY

A performance review of the Alaska Department of Health and Social Services (DHSS) was initiated in January 2015 and conducted according to the requirements of House Bill 30 (Chapter 19, SLA 2013). After a competitive procurement process, the Division of Legislative Audit (DLA) selected Public Works, LLC to conduct the DHSS organizational and administrative structure performance review, with subcontractor Morningside Research and Consulting, Inc. managing the project.

Methodology

As part of the data collection effort, Public Works conducted site visits and interviewed over 160 DHSS staff members and conducted six focus groups with over 60 staff members on topics covering quality assurance and quality improvement; licensing, certification, and inspections; and grants. Additionally, nearly 400 DHSS staff members participated in the review in response to an online questionnaire. Three public hearings were held to gain input from stakeholders. Best practices research was conducted on a wide variety of topics including licensing, fraud investigation, organization of health and human services departments and programs in other states, staff recruitment and retention, information technology (IT) spending, Medicaid spending and staffing, and federal revenue opportunities. This report incorporates findings identified from the research, interviews, and observations of department operations and includes recommendations for addressing those findings.

On May 27, 2015, Public Works met with the DHSS management team in a daylong session to review and discuss the preliminary findings and recommendations of this report. Comments and additional data provided by DHSS as a result of the meeting have been incorporated into the report.

DHSS Efforts and Challenges

The research for this performance review identified a number of areas where DHSS is performing well, implementing best practices, and addressing inefficiencies. For example, the performance review found knowledgeable, thoughtful, articulate and problem-solving directors, managers, and staff throughout the department; extensive cross-divisional and enterprise-level coordination; and evidence-based practices in place.

Given the unique geography of Alaska and the mission of DHSS to serve residents of rural and remote areas as well as the need to support DHSS employees who travel to and work in remote areas of the state, innovative solutions are needed to deliver services. Challenges across the department include limited flexibility and innovation regarding work schedules, telecommuting,

and the use of technology. The department should improve communication with employees about the status of project and program implementation and to better clarify administrative processes and procedures to decrease misinformation and frustration.

Findings and Recommendations

This performance review report is organized by eight objectives established in the project scope of work. Detailed information about the findings and recommendations for each objective are included in the full report. Below is a summary of the conclusions from each of the eight objectives:

In **Objective 1**, Public Works conducted a comprehensive review of the budget documents used by DHSS to present program and budget information to the Alaska State Legislature. This review determined whether the budget documents show the interconnectivity between divisions and whether the structure of the department facilitates a well-developed, well-informed budget. Of the three budget documents reviewed, the *Budget Overview Presentations*, prepared in PowerPoint, strike a good balance between the *Budget Alignment and Core Service Alignment* overview documents and the 300-page *Budget Summary Book*; they contain sufficient data to be informative, yet are streamlined enough to be easily reviewed, and thus could be a useful tool to legislators during the budget process.

To strengthen the *Budget Overview Presentations* – and make them more useful tools for achieving the transparency goals of the department – DHSS should increase the level of detail, refining individual elements, and adding metrics to put DHSS performance in context with national benchmarks. Interconnectivity between divisions was not demonstrated in any of the three documents reviewed, but could be achieved by phasing in a zero-based budgeting process, which considers the basis for every expenditure rather reviewing only incremental changes to the budget.

Objectives 2 and 3 are closely related, so are considered together in the performance review. Objective 2 examined department operations for efficiency and effectiveness and Objective 3 evaluated potential duplicative efforts within the department.

The performance review identified several obstacles for DHSS, including significant challenges to employee recruitment and retention. DHSS also needs to augment its succession planning and develop a plan to identify and prioritize training needs within the department. Two divisions are especially hampered by retention and training challenges: the Division of Public Assistance (DPA) training requirement is excessive and contributes to a five- to six-month backlog in eligibility determination; and the Office of Children's Services (OCS) has a training period that is

too short to prepare caseworkers for the heavy caseloads they are expected to carry after only two to three weeks of training.

Other significant challenges include a backlog in employee performance evaluations that contributes to delays in distributing pay increases; the need for a comprehensive internal audit function; a lack of qualified service providers across the state; uncoordinated communications with tribal communities; recouping federal funds for children in foster care; deficiencies in the way child abuse and neglect reporting calls are answered; and the decentralized administration of the institutions managed by DHSS (the Alaska Psychiatric Institute, the Alaska Pioneer Homes, and the DJJ facilities). Recommendations to address these challenges include creation of a Tribal Relationship Office, changes to licensing guidelines for foster homes, and consolidation of the administrative functions of the DHSS institutions.

Duplication was found in licensing and certification functions, in the scheduling of site visits across the state, and in program integrity efforts for federal benefit programs such as Medicaid and SNAP. The report includes recommendations for consolidating and better coordinating these duplicative functions.

The performance review also compared the administration of the Alaska Medicaid program to peer states for spending, reimbursement rates, and benefits. Recommendations include consolidating Medicaid policy, planning, and quality improvement efforts (which are currently located in four divisions); and continuing to expand efforts to coordinate medical care to control costs.

Objective 4 examined whether DHSS advisory groups are efficient and effective in overseeing DHSS services. Public Works reviewed 14 membership bodies using efficiency and effectiveness criteria developed for the report. The review notes that most of the DHSS advisory groups are required by federal regulations as a condition of federal funding. Specific recommendations for advisory groups include refocusing the efforts of the Alaska Council on Emergency Medical Services from professional advocacy to providing more formalized policy and budget advice to the DHSS commissioner and governor and discontinuing the travel budget for the Alaska Pioneer Homes Board, which duplicates the work of specialized DHSS staff.

Additional recommendations include evaluating opportunities for savings in advisory body travel; reviewing periodically whether each membership board is better equipped to determine policy or oversee programs compared to other available alternatives; establishing and enforcing expectations regarding the use of performance management tools by boards and commissions; and using the efficiency and effectiveness criteria developed for this review when considering the creation of any new advisory bodies.

Objective 5 sought to identify organizational management best practices that could be used to more effectively organize the department and reduce funds spent on administration. The performance review outlined a number of best practices from innovative states and reputable organizations, including strategies for budget presentations, licensing foster care homes, consolidating program integrity, continuous quality improvement, administrative organization of juvenile justice agencies, IT security, fee-setting protocols, and approaches to billing insurance for public health clinic services. Implementing these best practices is recommended.

Objective 6 recommended changes to the organizational and administrative structure of DHSS that may lead to more effective and efficient use of limited state resources. In addition, this performance review considered the benefits and challenges of the current comprehensive structure of DHSS as the single state agency for health and social services. Alaska is unique in supporting health and human services functions within a single department, but despite the vast array of services provided by the department, DHSS has made great strides in the last decade to eliminate the "silos" of each division and operate as a coordinated enterprise.

The following conclusions are discussed in more detail: DHSS should remain the single state agency for health and social services; privatization or an alternative should be considered for the Alaska Pioneer Homes; and one of the four early childhood prevention and early intervention programs should be relocated from OCS. At the conclusion of Objective 6, all of the recommended changes to the organizational structure of the department are summarized in a revised DHSS organizational chart.

Objective 7 evaluated whether the organization and administration of IT within DHSS effectively supports department programs and services. Recommendations focus on improving the IT Governance process; expanding video conferencing technology; enhancing IT project management and project management training, addressing the organization and management of IT services, maintaining IT security, resolving concerns about the service used to send secure documents by email, and addressing public health nursing technology limitations.

Objective 8 evaluated the FY 2016 budget reductions proposed by DHSS. In response to the specific questions posed in Objective 8, the review found that the DHSS proposed reductions were not submitted in time to meet the statutory due date and that the reductions did not total at least 10 percent of the general fund dollars in the DHSS budget that could be reduced or eliminated. While it is likely that the reductions proposed by the department will not impact its overall mission, many of the cuts would reduce its ability to serve vulnerable Alaskans. The department did make a good faith effort to minimize the impact of budget reductions across programs and services: the proposed reductions appear to be an effort to minimize the

disruption to any one program by distributing reductions widely, though perhaps not strategically. This performance review identified an additional $20 million in reductions or revenue enhancements that do not inhibit the ability of the department to fulfill its mission.

Recommendations for reductions and revenue enhancements include implementing licensing fees, reinstating fees for state lab tests, increasing insurance billing for services provided in public health clinics, expediting the implementation of electronic data imaging, eliminating the use of paper checks for benefit programs, ensuring that DJJ draws down all eligible federal funding for meal programs, and implementing revenue opportunities and identifying ways to reduce staffing ratios and costs per resident at the Alaska Pioneer Homes.

1. OVERVIEW

The Alaska State Legislature passed House Bill 30 (Chapter 19, SLA 2013) in 2013, which requires that the Division of Legislative Audit (DLA) facilitate performance reviews of state departments every 10 years.[1] In October 2014, a competitive request for proposals (RFP), "Request for Proposal: RFP No. 15-33-04 A Performance Review of the Department of Health and Social Services' Organizational and Administrative Structure," was issued by DLA to solicit a contractor with expertise in government agency organizational reviews to complete a performance review of the organizational and administrative structure of the Alaska Department of Health and Social Services (DHSS).[2] DLA selected Public Works, LLC to conduct the DHSS organizational and administrative structure performance review, with subcontractor Morningside Research and Consulting, Inc. managing the project. This DHSS performance review report is submitted to the Alaska Legislative Budget and Audit Committee (LBAC) for review.

This performance review included evaluation of the organizational and administrative functions of all nine divisions of DHSS:

- Alaska Pioneer Homes (APH)
- Division of Behavioral Health (DBH)
- Division of Juvenile Justice (DJJ)
- Division of Public Assistance (DPA)
- Division of Public Health (DPH)
- Division of Senior and Disabilities Services (SDS)
- Finance and Management Services (FMS)
- Health Care Services (HCS)
- Office of Children's Services (OCS)

1.1. Purpose of a Performance Review

A performance review is designed to challenge assumptions about why a program or service exists, as well as how business is conducted. It is not an audit that checks to ensure money is spent according to acceptable accounting practices. It is a process that defines how services are provided, how business is conducted, what emerging demands are being placed on government agencies and departments – and how effectively and efficiently the processes, procedures, policies, technology, and organizations responsible for the services are operating.

The end result of a performance review is the identification of recommendations to reduce inefficiency and ineffectiveness; to improve services and the way business is conducted; to identify new technology to support operations; to establish ways an organization must change to meet changing demands; and to establish organizational structures, policies and procedures to most effectively and efficiently deliver services to citizens.

This performance review report quantifies a number of recommendations that result in cost savings or revenue enhancements. While these recommendations generally include some discussion of how they can be implemented, detailed implementation planning is beyond the scope of this report. When the department begins to implement any recommendation, it often will need to consider the best option for doing so as well as a myriad of details involved in executing each one. Although the cost of changes recommended in this report will rarely outweigh the benefit of an improvement, the details – including what staff positions, offices in a building, or files on a server might need to be moved – can loom large to a government entity. This report makes every attempt to identify the benefits, costs, and challenges of any change it proposes. The full list of all suggested obstacles, and their actual costs, however, can only be compiled as the department considers implementation; a performance review cannot conduct a complete cost/benefit analysis of every recommendation.

1.2. Eight Objectives

The DHSS performance review was conducted in accordance with HB 30, and guided by eight objectives in the scope of work established by DLA. The report is organized by each objective. As required by the RFP, Public Works developed methodologies for each of the eight objectives specified in the scope of work. This report is organized by the eight objectives, with detailed findings and recommendations under each.

1.3. Methodology

The performance review began with an initial onsite visit to DHSS offices and field sites in January 2015 and was followed by an additional site visit in March 2015. Field sites visited included the DPH clinics and lab, DPA eligibility offices, Pioneer Homes, API, and DJJ facilities. The performance review is informed by interviews and focus groups that Public Works and Morningside conducted with DHSS staff, as well as a staff questionnaire and best practices research. Public Works interviewed over 160 DHSS staff members, nearly 400 DHSS staff members responded to the questionnaire, and over 60 staff members participated in six focus groups on topics covering quality assurance and quality improvement; licensing, certification, and inspections; and grants. Focus group attendees included staff members directly involved in these functions. Two general topic focus groups were also conducted, one with front line staff and one with supervisory staff. Best practices research was conducted on a wide variety of topics including licensing, fraud investigation, organization of health and human services departments and programs in other states, staff recruitment and retention, information technology spending, Medicaid spending and staffing, and federal revenue opportunities.

Three public hearings were held to gain input from the public. Public Works met with the management team at DHSS on May 27, 2015, in a daylong session to review and discuss the preliminary findings and recommendations. Comments and additional data received as a result of the meeting have been incorporated into the report.

A. Choosing Comparison States

Throughout this performance review report, Alaska is compared to several other states. During interviews, DHSS staff identified several states as peer states. As described in more detail in Section 3.3.A, the Alaska Medicaid program is compared to other states with a similar Medicaid structure, called fee-for-service Medicaid.

Table 1-1 shows the states generally used for comparisons with Alaska throughout the report.

Table 1-1: Comparison States

Peer States	Medicaid Fee-for-Service States	Both Peer States and Medicaid Fee-for-Service States
Georgia	Alabama	Arkansas
Hawaii	Maine	Idaho
New Mexico	North Carolina	Montana
North Dakota	Vermont	Oklahoma
		South Dakota
		Wyoming

The Medicaid fee-for-service states are identified in a Kaiser Family Foundation report.[3]

When states other than these are referenced in the report, the reason for the comparison is included in the relevant discussion.

1.4. Acknowledgment of On-Going DHSS Efforts

Performance reviews focus on identifying areas where organizational improvement is needed. The research for this performance review also identified a number of areas where DHSS is performing well, implementing best practices, and addressing inefficiencies. DHSS has made considerable strides over the last decade to create enterprise-level cooperation and coordination, from consolidating grant administration to developing cross-divisional Core Services Champion Teams to address specific issues.

In addition, the department has improved service delivery and outcomes by implementing evidence-based practices, with examples identified in nearly every division. Over the past year, the department has identified general fund costs savings in several areas and moved forward to implement the changes needed to realize those cost savings. Public Works noted evidence of many efforts by DHSS to identify and mitigate inefficiencies in staff Interviews and focus groups as well as in documents reviewed for this performance review.

1.5. Department Challenges

Two notable themes emerged from the evaluation conducted for this performance review, each indicating an area of challenge for the department:

A. Flexibility

Given the unique and challenging geography of Alaska and the mission of DHSS to serve residents of rural and remote areas as well as the need to support DHSS employees who travel to and work in remote areas of the state, innovative solutions are needed to deliver services. Unfortunately, Public Works noted a surprising lack of flexibility in state administrative functions, which limits the ability of DHSS staff to efficiently and effectively deliver essential safety-net services to vulnerable Alaskans. The rigidity in state policies and procedures severely hampers the ability of staff to do their jobs. Specifically:

- Flexible work schedules are needed to accommodate workers who travel as a requirement of their job, to relieve workers from the stress of providing direct services, and to fill on-going vacancies in critical positions. Flexible schedules, even four-day or 10-day schedules, are not uniformly permitted across the department. Staff throughout the department report that innovative schedules – such as two weeks on, two weeks off – are very difficult to get approved.

- Staff report that telecommuting is also not uniformly permitted, even in programs where employees travel extensively for work. Allowing employees to work from home would save travel expenses by assigning travel based on where employees live, rather than requiring employees to work and travel from an office in Anchorage or Juneau. Telecommuting would also benefit recruitment efforts by allowing people to work from more remote communities rather than requiring relocation to a city with a DHSS office.

- Flexible IT arrangements, such as variances from DOA and DHSS requirements to provide tools for mobile staff to remain productive, increase broadband access across the state, and utilize innovative tools that save time and money, are needed.

Resolving these issues - flexible work schedules and arrangements for workers, creative recruiting strategies, and IT variances - requires negotiation with other departments. Such negotiations are often left to staff employees without executive support and intervention and occur piecemeal throughout the department. While collective bargaining agreements, IT security concerns, and other issues impact work arrangements, inconsistencies among divisions and programs should be addressed and executive level advocacy for efficient and cost-saving staffing and support solutions should be provided.

B. Communication

Communication throughout the department should be improved. Interviews, focus groups, and questionnaire responses indicate a significant level of misinformation and misunderstanding about policies and procedures. In many cases, information from managers and supervisors differed from the understanding of staff. Many employees express confusion and frustration about the way things are done, especially related to IT challenges (such as Direct Service Messaging (DSM), a secure system for emailing documents, and ARIES, the new benefit eligibility system), but also with travel policies, flexible work schedules, and other policies. Regular communication about the status of project and program implementation and better clarification about administrative processes and procedures would decrease misinformation and frustration.

2. OBJECTIVE 1: BUDGET DOCUMENTS

Objective 1: Develop a format for a comprehensive overview of DHSS' budget, showing the interconnectivity of each individual division and the organizational structure utilized to connect individuals to services within each division and coordinate activities for those services through multiple divisions. This should address the following:

a) Identify and provide recommendations for how the number of individuals served, cost of services provided, and funding sources utilized can be organized and presented to provide a comprehensive yet easily understood annual review of services and funding needs.

b) Identify strengths and weaknesses of the current budget-reporting format.

c) Does the department's organizational and administrative structure facilitate the development of a well-developed, well-informed budget for the department as a whole?

The primary sources of best practices research for Objective 1, 1(a), and 1(b) were: the Government Accounting Standards Board (GASB) white paper on government financial reporting,[4] the National Advisory Council on State and Local Budgeting (NACSLB) recommended practices for state and local government budgeting,[5] and the Government Finance Officers Association (GFOA) *Distinguished Budget Presentation Award* winners.[6] These sources provided recommendations for both the content and format of the DHSS budget reporting documents. Staff interviews provided background and understanding of the interconnectivity of the divisions and how activities are coordinated among them.

The following DHSS documents were compared to the best practices research. All of these documents are produced by DHSS independently of any reporting requirements directed by the Alaska Office of Management and Budget:

1. The FY 2015 *Budget Alignment and Core Service Alignment* documents,

2. The FY 2015 *Performance and Budget Summary Book*, which is available on the DHSS website site, and

3. The department-wide and division-level *Budget Overview Presentations* for the House Finance DHSS Subcommittee hearings.

Generally speaking, budget documents fit in two broad categories – retrospective, those that look backward, providing a detailed history of appropriations and spending, and prospective,

those that look forward and backward, detailing both past history and future needs. There are multiple possible audiences for such documents (department staff and leadership; legislators and legislative staff; the governor; stakeholders; the press; and the general public). This analysis considered an annual review of services and funding needs from the perspective of legislators who would use such documents during annual budget deliberations.

Additionally, the analysis for Objective 1(c) was informed by the review of other objectives in this report.

2.1. Best Practices Research

Key findings from best practices research on written budget presentations include:

- Financial reports should be public communication tools. They should be relatively short, simple, free of complex language, and produced in time to be useful during the budget process.7

- As part of the budget process, government should disseminate broad goals and review them with stakeholders.8

- Government should include a description of key programmatic and financial policies, plans, and goals in its budget documents.9

- The budget and the budget deliberation process should highlight key issues and decisions.10

- Budget documents should include information that provides the reader with a guide to the programs the government operates and the organizational structure in place to provide those programs and services.11

- Budget documents and related materials made available to stakeholders should be presented in a clear and readily comprehensible format.[12]

2.2. Strengths and Weaknesses of DHSS Budget Documents

Discussion of findings for Objective 1 begins with looking at Objective 1(b), so that the strengths and weaknesses of the current budget reporting documents are examined before making recommendations for improvements to the reporting format (and before discussing how the organizational and administrative structure facilitates good budgeting practices).

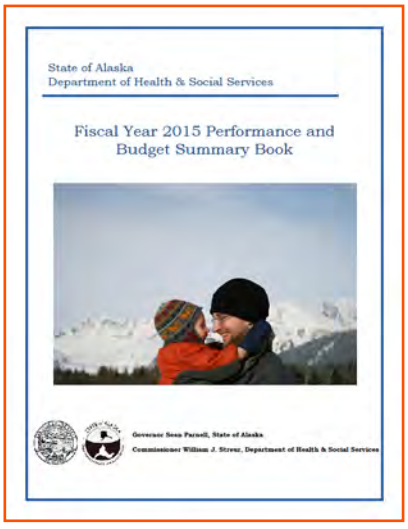
A. Alignment Documents

The DHSS *Budget Alignment and Core Service Alignment* documents are developed by the DHSS Commissioner's Office to support the move to accountability-based budgeting.

The documents are designed to show how funding and services provided within the department align with the priorities and core services. These documents provide clear, descriptive graphics illustrating how each division contributes to DHSS priorities and core services and can be a useful planning and communication tool for department leadership and staff.

These documents were not intended to provide a detailed budget summary or overview. They do not contain information about the number of individuals served or funding sources.

While they do provide a broad overview of current funding and programs, they do not present information regarding service levels or changes in programmatic or funding needs that might be useful to legislators during the state budget development process. Additionally, the titles of the three priorities and the seven core services use similar language and are not sufficiently descriptive, making it difficult to distinguish among them without reading more detailed descriptions.



B. Budget Book

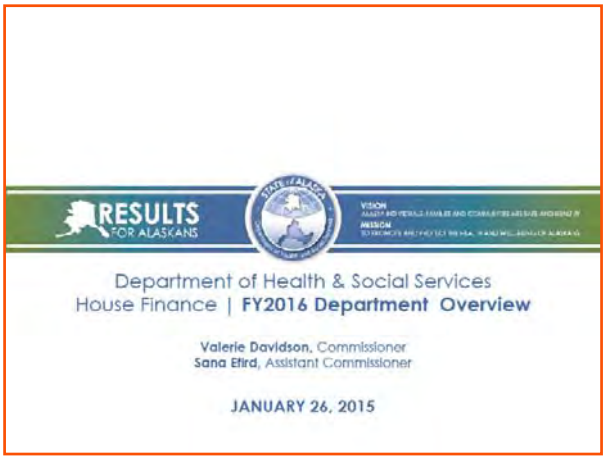
The approximately 300-page *Performance and Budget Summary Book*, by contrast, provides extensive detail about the DHSS budget, including descriptive program and funding narratives; comparisons between FY 2005 and FY 2015 departmental funding, and FY 2014 and FY 2015 funding by program; department priorities, core services, and objectives;

demographic data on populations served; and organizational charts and business plans for all divisions.

The best practices documents reviewed for comparison to the DHSS documents were lengthy budget overviews, similar to the DHSS *Performance and Budget Summary Book*. While this book provides important historic and spending details that are useful to some audiences (including legislative staff and the public), it is long and unwieldy and may not be useful to legislators during the state budget development process.

C. Overview Presentations

The *Budget Overview Presentations*, prepared in PowerPoint, strike a good balance between the *Budget Alignment and Core Service Alignment* Documents and the *Performance and Budget Summary Book*. They contain sufficient data to be informative, yet are streamlined enough to be easily reviewed, and thus are a useful tool to legislators during budgeting.



The *Budget Overview Presentations* for each division and the department overall were similarly, but not identically, formatted. Key elements included:

- Organizational chart
- Overview (including the mission, total funding, percent of department funding, total positions, and total service population)
- Continuum of care (which provided different information depending on the division)
- Efficiency and effectiveness measures
- Service population overview
- Challenges and looking forward
- General fund allocation history
- Proposed funding changes

2.3. Enhancing the Existing Documents

Objective 1 requires an assessment of how well DHSS budget documents show the interconnectivity of individual divisions within the organizational structure, how this structure connects individuals to services within each division, and how activities are coordinated for those services through multiple divisions. Objective 1(a) specifically asks how well the documents identify and provide recommendations for the number of individuals served, cost of services provided, and funding sources utilized.

Findings

Demonstrating programmatic interconnectivity within a budget document is a good, but difficult goal to achieve. Ideally, this information helps decision-makers understand how changes to individual programs affect other programs, program participants and costs. While the *Budget Alignment and Core Service Alignment* documents show how individual divisions contribute to the priorities and mission of the department, they do not show interconnectivity at a level of detail that specifies how the divisions and their services relate to one another.

The best practice budget documents reviewed for this objective did not cite any examples of how interconnectivity can be clearly illustrated. In part, this is due to the nature of government budgets, which tend to be driven by individual programs, of which there are many within divisions and departments. This program-focused structure drives budgeting, accounting, and accountability, and makes it difficult to see how various programs relate to each other, both programmatically and financially.

The *Budget Alignment and Core Services Alignment* documents do not identify and provide recommendations for the number of individuals served, the cost of services provided, and the funding sources utilized. These elements are shown to some degree in the *Performance and Budget Summary Book*, but due to the length of this book, these and other items of interest to elected officials may be difficult to find. The divisional *Budget Overview Presentations* provide this information clearly.

There are examples of how the department has moved from a “confederation” of divisions to a more enterprise-focused organization. Despite these efforts, the formulation of the department budget is based on incremental changes to division budgets, as evidenced by the budget reductions proposed and discussed in more detail under Objective 8.

Recommendations

A budget overview intended to inform legislators during annual budget deliberations must be relatively short, highlight information that is crucial to decision-making, and be written in easy-to-understand language. The *Budget Overview Presentations* are good efforts toward this end. The following recommendations serve to strengthen these documents and make them more useful tools to achieve the DHSS transparency goals. These recommendations primarily address formatting and organization of the documents to improve readability and do not significantly alter the content of the documents. Any changes to the documents may need to reviewed and approved by the legislature.

Recommendation 2.3.1.

Increase the level of detail in the *Budget Alignment and Core Services Alignment* documents. These documents are designed to support a results-based budgeting approach within the department. To better support this effort, these documents should be improved by clarifying the titles of the priorities and core services and by creating hyperlinks to make the documents interactive in an electronic format, allowing the user to click down to get increasingly greater detail, such as program budgets, funding sources, and numbers of staff.

Recommendation 2.3.2.

Use the *Budget Overview Presentations* to make a case. Even simplified budget synopses such as the *Budget Overview Presentations* contain a wealth of information that can be difficult to digest. While all of the *Budget Overview Presentations* contain similar data, they are not consistently formatted. All of the documents should be consistently organized to make the case for the department and/or division budget. The document should begin by providing context and the background information that drives the budget request. This information should be followed by relevant information from the budget. For example:

- The context and background sections should include:
    - What we do*:* organization chart, brief program overview (illustrated for some divisions on the continuum of care pages), and budget alignment.
    - Who we help: service populations.
    - How effective we are*:* efficiency and effectives measures.
    - The context in which we work: partly shown in the “Challenges” and “Looking Forward” pages.

- The budgetary overview should include:

    - Funding history: Historic funding allocations.
    - Budget request: Currently shown, in part, on the "Budget Request" and "Overview" pages.
    - Proposed budget changes: Not clearly or consistently shown in most recent presentations.

Recommendation 2.3.3.

Refine individual elements of the *Budget Overview Presentations*. Although the *Budget Overview Presentations* contain most of the elements recommended above, the presentation of specific elements could be revised to enhance their usefulness. On the following pages are the individual elements recommended for inclusion in the document and descriptions of how they could be formatted.

- Organizational charts: Currently the detail on the charts ranges from just the number of staff, to the names of division/program heads, funding by division/program, and total funding and staffing. Additionally, at least one chart (Pioneer Homes) does not visually display the organization of the division. Not only should the organizational charts illustrate the actual organization of the unit, but in this context, they should contain information to provide a picture of the cost of business, including elements such as total staffing and funding and staff/funding per subdivision. The DHSS organizational chart in the department-wide *Budget Overview Presentation* is a good example.

- Continuum of care**:** *Continuum of care* is a concept describing an integrated system of care for consumers over time that includes a comprehensive system of health services spanning all levels of intensity of care. Currently, there is some inconsistency in how the continuum of care information is displayed. For the divisions that include this illustration, the continuum of care programs and services are displayed from left to right across the spectrum from low to high levels of care or intervention. The total cost, the number of people served, and cost per unit is noted for each program or service. Total division costs are also shown. However, at least one division, the Division of Juvenile Justice (DJJ), did not include a continuum of care, and one division (the Office of Children's Services (OCS) lists their services without any additional detail. The detailed continuum of care documents provide an excellent picture of how funding is allocated and should be standardized for all division. The continuum of care document for Division of Behavioral Health (DBH) provides a good template.

- Budget alignment: The "Budget Alignment" pages are all standardized, and illustrate how funding is allocated to each division based on core priorities. Currently, the totals at the top of the page for each division under priorities and core services are DHSS totals. This information would be more clearly displayed and more useful if the totals shown were the division totals. Additionally, the boxes showing the priorities across the top of the page are all the same size, implying equal weight, and the color scheme makes it difficult to distinguish between levels. The department should consider a visual aid to illustrate that different priorities receive different amounts of resources. This could be shown either by resizing the boxes proportionately based on the percentage of funding they receive or including a notation with the percentage of division funding allocated to each. See Attachment A for a reformatted example.

- Service populations. On the current "Service Population" pages, the top two-thirds shows the core services for the division by priority, while the bottom third visually illustrates the target age for the service population going from left to right across the spectrum from birth to death. The presentation makes it appear both items are shown along the same spectrum, but that is not the intention. It is recommended that the core services be included in the "Budget Alignment" pages and not repeated here. The additional space on this page could be used for supplemental service population information that some divisions included on separate pages.

- Efficiency and effectiveness measures: The current format most divisions use to show performance measure data is a line graph, which is a good choice for illustrating performance over time. However, the graphs only show the achievement level. Without knowing the targets or goals, this data provides limited usefulness for understanding how efficient and effective the program is. An additional line illustrating the targets or goals should be included.

- Policy context: The budget presentation needs a section that explains the major policy issues facing the division or department. These are the issues decision-makers need to understand in order to make informed decisions. Currently, this information is presented to some extent in the "Challenges" and "Looking Ahead" pages. The budget overview includes a clear presentation of major policy issues that need to be considered. An example of how to display this information can be found in the Kodiak, Alaska annual operating budget that provides such a synopsis beginning on page 1.[13] The Kodiak example may provide more information than is needed in a budget summary for legislators during the budget process, but is a good illustration of this idea. Medicaid spending consumes the largest piece of the DHSS budget, so factors affecting costs there will always be a key issue. Other major budget drivers and variables that may be

included for the department or divisions include: changes in client demographics, personnel costs, applicable state and federal regulations, facility issues, and federal funding or grants.

- Historic funding allocations: Currently, most divisions have two pages showing historic general fund allocations. Typically both pages have a table with allocations by program and a matching line graph. However, these pages are redundant. A single page with graph and data would be sufficient. Additionally, the divisions should ensure that the scale of the graph is set so that trends are usefully illustrated and not artificially flattened out. If necessary, two graphs, or two different Y-axis scales should be used.

- Budget request and overview: The current "Overview" page is oversimplified, showing only the division mission; funding and staffing totals; divisional percentage of the total department budget; and the number of clients served. Similarly, the "Budget Request" page only shows the total request by fund source. A table showing funding and staffing request by program and fund source would be more useful to decision-makers.

- Proposed budget changes: In the *Budget Overview Presentations*, proposed budget changes are not highlighted. Some divisions such as the Division of Senior and Disabilities Services (SDS) have a section entitled "Status of FY 2015 Budget Increments" that shows funding changes from the prior year. Others (Pioneer Homes) have sections entitled "FY 2016 Governor's Operating Budget Transactions" which appear to show proposed changes in the budget. And, still others (such as DJJ) have neither. There should be a clearly labeled page that shows the major funding and/or staffing changes for each subunit, and the total proposed changes, from the current to the proposed fiscal year. The "FY 2016 Governor's Operating Budget Transactions" page in the Pioneer Homes' overview presentation is a good example, although it should include columns showing current and proposed totals (not just changes), and total proposed changes for the division. Additionally, the page should be renamed for clarity.

Recommendation 2.3.4.

Improve readability and usefulness. The *Budget Overview Presentations* are an excellent starting point for a budget overview document for legislative decision-makers. Currently, they are only intended as presentations for the House Finance DHSS Subcommittee. However, with the changes described on previous pages – including a bit more detail in lieu of bullet points in some sections – the information can be of use to other legislators not in attendance as well as the public. Additionally, a table of contents would assist readers with content navigation.

Recommendation 2.3.5.

Illustrate interconnectivity at fiscal analysis stage. Interconnectivity of government programs can be documented during the fiscal analysis process. When analyzing proposed legislation, fiscal analysts should consider any impact the legislation may have on state and local government programs. In a budget, there are so many potential moving parts that it would be cost-and time-prohibitive to include an analysis of all possible changes. However, an analysis could look at the interconnectivity of programs on major cost drivers, such as Medicaid or child welfare. Budget analysts could build models to analyze how increasing or decreasing funding and capacity for other department programs – such as public assistance payments, and/or prevention and early intervention programs – would affect Medicaid or child welfare costs or other major programs within the department.

Recommendation 2.3.6.

Consider phasing in a zero-based budget process. In order to truly achieve an interconnected, enterprise-level budget, the department will need to engage in zero-based budget discussions, perhaps on a rolling basis (i.e., one or two cost centers or divisions each year), to review the justifications for every expenditure of each division within the department. Zero-based budgeting is a process of reconsidering the basis for every expenditure rather than just focusing on incremental changes to the budget. This analysis would include brainstorming alternative ways of doing business, calculating cost/benefit ratios for each expenditure, and building models to determine the level of impact that each expenditure has on other components of the department. This level of discussion and analysis can occur within the current administrative and organizational structures of the department since an enterprise mentality already exists. The department would need to commit time and staff to this effort.

3. OBJECTIVES 2 AND 3: INEFFICIENCIES AND DUPLICATION

Objective 2: Evaluate whether the organizational and administrative structure of the department is conducive to or inhibits DHSS' ability to ensure services are provided efficiently and effectively. The evaluation should include the general organization and administration as well as the specific organization and administration of Alaska's Medicaid program. This should address the following:

a) ***Identify strengths and weaknesses of the current organizational structure.***

b) ***Are the department's services and programs delivered effectively?***

c) ***Are the department's services and programs delivered efficiently?***

d) ***Are there changes that could be made to the department's organizational structure that would improve the efficiency and effectiveness of service delivery and administration?***

Objective 3: Determine whether DHSS' organizational and administrative structure unintentionally facilitates duplication of services among or within any of its divisions, including a review of the Departmental Support Services RDU and its programs. Determine whether each division has developed or been assigned programs, activities, or services that would be better placed within another division or department, or are driving duplication of service provided through a separate department.

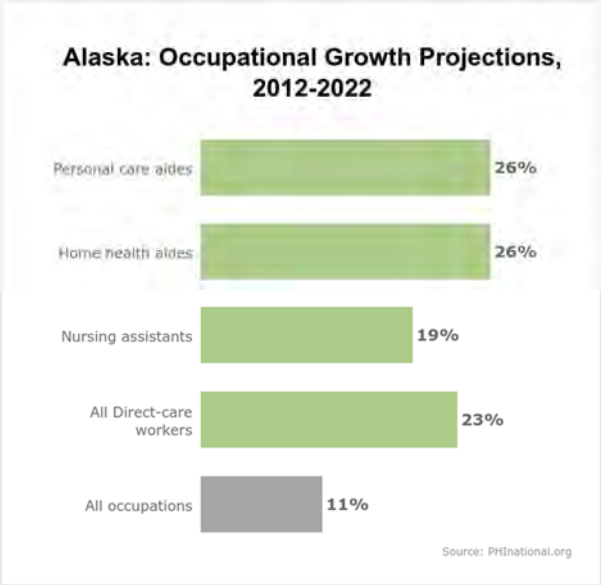
3.1. Workforce Stability

DHSS has a number of challenges to its workforce, including recruitment and retention, succession planning, and identifying the most cost effective ways to provide training.

A. Recruitment and Retention

Alaska, like most states serving a significant rural population, struggles to recruit and retain health professionals to serve remote parts of the state. This challenge will only worsen as occupational growth projections for health professionals in Alaska are more than twice that of other fields as shown in Exhibit 3-1.

Exhibit 3-1: Occupational Growth Projections



Source: "Alaska: Occupational Growth Projections, 2012-2022." *PHI: Quality Care Through Quality Jobs*. Paraprofessional Healthcare Institute. Web. http://phinational.org/node/16101/occupational-growth-projections. Accessed June 24, 2015.

Findings

One of the most significant recruitment and retention challenges in the department is for employees who are required to travel extensively for their positions, particularly public health nurses and child welfare workers. For a state with such expansive geography and weather-related travel challenges, policies regarding work arrangements (e.g., alternative work weeks, being home-based) and recruitment efforts are notably inflexible.

A.1 Recommended Recruitment Strategies

The World Health Organization (WHO) has identified attraction and retention of health care workers in rural areas as a global problem. WHO has recommended several strategies to address this challenge, including:

- Introducing a financial rural allowance;
- Providing better housing facilities for health care workers;
- Developing preferential opportunities for specialist training;
- Offering generous benefit packages;

- Changing the workplace culture from hierarchical to relational management; and

- Making it compulsory for health professionals to work in underserved areas for a certain period of time as either a condition of employment or professional advancement within a state government agency.

The National Rural Health Association advocates additional strategies such as:

- Implementing scope of practice changes: Scope of practice restrictions can prevent healthcare professionals from performing the full range of skills for which they have been trained. The impact of such restrictions can be particularly harsh for already underserved rural areas.[14] States can address this issue by ensuring that state-specific scope of practice laws allow non-physician primary care providers to diagnose, order tests, write prescriptions and make referrals.[15]

- Reforming reimbursement and payment policies: Review and adjust reimbursement models to better reflect the realities of rural settings.[16]

- Expanding the use of telemedicine: The Alaska Telehealth Advisory Council (ATAC) was established in 1999[17] with ongoing efforts to further enhance the use of telemedicine in Alaska.[18] The expanded use of telemedicine can help build capacity and increase recruitment and retention of health care providers in rural areas.

In 2010, the Alaska Department of Labor published the Alaska Health Workforce Plan that outlines the following strategies for recruiting health care workers:

- Engage Alaskans in the health care workforce by expanding career awareness and counseling, and marketing high needs professions to attract job seekers.

- Train Alaskans for health care employment ("growing your own" is especially important in rural areas) by strengthening secondary school offerings and programs, providing occupational training, delivering post-employment training, and developing needed faculty.

- Recruit qualified candidates by promoting Alaska opportunities, expanding post-graduate opportunities, improving coordination in recruitment, and establishing incentives.

DHSS staff members have made extraordinary efforts to develop strategies and pursue more flexible policies for employee recruitment and retention. However, these arrangements vary

widely by division. Some of the strategies implemented to address this continuing workforce challenge include:

- Creating an Emmy-award winning recruitment video in the Division of Public Health (DPH);
- Developing a realistic recruitment video for child welfare workers in Office of Children's Services (OCS);
- Establishing a continuous recruitment process for child welfare workers in OCS, which required months of negotiation with the Alaska Department of Administration (DOA);
- Developing alternative work arrangements in OCS (such as two weeks on, two weeks off);
- Creating a travel team in OCS to address vacancies in field offices across the state; and
- Implementing the SHARP I and SHARP II direct incentive and loan repayment programs to grow the health care worker pool statewide.

A.2 Child Welfare Workers

Extensive research is available on the recruitment and retention of child welfare workers. While this challenge is not unique to Alaska, the turnover rate among Alaska child welfare workers is alarming; according to data provided by OCS, over 50 percent annually and on track to reach 84 percent for 2015. A comprehensive review of research on the recruitment and retention of child welfare workers in 2009 enumerated several successful strategies for improving retention of child welfare workers.[19] These included:

- Creating an empowering and supportive work culture.
- Removing administrative barriers.
- Decreasing workers' safety risks.
- Clearly communicating expectations and standards.
- Assigning a gradual build-up of caseloads.

- Developing a two to four-year plan for new worker development that includes mentoring, core training, on-the-job training, and opportunities to attend ongoing skill development trainings.

- Strengthening the skills of field supervisors - Research shows that successful supervisors are well trained and spend time working with their staff rather than on administrative tasks.

- Developing customized solutions, such as "design teams" composed of workers at all levels who focus on solving problems that cause worker turnover. This inclusive approach addresses many workers' greatest area of dissatisfaction – a lack of recognition and respect. The process also helps workers move from blaming others for agency problems to working as a team to find solutions. Studies have found that many child welfare workforce problems are unique to each location and require solutions designed to address those specific problems. For example, in New York, the design teams used job satisfaction survey results and logic models to identify the problems causing turnover at particular sites. When confronted with case record inconsistency, the design team recommended developing new agency procedures. Similarly, when employees cited parking problems, the design teams recommended persuading the county to change restrictions. Design teams in New York have been successful in multiple environments, including rural and urban offices and work with tribal communities.

A number of studies have quantified the cost of turnover in different industries. A 2012 report reviewed 11 research studies on employee turnover and concluded that the cost to replace an employee earning between $50,000 and $75,000 averages about 20 percent of the salary for that position.[20] The average salary for a child welfare worker in DHSS is about $57,924 (excluding benefits). Using the 20 percent estimate for the cost of turnover, the estimated DHSS cost per new caseworker hire is $11,585. If 240 new front-line child welfare workers must be hired in 2015 to fill vacant positions (based on current estimates), the direct and indirect costs to the department will total $2,780,352. In addition, high turnover has a negative impact on the quality and quantity of services provided.

A.3 Workforce Demographics

When developing successful employee recruitment and retention strategies, DHSS must also consider the ethnic composition of its workforce. While DHSS has the highest percentage of minority employees of any Alaska state agency – 32 percent - the percentage of staff who are Alaska Native or American Indian is just under 5.5 percent.[21] In comparison, the Alaska Native and American Indian population in the state is 14.1 percent.[22] In recognition of this disparity and

the challenges it creates in working with tribal communities, the Division of Juvenile Justice (DJJ) is leading an inter-departmental work group on workforce development and identifying opportunities to encourage minorities to consider a career in state government.

A.4 Lack of Flexibility

Staff across the department reported inconsistencies in state, departmental, and division policies related to flexible work hours and working from home, which can make many jobs less difficult and more desirable.

Recommendations

More planning, flexibility, and innovation is needed to recruit and retain a diverse and stable workforce in the unique rural environment in Alaska. Strategies that can be implemented by DHSS include the following:

Recommendation 3.1.A.1.

Form a multi-disciplinary work team to develop a long-range plan for recruitment and retention of field workers in the department. This team should include, at a minimum, representatives from affected divisions, the DHSS training coordinator, a fiscal representative from Finance and Management Services (FMS), and a representative from the Office of Tribal Relationships recommended for development (discussed in Section 3.2.F of this report). This team should consider the suggestions provided in this report as well as others.

Recommendation 3.1.A.2.

Implement the targeted strategies identified in the newly developed DHSS plan to recruit and retain field staff. The following strategies will require extensive executive-level coordination with the Alaska DOA to implement:

- Increase flexibility to allow staff to work alternative schedules and work from home.
- Expand continuous recruitment across the department for hard-to-fill positions or positions with high turnover. [Note: This has been negotiated by OCS for child welfare workers.]
- Identify ways to recruit Alaska Natives and American Indians to work in the department. Identify the barriers that make it difficult to recruit, hire, or retain Alaska Natives and American Indians and develop a plan for addressing the barriers. For example, some minimum qualifications for positions in field offices may be barriers to hiring otherwise

qualified individuals. Changes to minimum qualifications may require action by the executive branch, collective bargaining entities, and the legislature.

B. Succession Planning

While employee retention and recruitment issues plague the department, creating a large number of vacant positions, succession plans for replacing key personnel are not formalized. Succession planning is needed even more as the agency faces a large number of potential retirements in the next few years.

Findings

As of April 20, 2015, out of 3,985 positions (PCNs) in DHSS, 334 (8.4 percent) were vacant. On average, the length of the vacancy is 162 days, with a range of 5 to 1,492 days. Of the 334 vacant positions, 49 have never been filled. Vacancies exist in every division, with vacancy rates ranging from just under 6 percent to 15 percent of all authorized positions, including permanent, temporary and internships. Table 3-1 shows the vacant positions by division.

Table 3-1: Vacant Positions Summary by Division as of April 20, 2015

Division	Positions	Vacant Positions	Percent of Positions Vacant
APH	723	49	6.8%
Commissioner's Office	40	6	15.0%
DBH	421	25	5.9%
DJJ	537	36	6.7%
DPA	640	72	11.3%
DPH	507	61	12.0%
FMS	235	20	8.5%
HCS	137	16	11.7%
OCS	550	35	6.4%
SDS	195	14	7.2%
Total	3,985	334	8.4%

Source: *Human Resources Section*. Alaska Department of Health and Human Services. April 20, 2015.

According to department officials, although there is no formal DHSS succession plan or planning process, the department has engaged in succession planning by analyzing DOA retirement eligibility data, assessing training needs, and developing new training classes. DHSS has reviewed the DOA Division of Personnel and Labor Relations' annual workforce profile that provides departments with figures on the number of employees (by job classification) who are eligible to retire immediately, within one year, between one and five years, and more than five years. That information is used by divisions, and by the department as a whole, to assess gaps in knowledge and skills for potential future leaders, and to develop training that will minimize the gaps. DHSS is also developing a leadership development program.

Table 3-2, from the DOA 2014 Annual Workforce Profile, shows the number of employees eligible for retirement over the next few years.

Table 3-2: State Employee Retirement Eligibility

Department	Number of Employees	Less Than One Year (# and %)	One to Five Years (# and %)	More than Five Years	No Retirement Date Available
Administration	993	107 (10.8%)	87 (8.8%)	328	471
Commerce, Community and Economic Development	464	66 (14.2%)	43 (9.3%)	133	222
Corrections	1,749	203 (11.6%)	170 (9.7%)	433	943
Education and Early Development	317	58 (18.3%)	30 (9.5%)	115	114
Environmental Conservation	504	66 (13.1)	46 (9.1%)	158	234
Fish and Game	1,451	170 (11.7%)	102 (7.0%)	533	646
Health and Social Services	**3,253**	**403 (12.4%)**	**320 (9.8%)**	**951**	**1,579**
Labor and Workforce Development	740	136 (18.4%)	80 (10.8%)	223	301
Law	535	71 (13.3%)	43 (8.0%)	159	262
Military and Veterans Affairs	272	38 (14.0%)	25 (9.2%)	67	142
Natural Resources	894	127 (14.2%)	86 (9.6%)	294	387
Office of the Governor	143	24 (16.8%)	86 (9.6%)	34	67
Public Safety	837	120 (14.3%)	99 (11.8%)	268	350

Department	Number of Employees	Less Than One Year (# and %)	One to Five Years (# and %)	More than Five Years	No Retirement Date Available
Revenue	522	68 (13.0%)	43 (8.2%)	164	247
Transportation and Public Facilities	3,278	457 (13.9%)	351 (10.7%)	1,022	1,448
Statewide	15,952	2,114 (13.3%)	1,543 (9.7%)	4,882	7,413

Source: "State of Alaska Workforce Profile: Fiscal Year 2014." Alaska Department of Administration, Division of Personnel and Labor Relations, June 2014. PDF File. Web. http://doa.alaska.gov/dop/fileadmin/DOP_Home/pdf/dopannualreport.pdf. Accessed June 24, 2015.

The percent of DHSS employees eligible for retirement within a year (12.4 percent) is just under the statewide average of 13.3 percent. Of important note, however, is the number of employees eligible for retirement by job classification. There are more than 50 job classifications out of 292 in the department with 25 percent or more of staff eligible to retire in one year or less. The highest percentage of employees eligible to retire in one year or less, by classification, are:

- Admin Operations Managers II (33 percent)
- Certified Nurse Aide II (37.5 percent)
- Division Operations Managers (37.5 percent)
- Grants Administrator III (29 percent)
- Health Program Manager IVs (50 percent)
- Maintenance Generalist Foremen (33 percent)
- Mental Health Clinician III (41 percent)
- Public Health Nurse Aides (75 percent)
- Nurse Consultant II (40 percent)

Of the 97 job classifications for which there is an employee count of only one, 15 have incumbent employees eligible for retirement within one year.

Many employees do not retire upon eligibility, and often work for years beyond their eligibility date. This is often the case with many long-term, dedicated DHSS staff. Nevertheless, they will leave eventually and often unexpectedly and the department needs to be ready.

In 2013, DHSS undertook an important step in the succession planning process by conducting a training needs assessment to identify gaps between required and current performance and employee competencies. Such an assessment is not only key to a succession planning process, but it also helps with current operational and staff retention issues. The assessment was based on an alignment of critical personnel competencies (defined as skills, abilities and

knowledge) with the department mission. Assessment goals included identifying current training needs; reducing unnecessary training costs; eliminating redundant training; developing department-wide and individual training plans; and helping determine and direct resources to areas of greatest need to eliminate identified gaps.

Recommendations resulting from the assessment included:

- Make external and individualized training opportunities for specific positions more accessible.
- Offer training at times when it is needed and according to the level of expertise required by different categories of personnel.
- Limit training to three days and offer training in separate modules or sections.
- Implement a department-wide training system and computer-based and distance learning opportunities.
- Explore opportunities for easier access to available resources and sharing those among divisions for increased training efficiency.

Recommendations

Recommendation 3.1.B.1.

Evaluate positions that have been vacant for more than six months to determine need. This evaluation should be mandatory, although a process can be developed for allowing exceptions so that positions with sufficient justification because of need or recruitment or other documented difficulties remain open until filled.

Recommendation 3.1.B.2.

Repurpose vacant positions that have never been filled. There are 91 positions that have been vacant for more than six months; 48 of those positions have never been filled.

Recommendation 3.1.B.3.

Develop a formal succession plan to internally cultivate future leaders and certain skilled non-management positions. This effort should go beyond creating some new training offerings, and include such measures as:

- Identifying key positions that are critical for the success of the organization. For these positions, a succession plan is essential. Key positions include senior managers, long-time staff with institutional and/or essential process knowledge and memory, those with unique, highly skilled credentials and qualifications, and those with positions that present challenges to recruitment.

- Identifying a pool of talented staff members who are interested in being promoted to future positions of leadership and/or positions requiring a mastery of unique skills and/or professional certifications/licensing, including identifying staff who can be placed on a "fast-track" for learning, advancing and taking on more responsibility at a rapid pace.

- Creating mentorship teams and a means to manage and capture a transfer of institutional and technical knowledge.

- Developing and providing training offerings and creating other opportunities for competency building.

- Assessing plan progress.

These efforts should be consistent with collective bargaining agreements or, if not currently permissible, future agreements should be negotiated to allow for achievable succession planning efforts.

Recommendation 3.1.B.4.

Implement all recommendations resulting from the DHSS training needs assessment.

C. Training: Planning and Prioritization

Training is an important component of an effective retention policy. DHSS has a department-wide training coordinator, who has conducted several activities to identify the training needs and training activities in the department, including:

- Extensively documenting the training courses offered to employees by division.

- Tracking progress on training goals and objectives at the department level.

- Conducting a survey of training needs.

- Identifying position-specific training needs within the department.

- Developing training plans for 2013, 2014, and 2015.

- Convening a monthly training meeting attended by training staff across all of the divisions.

Findings

The department-wide training coordinator is a relatively new position within DHSS and considerable progress has been made to gain a full understanding of the training needs and practices within the department. However, during the course of this performance review, two training issues that significantly impact the budget and operations were identified:

1. A very short training period for new OCS workers, resulting in reduced federal revenues and leading to high staff turnover.

2. An extensive training period for the Division of Public Assistance (DPA) eligibility workers that has hindered the ability of DPA to address a significant backlog in eligibility applications.

Both of these issues are addressed more fully below, however they illustrate how training challenges within divisions have department-wide fiscal impacts.

Recommendation

Recommendation 3.1.C.1.

Prioritize training needs based on risk to the department budget (including the direct and indirect costs of staff turnover) and to vulnerable populations. The IT Governance system includes a prioritization process for each project, which can serve as a model when developing a system to prioritize training and professional development needs. Priority training issues should be discussed at department leadership meetings on a regular basis. For persistent issues, such as those in OCS and DPA, a multi-divisional task force should be convened to study the issue and submit recommendations to the leadership team for consideration.

D. Division of Public Assistance Training

DPA has a backlog of approximately five months in processing eligibility applications. DPA is developing a new eligibility system that has not yet been fully implemented. While working with two concurrent eligibility systems contributes to this backlog, another factor is the five-to-six-month training period required for all new eligibility workers.

Findings

All new employees are sent to Anchorage for two to three weeks to receive training (three weeks if receiving training in all programs), incurring airfare, hotel, and per diem expenses. This training is only offered quarterly. Employee recruitment is currently based on the training schedule, rather than driven by staffing needs. After participating in the on-site core training sessions, new employees remain on limited work duty (working half of a normal caseload) for up to four months post-training as they receive ongoing distance learning via Blackboard, an electronic distance-learning program. For the Gambell office in Anchorage, new hires are unavailable for six months after hire because they complete their distance learning training at the nearby Muldoon office and do not return to the Gambell office until they have completed their full training program.

There is no federal financial incentive for this extended training period. Unlike OCS, an enhanced federal reimbursement for workers in training with reduced caseloads is not available. In addition, no federal requirements specify the length or duration of training; federal requirements only specify error rates for determining eligibility for federal programs.

Over the last three years, DPA has reduced the duration of its training; however, the training period still far exceeds those in other divisions in DHSS and requires a larger amount of dedicated training personnel than any other division. DPA employs six trainers and an administrator in the central training office.

DJJ utilizes a train-the-trainer model for its aggression replacement program for juveniles in state custody. A train-the–trainer model enables an experienced master trainer in the central office to teach less-experienced personnel how to deliver services, courses, workshops, or seminars. The master trainer observes training classes delivered by local trainers on a routine basis to ensure that they are implementing the program according to guidelines. Master trainers conduct quality assurance reviews and mentor and counsel the local trainers. Local trainers are usually supervisors with training as one of their job functions. Local trainers receive follow-up training via video conferencing and take a refresher course every other year. A one-week training course for new trainers is held every other year in Anchorage. DJJ has found that the train-the-trainer model is cost effective and efficient, and is moving to implement the model for all of its programs.

The travel budget for DPA is the third highest among the divisions in DHSS, only behind DPH and OCS, which each have programs that require staff to travel extensively throughout the state. DPA staff members are not required to travel for their jobs, except to attend new hire training in Anchorage.

DPA has an excellent quality assurance system in place, with the ability to identify errors in each individual worker's caseload. The Quality Assessment Review Committee (QARC) conducts monthly conference calls to review errors across DPA offices. When errors are identified, the issue can be isolated to a particular eligibility office and worker. These offices and workers can be flagged to receive further training or policy clarification on the particular issue related to the error, if needed. DPA currently reviews 100 percent of trainee caseloads for errors.

The current DPA training system is inefficient, expensive, and as evidenced by the considerable backlog in workload, does not meet the staffing needs of the division.

Recommendations

Recommendation 3.1.D.1.

Create a master trainer program in DPA modeled after the DJJ program and allow eligibility workers who have low error rates (comparable to experienced employees) to take on greater caseloads as early as possible. Under this proposed training model, a local trainer would be identified at each local office and/or regional office (as determined by local needs). This will likely be an experienced, high-performing staff or supervisory position in most offices that would not be solely devoted to training. Large offices, such as those in Anchorage, may have one position dedicated to this on-site training function. These instructors would be trained centrally in Anchorage to become "certified trainers" by a DPA master trainer. Certified trainers would then be responsible for providing onsite training locally and/or regionally to new DPA employees on an ongoing schedule that best fits local staffing needs. It is important to note that there is very little turnover in some of the smaller DPA offices; training needs in these offices may be minimal.

The master trainer model will produce savings in travel and personnel costs. The curriculum already exists; only the training delivery mechanism will need to change. The recommendations below keep in place a core central training staff to provide support and assistance to local and regional staff identified as the trainers for their offices or regions. This model will enable DPA to address its backlog faster by speeding up the process of recruitment and training so that new staff can begin to take cases much earlier than they are now. The transition to a local training model should be coordinated with the full implementation of the new eligibility system.

The cost savings are estimated to be:

- $400,000 in general funds and federal reimbursements by eliminating four training positions in the DPA central office.

- $292,091 in expenses for training new hires, who will receive training in their home office rather than traveling to Anchorage for training. This amount represents about one-third of total DPA travel expenditures. Infrequent travel expenses may be necessary for master trainers and local trainers; to the extent possible, those expenses should be subsumed in the remaining DPA training budget.

Recommendation 3.1.D.2.

Eliminate the additional four months of continued distance learning and reduced caseloads for DPA eligibility workers. If monitoring of new employee caseloads indicates unacceptably high error rates, ongoing hands-on learning should continue on a case-by-case basis in the employee's local office under the supervision of DPA managers and supervisors. Quality assurance can pinpoint which new employees need to remain at a reduced workload, which need additional training, and which can increase their workload. Monitoring of every case for new hires should continue for the full six months, as is done currently.

E. Caseworker Training

OCS caseworkers receive two to three weeks of training (three weeks if specialized training is required) prior to assuming a full caseload. Once training is completed, OCS caseworkers have caseloads that typically exceed the standards recommended by the Child Welfare League of America (CWLA) – between 12 and 15 children per social worker.[23]

The average caseload of an OCS worker statewide is 29 families, often including more than one child. Assuming 1.5 children per family, OCS caseworkers have triple the recommended caseload. In addition, caseworkers outside of Anchorage must travel extensively to meet with the children and families in their caseload.

Findings

OCS experiences a turnover rate higher than 50 percent annually. In 2014, 147 new front-line caseworkers were hired out of a total staff of 286 front-line caseworkers. For 2015, about 20 new caseworkers are hired each month. If this trend holds, there will be 240 new caseworkers this year for a turnover rate of 84 percent. Staff members attribute the high turnover to the fact that new employees are asked to assume a full and overwhelming caseload after only two to three weeks of training.

Given the emotional and tense testimony from individuals reporting negative personal experiences with OCS at the public hearing in Fairbanks on May 14, 2015, along with the extensive complaints logged by the Alaska State Ombudsman's Office, there is a dire need to remedy this situation for the benefit of Alaska children, their families, and the OCS staff.

An enhanced federal matching rate is available for caseworkers during their training period, which can extend up to six months. According to OCS:

- The current federal financial participation (FFP) rate for OCS front-line staff is 50 percent. Section 474(a)(3) of the Social Security Act provides for an enhanced FFP of 75 percent for the cost of training employees.

- OCS may claim the enhanced rate of 75 percent FFP for various expenditures, including payroll and travel, for up to six months of a new hire's employment.

- The estimated additional revenue over a 12-month period would be $768,000 (as illustrated in Table 3-3).

Table 3-3: Savings from Extending New Hire Training

New Hire In Service Training Program	
Savings per new front line staff	$3,200
Yearly average of new front line staff (20 per month)	240
Total annual savings	$768,000

Source: Data provided by Alaska Office of Children's Services.

To receive the enhanced FFP rate, new front-line staff would have to carry a reduced caseload in comparison to a seasoned worker and must have increased supervision in the first year of employment. Recognizing that reduced caseloads will require greater demands of experienced caseworkers, OCS has never claimed the enhanced rate beyond the first two to three weeks of training.

Recommendations

Recommendation 3.1.E.1.

Reduce the caseloads for new child welfare workers to meet the enhanced federal Title IV-E reimbursement rate requirements for workers in training, as well as during the first six months of employment.

Recommendation 3.1.E.2.

Use the estimated additional revenue of $768,000 to hire additional caseworkers and supervisors in the appropriate ratio. Eight to 10 additional caseworkers or supervisors can be hired with these funds, with each new caseworker hire resulting in additional Title IV-E revenue for their six-month training period.

These changes will also have a positive long-term impact on employee retention and increases in Title IV-E reimbursement. As turnover among staff is reduced, the savings will diminish (fewer new caseworkers will need to be hired); however, OCS would be able to increase staffing to match increasing caseloads over the next two to three years.

3.2. Specific Efficiency Issues

A. Performance Evaluations

According to state human resource statutes and policies, employee merit increases may be granted or withheld based upon an evaluation of an employee's performance by the appointing authority. These evaluations are used to determine possible pay increases (if the evaluation is mid-acceptable or higher) and must be completed before a merit raise is given.

Findings

In DHSS, as many as 200 annual employee performance evaluations are past due at any given time. This delay creates concerns for employees who cannot receive a raise until a performance evaluation has been completed. This delay in pay increases contributes to low morale throughout the department according to at least one DHSS staff interviewed by the review team.

This creates issues not just for employees, but also for divisions and the department as a whole. Often delays are several months, and because employee salary actions are retroactive to the due date, there is frequently a need for a lump sum payment once paperwork has finally been completed. The amounts of the lump sum payments can be significant when reviews are

delayed several months, or for some, more than a year. Large lump sum payments may negatively impact budgets, especially when delays go past the end of a fiscal year.

Analysis of DHSS human resource data indicates that, as of April 1, 2015, 386 performance evaluations were pending completion by the close of FY 2015. Of those, 219 evaluations were past due. The number of days evaluations were delinquent ranged from 16 to 820 days. The average number of days late was 174 days; 82 evaluations were more than six months past due.

Table 3-4: Performance Review Delays By Division

Division	Performance Evaluations Pending Completion Prior to the Close of FY 2015	Number Late	Percent Late	More than Three Months Late	More than Six Months Late	Average Number of Days Past Due (As of April 1, 2015)
APH	117	82	70%	49	32	192
COMM	7	6	86%	4	3	217
DBH	39	22	56%	9	5	111
DJJ	42	8	19%	0	0	36
DPA	60	37	62%	26	17	175
DPH	46	28	61%	16	12	215
FMS	26	14	54%	9	6	166
HCS	6	3	50%	2	1	162
OCS	26	12	46%	8	3	131
SDS	17	7	41%	5	3	248
DHSS	**386**	**219**	**57%**	**128**	**82**	**174**

Source: Table provided by DHSS.

As observed in Table 3-4, more than 40 percent of performance evaluations were past due in all divisions other than DJJ.

Recommendation

Recommendation 3.2.A.1.

Implement a system that requires the timely completion of employee performance evaluations and holds supervisors and managers accountable for meeting this requirement. In fact, the timely completion of performance evaluations should be one of the areas included in supervisor and manager evaluations.

The process and policies used in DJJ should be reviewed, and possibly replicated, since it is the division that is significantly above average for the department in timely completion of evaluations. At the time of this review, no evaluations in DJJ were more than three months late.

B. Internal Audit

Internal control is a process to provide reasonable assurance that an organization is safeguarding its assets, data is accurate and reliable, operational efficiencies are considered and encouraged, and policies and procedures are established, updated as needed, and monitored for compliance. According to the Alaska Administrative Manual, each agency is to adopt methods to periodically assess risk, and to develop, implement and review its system of internal controls.[24]

Findings

Several recent audits, and a risk assessment conducted by an outside firm, found weaknesses in the internal controls throughout DHSS.

The U.S. Department of Health and Human Services (DHHS) audit/investigation of DHSS in 2012 found no recently prepared risk assessments, which are a federal requirement. The investigation also found DHSS did not have required policies and procedures in place. Despite DHSS disagreement with some of the findings, the department did pay a federal fine.

Several recent reviews/audits by the Alaska State Legislature Division of Legislative Audit identified instances of lack of compliance with internal controls. They found inadequate controls to manage timely and accurate reconciliation of federal revenues to federal expenditures and insufficient monitoring of reports required for the WIC program, due to a "lack of adequate procedures for report review."[25] One division lacked adequate procedures to ensure provider certification files were accurate and complete, and department revenue shortfalls were identified as "due to weaknesses in internal controls over monitoring revenue collections."[26] Findings from these audits have been or are being resolved; nevertheless, the frequency and consistency of

these findings show that a greater priority needs to be placed on establishing on-going structures and management of an internal control process for the department.

While agency management is ultimately responsible for establishing and ensuring compliance with internal controls under their organizational purview, many organizations – especially larger, complex organizations – use internal audit departments to assist in developing controls; assessing risk and conducting reviews or audits to help ensure controls are working as expected; and ensuring all required activities are occurring.

Although DHSS has an internal audit unit within the FMS division, managed by an Internal Auditor IV, this two-person unit conducts very limited reviews of control activities. The unit has conducted only three departmental internal reviews in the last 18 months. Most of the resources of this unit are devoted to required activities such as sub-recipient monitoring, grantee risk analysis, reconciliation of grantee financial statements to grant expenditures, and other (mostly federal) grant-related activities.

The audit unit, organizationally within FMS and reporting to the Assistant Commissioner, has an extremely important and vital role to help ensure reports required of DHSS grantees are accurate and current. Reconciliations and desk and on-site audits conducted by this unit hold grantees accountable for complying with state and federal requirements and help to ensure funds are spent appropriately.

According to unit staff, most of their time is spent dealing with grantees and the reports they submit. Due to its small staff size, the unit is more limited in scope than a fully functioning internal audit office. Given the diversity and complexity of DHSS' programs, its reliance on non-government organizations to provide services, and the scrutiny of the federal government, such limited internal audit activities are detrimental to the ability of the department to provide effective and efficient services and help ensure internal controls are operating as intended. A full-scoped internal audit office should develop a charter explaining its mission, vision and duties; assess risk throughout the department; develop an annual audit plan to ensure critical items are identified in its assessment; schedule audits targeted at high-risk areas; conduct occasional random audits; and report directly to the highest level in the organization – for DHSS, the Commissioner.[27]

According to a recent Institute of Internal Auditors Research Report, the nine key elements of effective public sector audit activity are: [28]

- Organizational independence
- A formal mandate

- Unrestricted access
- Sufficient funding
- Competent leadership
- Objective staff
- Competent staff
- Stakeholder input
- Professional audit standards.

To address state and federal audit findings, DHSS prepared a list of corrective actions taken in the past three years (FY 2012 - 2014). Of the 55 actions reported, 65 percent had a finding related to internal control weaknesses. DHSS has done a good job in the past three years to resolve these findings, some of which were from audits more than 10 years ago. If the department had an internal audit office with department-wide responsibility and sufficient resources, many of these findings would have been discovered and corrected internally prior to outside audit findings. Internal auditing is an essential part of a system of internal controls for an organization of DHSS' size and complexity.

Recommendation

Recommendation 3.2.B.1.

Establish an internal audit section for the entire department. Certain functions currently performed by the audit group, such as reconciliation of financial reports to expenditure data, should be conducted by the Grants and Contracts section or another DHSS section. By having an internal auditor with an enterprise-wide focus on internal controls and reviews, DHSS should reduce errors, reduce adverse and costly federal audit/investigation findings, and improve efficiency.

Rather than benchmarking to other Alaska state agencies or to other states' health and human service agencies to determine how many professional and support staff should be employed by DHSS' Internal Audit unit, the department should first determine the activities it wants to do (understanding the constraints imposed by limited resources, at least in the short term) and develop a conceptual model to help determine the optimal size of the audit program. Research from the Institute of Internal Auditors (IIA) provides a methodology for developing an appropriately sized internal audit program.[29]

C. Licensing and Certification

DHSS conducts licensing in five divisions, as shown in Table 3-5.

Table 3-5: Licensing Activity by Division

Division	Function	Number of Staff	Number of Facilities	Frequency of On-Site Reviews	FY 2015 Governor's Amended Budget
DPA	License child care facilities and homes	20	107 homes; 76 group homes; 104 centers; 80 DEED programs	At least every 2 years	$ 2,200,000
HCS	License and certify health care facilities	14	116 facilities	At least annually	$2,260,400
HCS	License residential care facilities	19	636 assisted living facilities; 54 residential treatment facilities	At least annually	$4,697,300
SDS	Certify residential care facilities and personal care attendants	10	912 provider agencies	At least every 2 years	$20,578,900
OCS	License foster care homes	33	1,480 licensed facilities; 222 licensing applicants; 253 unlicensed relative caregiver homes	At least every 2 years	$4,378,700

Source: Data provided by DHSS.

Findings

Although licensed by separate divisions within DHSS, child care homes and centers (licensed in DPA) and residential care facilities (licensed in the Division of Health Care Services (HCS)), are governed by the same state statute. Foster care home licensing, conducted by OCS, is also included in the same statute.

These licensing functions require considerable travel throughout the state by each division. Each division also has various automated systems that are used to track and monitor licensing activity.

Staff members report good working relationships and coordination among the various divisions. However, there is some overlap among divisions. For example, the Division of Senior and Disabilities Services (SDS) certifies about 300 of the residential care facilities that HCS licenses. An investigation of a provider by one division may reveal a violation regulated by another division that necessitates a subsequent investigation.

Of 14 states reviewed, 10 combine health care facilities licensing and certification into a single division or unit within a department. The 10 states that have these functions combined are shown in Table 3-6.

Table 3-6: States with Combined Health Care Facilities Licensing and Certification

State Reviewed	Department	Division
Georgia	Department of Community Health	Healthcare Facility Regulation
Hawaii	Department of Health	Office of Healthcare Assurance
Idaho	Department of Health and Welfare	Licensing and Certification Division
Minnesota	Department of Health	Health Regulation Division
Montana	Department of Public Health and Human Services	Quality Assurance Division
New Mexico	Department of Health	Health Facility Licensing and Certification Bureau
North Dakota	Department of Health	Division of Health Facilities
Oklahoma	Department of Health	Medical Facilities Division
South Dakota	Department of Health	Office of Health Care Facilities Licensure and Certification
Wyoming	Department of Health	Healthcare Licensing and Surveys

Source: Data available from other states.

One state, Montana, includes child care facilities in the same division as health care facilities.

Recommendations

Recommendation 3.2.C.1.

Combine the DPA, HCS, and SDS facility licensing and certification functions into a single office or new division. This will allow more efficient and effective coordination of travel and personnel. Savings targets are based on the assumption that instead of sending three DHSS staff, for example, to inspect three facilities, one staff would be sent to inspect the three

facilities. Assuming a modest savings in travel of $50,000 (the elimination of 33 field visits each year, assuming $1,500 per trip) and the elimination of at least two of the 63 positions as a result of consolidating these programs, the targeted annual savings would be $250,000. Additional savings can be achieved by cross-training staff to ensure licensing requirements for each type of facility are understood. Calculations of additional savings would need to account for the cost of additional training.

Recommendation 3.2.C.2.

Foster care home licensing should remain a separate function because it is so closely integrated with the fieldwork performed by child welfare workers. A recommendation is included in Section 3.2.I of this report to separate the licensing of foster care homes from the current state statute governing the licensing of other facilities.

D. Site Visits

Multiple DHSS divisions conduct site visits for a variety of purposes, including review of 555 grants to about 250 grantees across the department.

Findings

During focus groups conducted for this project, DHSS staff members repeatedly noted that grant compliance monitoring efforts are limited by reduced travel budgets and staffing resources.

DHSS divisions have developed a variety of strategies to deploy limited resources as effectively as possible. For example, DJJ trains Juvenile Probation Officers (JPOs) to incorporate site visits while in communities to check in with youth currently on probation. This has reduced travel costs for separate reviews while simultaneously supporting community relations. DJJ reports that site check-in visits have helped change community perceptions that DJJ staff members only come to town when something is wrong or to “take the kids.”

Recommendations

Recommendation 3.2.D.1

Expand cross-training opportunities so staff can conduct multi-purpose site visits. With limited resources for on-site compliance reviews, this can reduce travel costs and increase compliance at sites where limited staff resulted in infrequent or untimely visits. To minimize additional training costs, DHSS should evaluate opportunities to incorporate elements of cross-training into current employee training curriculum.

Recommendation 3.2.D.2.

Consider creating a formal process for coordinating site visits. For example, assign a regional travel coordinator who coordinates site visits for grantees by region.

Recommendation 3.2.D.3.

While maintaining needed subject matter expertise, explore opportunities for interdivisional DHSS site visit compliance teams that can evaluate multiple department grantees during limited visits to remote areas of the state.

Recommendation 3.2.D.4.

Expand collaboration with other local and state agencies that perform site visits (such as the Fire Marshal) to alert the department to any potential issues. Such collaborations can be formalized in MOAs/RSAs or may be just informal courtesy calls.

E. Mini Grants

Alaska – like most states serving disperse rural populations – struggles to find qualified service providers in remote parts of the state. This is particularly true in the health and human services arena.

Findings

Often, even when providers possess the subject matter expertise to provide services, they do not have the staff or technological resources needed to access and comply with complex grant requirements of state and federal agencies. In focus groups for this project, DHSS staff members noted that this is particularly true for potential grantees that cannot navigate the DHSS Grants Electronic Management System (GEMS).

DJJ has addressed this challenge by allowing larger regional non-profit organizations with the internal capacity to manage administrative and compliance requirements to serve as primary grant recipients. They, in turn, coordinate a delivery plan and issue “mini-grants” to smaller providers who can best support services at the local level.

This approach is utilized in the DJJ Rural Alaska Community Action Program (RurAL CAP), the Culture Grant Program supported by “Native American Pass Through” (NAPT) funds, and with delinquency prevention funds from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Federal Title II formula grant program.

RurAL CAP passes through funds to individual communities under a sub-grant program arrangement. Applicants (federally-recognized Tribes with a law enforcement presence) receive grants up to $10,000 bi-annually to design, develop and implement culturally centered projects that empower Alaska Native and American Indian youth ages 12-17 in making positive life choices. In this program, DJJ not only works with partners to reduce the disproportionate number of minority youth in the juvenile justice system, but does so in a manner that increases the ability of Alaska Native and American Indian communities to better develop and manage grant programs. Along with grant funds, RurAL CAP also provides sub-grantees with training and technical assistance to build the capacity of each applicant to apply and manage other grants in the future.

Recommendation

Recommendation 3.2.E.1.

Using the DJJ approach to "mini-grants" as a model, all DHSS divisions should explore opportunities to expand the pool of service providers in remote or hard-to-serve areas of the state. This approach can be valuable not only for initial service delivery but also to cultivate a provider pool with grant application and management experience in smaller and tribal communities. No additional costs to DHSS are envisioned; any costs for coordination between the primary grant recipient and the local "mini-grantees" would be incorporated into the grant proposal/agreement.

F. Tribal Relations

Most of the divisions within DHSS have extensive interactions with tribal communities, and many of these divisions have a tribal office or liaison: HCS, OCS, Division of Behavioral Health (DBH), and DJJ, for example.

Findings

Multiple DHSS staff have on-going communication with tribes, resulting in multiple points of contact on a variety of issues, such as health care, child welfare, social services (i.e. SNAP and TANF), regulatory issues, and public health. Staff members in DPH and OCS regularly travel to tribal communities; however, they communicate separately with those communities.

There are two formal mechanisms for communicating with the tribes on health care. The quarterly State/Tribal Medicaid Task Force is co-chaired by DHSS and an elected tribal leader. All of the DHSS division directors (or their designee) participate as well as lead program staff from HCS. Twice per year, DHSS participates in a meeting with the Native Tribal Health

Consortium. These meetings are co-chaired by the DHSS Commissioner and the President of the Alaska Native Health Board. No department-level policy on or coordination of tribal relationships beyond health care was identified within DHSS. DHSS has a tribal consultation policy for Medicaid and CHIP;[30] however, a department-wide policy was not identified during this review.

Research of 10 peer states indicates that two have a tribal office or designated tribal liaison within the state health and human services department: Montana has a Tribal Relations Manager reporting directly to the Director of the Department of Public Health and Human Services and Idaho has a Statewide Tribal Relations liaison in the Department of Health and Welfare. Eight of the states reviewed have a tribal office or liaison that reports directly to the Governor as shown in Table 3-7.

Table 3-7: States with Tribal Offices

State	Name of Office or Position
Georgia	Georgia Council on American Indian Affairs
Hawaii	Office of Hawaiian Affairs
Idaho	Council on Indian Affairs
Montana	Governor's Office of Indian Affairs
New Mexico	Indian Affairs Department
North Dakota	North Dakota Indian Affairs Commission
Oklahoma	Native American Affairs Liaison
South Dakota	Department of Tribal Relations

Source: Information available from websites or organizational charts in each state.

In Alaska, the Department of Transportation and Public Facilities (DOT&PF) has a policy on tribal relationships that may serve as a guide for DHSS; the DOT&PF policy recognizes the sovereignty of tribal nations and specifies how communication with tribes may be initiated and conducted by department staff.[31]

Recommendation

Recommendation 3.2.F.1.

Create an Office of Tribal Relationships in the Office of the Commissioner at DHSS. This position should be supported either moving a tribal liaison from one of the divisions to serve in

this role or by repurposing a vacant position within DHSS. This office should consist of one or more staff.

This office should coordinate with the tribal liaisons in each division to identify areas of overlap in tribal communications, develop policies and procedures for tribal communications, identify priority areas for improving relationships with tribal communities, develop on-going work plans to address priority areas, and support and coordinate communication for staff who regularly travel to tribal communities.

G. Division of Juvenile Justice Fairbanks Kitchen

The Fairbanks Youth Facility (FYF) opened in 1986, with additional construction in 2004. The on-site kitchen has never been used to produce meals for residents on a daily basis. Currently, the Boys and Girls Home of Alaska provides meals for the FYF at an annual cost of $250,100.[32] DJJ reports that it is uncertain how long the Boys and Girls Home will be able to continue this service. DJJ estimates that it spends an additional $5,000 each year for supplemental food needs beyond the provided meals, for a total annual cost of $255,100.[33]

Findings

DJJ has compared costs of its current food service contract with estimated in-house food preparation costs. If DJJ could provide food service with no new positions (moving PCNs from another location as they become available), the estimated annual savings would be just over $84,000.[34] If DJJ adds one new food service staff position, the cost is roughly comparable to the current food service contract (an estimated $3,700 increase annually).[35]

DJJ has collected and evaluated costs for remodeling the Fairbanks kitchen. DJJ estimates a minimum of $134,500 to update the kitchen equipment for full-time meal service, with potentially another $105,000 needed for sewer line, electrical and range hood improvements (pending evaluation).[36]

Based on these estimates, it would take DJJ two to three years to recoup the remodeling cost from potential food service savings (if no new PCNs are added).

DJJ currently offers vocational and occupational training programs, including a Culinary Arts program. Federal grant funds from the Workforce Investment Act (WIA) help support these programs. Participating youth remain eligible for WIA support (for appropriate work attire, vocational training classes and other incidental expenses necessary to facilitate successful reentry back into the community) for twelve months after they exit WIA programs.

Federal funds are also available specifically for school kitchen equipment purchases through programs such as the USDA National School Lunch Program Equipment Assistance Grants.[37]

Currently, the University of Alaska Fairbanks Career and Technical College provides a sequence of three culinary arts classes for students in the Fairbanks Treatment Unit. These classes are paid for using Title IA, Subpart 2, Neglected and Delinquent Grants (provided in conjunction with the Fairbanks North Star Borough School District).[38]

According to DJJ, the limitations of the current FYF kitchen prevent any additional culinary course work. If the kitchen is brought back online, a culinary certificate program could be instituted at the facility. Both the FYF Superintendent and the UAF Career and Technical College have expressed an interest in establishing such a certificate program to offer career experience and community connections to residents prior to exiting FYF.

If implemented, this program could be eligible for additional Workforce Investment Act funding.

Recommendations

Recommendation 3.2.G.1.

Continue to evaluate opportunities to update the Fairbanks Youth Facility kitchen for full-time meal service.

Recommendation 3.2.G.2.

Pursue federal and private grant funding to help offset the cost of needed kitchen remodeling and equipment purchases.

Recommendation 3.2.G.3.

Review opportunities to increase DJJ Workforce Investment Act funding as vocational training opportunities – including a culinary arts certificate program – are expanded.

H. Juvenile Offender Prosecution Sentencing

The Alaska juvenile justice system – supported in large part by the DJJ and the Alaska Juvenile Justice Advisory Committee (AJJAC) – is nationally recognized for its work with youth offenders.

DJJ has a well-documented record of providing rehabilitation services and supports to youth who return successfully to educational or vocational settings.

Findings

Referrals to DJJ have declined 56 percent over the past 12 years (FY 2003-FY 2014), while the overall population of Alaska youth (ages 12-17) fell by only 11 percent during that same time period. The number of admissions to DJJ facilities has similarly decreased between FY 2003–FY 2014, with the average daily population declining by 33.2 percent over this time period.[39]

In its 2014 annual report, the AJJAC recommended several statutory tools for prosecutors and the courts when confronted with juveniles who commit serious offenses.[40] The AJJAC noted that these recommendations were intended to preserve the ability to provide treatment and rehabilitation to juveniles, whose brains and social development are not yet complete.

Recommendation

Recommendation 3.2.H.1.

Implement juvenile prosecution and sentencing strategies that will reduce recidivism, lower costs, and improve outcomes for youth, including the following advocated by the Alaska Juvenile Justice Advisory Committee. These recommended public policy changes would place youth offenders in DJJ (versus in the Alaska Department of Corrections) settings which are better equipped to provide treatment and rehabilitation to juveniles, whose brains and social development are not yet complete. Long-term, these recommendations will reduce recidivism and reduce correctional costs to the state.

DJJ and DHSS cannot implement changes to the prosecution and sentencing of juvenile offenses unilaterally. These prosecution and sentencing strategies will require collaboration with other agencies and statutory modifications for implementation. As these recommendations are implemented, admissions to DJJ facilities will increase in correlation to decreases in the adult corrections population. The DJJ operational and personnel budget should be reevaluated and increased to account for the increased population. Savings recognized by removing the youth from the adult correctional system should be used to offset increased DJJ costs. Longer term, more appropriate treatment and rehabilitation options for youth should reduce recidivism and create additional savings.

I. Federal Reimbursement for Foster Care

Federal Title V-E funding can be claimed by states for eligible children in foster care who are in qualified foster care placements. The amount of Title IV-E funding that a state can receive is determined by a federal matching rate derived from a formula that considers the state per capita

income. In 2015, the federal matching rate for states ranged from 50 to 73.58 percent; the rate for Alaska in 2015 is 50 percent.[41]

The Title IV-E "penetration rate" is the percentage of foster care children in a state who are eligible for Title IV-E funds. Nationally, there has been a downward trend in penetration rates with a nearly 10 percentage point decrease: In 2002, the national penetration rate was 60.2 percent, decreasing to 51.6 percent in 2012.[42]

Findings

The top reasons cited for the drop in penetration rates nationwide are growing parental income (making them ineligible for federal assistance) and children being placed in homes that are not fully licensed.[43] While the first factor is beyond the control of state government, the second factor is not.

In Alaska, the same statute that governs the licensing of foster care homes also covers assisted living homes, residential child care facilities, and residential psychiatric treatment facilities. Combining the foster care standards with those of other licensed facilities increases the requirements for foster homes to be Title IV-E eligible.

Best practices for licensing foster care homes include the following:

- **Waiving training requirements for children placed with grandparents or other relatives.**

  A 2014 review of foster care home licensing requirements by the Child Welfare Information Gateway and the Children's Bureau noted that waiving foster parent training for relatives can facilitate placement of a child.[44] OCS currently has a policy for waiving relative training requirements, but it is not yet part of department regulations. The extent to which waivers are granted is unknown.

- **Separating licensing statutes for foster care homes from other residential care facilities.**

  Generations United and the American Bar Association Center on Children and the Law made this recommendation after conducting comprehensive legal research of foster care licensing standards in all 50 states and the District of Columbia. California made this change and now treats residential foster homes separately as private residences with an entirely distinct regulatory framework from that of all other community care facilities.[45]

Alaska grants emergency licenses to relative foster care homes, which allow the relative to begin receiving a general fund foster care payment. Monthly payments to relatives with an emergency license are not eligible for Title IV-E reimbursement. This policy reduces or eliminates the incentive for a relative to become fully licensed, which would allow the state to receive federal funds. OCS is developing a process that will replace emergency licenses. In the new process, OCS will provide a one-time payment to a relative to initiate care for a child, but still require that the family become licensed before monthly foster care payments begin.

Penetration rates are also affected by caseworker errors in completing documentation. The 2012 Title IV-E Foster Care Eligibility Primary Review for Alaska[46] found seven cases with errors in the 80 cases reviewed. Federal compliance allows no more than four errors in this number of reviewed cases.

A common source of documentation errors is inexperienced and overworked caseworkers. New York and Maryland use a Title IV-E checklist or template to assist caseworkers in providing complete documentation for each child.[47] Both states were in substantial compliance with federal regulations in their last Children's Bureau review. In New York, no case errors were found and in Maryland four case errors were found.

As noted throughout this report, a factor unique to Alaska is the remote travel required of OCS workers. Workers routinely fly to a rural village, arrange a ride or must walk to the home they are investigating, and sleep in a school or other public facility if they cannot catch another plane out the same day. Also somewhat unique to Alaska is the lack of cell phone service and internet service in rural areas. Workers generally have laptops and cell phones; however, useful applications – such as automatic voice dictation services, VPN access to state servers, and additional mobile technology – are difficult to acquire due to state policies related to technology purchases and implementation. Having access to additional tools to connect to state information databases would allow greater productivity in the field. Without such technologies in the field, the work overload for OCS workers continues to grow. According to Child Trends, penetration rate for Alaska was 28.5 percent in 2008; by 2012, it had increased to 38.5 percent, still low compared to the national average of 51.6 percent in 2012.[48]

Recent data from OCS indicate that the rate has increased to 56.19 percent as of the first quarter ending of 2015. However, this rate cannot be compared to other states because the source of comparative data across the states (Child Trends) uses the maintenance penetration rate which is a calculation of the percentage of eligible children placed in a fully licensed home and eligible for Title IV-E maintenance (room and board) reimbursement at a 50 percent match. OCS uses the administrative penetration rate, which is a calculation of the number of children eligible for the maintenance rate plus children placed with a relative in the process of being

licensed.[49] Because Alaska cannot claim federal reimbursement for the maintenance costs of eligible children in unlicensed placements, the Child Trends calculation better reflects the financial implications of the penetration rate.

The fiscal impact of increasing the Title IV-E penetration rate is significant. For example, for the quarter ending March 31, 2015, 276 Alaska OCS children were temporarily ineligible for Title IV-E due to lack of a court order or placement in a home that is not fully licensed. OCS provided Table 3-8 demonstrating the potential general fund savings if these 276 children were deemed eligible for Title IV-E reimbursement.

Table 3-8: Fiscal Impact of Increasing Eligibility of Children in Foster Care

Percent of Ineligible Children Made Eligible	Increase to Title IV-E Ratio	Administrative Estimated Annual General Fund Savings[a]	Maintenance Estimated Annual General Fund Savings[b]	Total Estimated Annual General Fund Savings
25%	3.40%	$1,972,000	$351,900	$2,323,900
50%	6.81%	$3,949,800	$703,800	$4,653,600
75%	10.21%	$5,921,800	$1,055,700	$6,977,500
100%	13.62%	$7,899,600	$1,407,600	$9,307,200

Source: Data provided by Alaska Office of Children's Services.
Notes: [a] Based on an estimate of $580,000 increase in Title IV-E revenue per year per one percent increase in the ratio. [b] Based on an estimated average foster care payment of $850 per month per client.

Recommendations

Increase the Title IV-E penetration rate for Alaska by specifically focusing on the following areas:

Recommendation 3.2.I.1.

Maintain sufficient staffing by hiring caseworkers and providing all workers with manageable caseloads. This will reduce paperwork error rates and reduce general fund expenditures on children in foster care. OCS should provide an accurate estimate of the number of additional workers needed to bring caseloads to between 12 and 14 foster care children per worker. This report provides a source of revenue for hiring an additional 8 to 10 case workers in Recommendation 3.1.E.1.

Recommendation 3.2.I.2.

Separate foster care licensing statutes and regulations from other residential care facilities. This will make it easier for foster care homes to become fully licensed and easier for relatives, in particular, to become licensed. Streamline and clarify what constitutes a fully licensed foster care home for the purpose of Title IV-E eligibility.

Recommendation 3.2.I.3.

Clarify the waiver and variance process for kinship placements in department regulations. While placement decisions should always be guided by the best interests of the child, caseworkers should consider the secondary goal of placing children in relatives' homes that are fully licensed foster care homes, and assisting relatives in obtaining licensing when possible.

Recommendation 3.2.I.4.

Develop a template or checklist for OCS workers and/or eligibility technicians to assist in correctly documenting the components of Title IV-E eligibility within the appropriate timeframes. A checklist is a timesaving tool to assist caseworkers to more accurately and efficiently document Title IV-E eligibility.

Recommendation 3.2.I.5.

Prioritize technology purchases and implementation to assist OCS workers. OCS workers need more tools to be productive and efficient during the considerable amount of time they spend in the field.

J. Centralized Intake for Reports of Child Abuse and Neglect

OCS currently operates a regional intake system in each of the OCS service regions for receiving and responding to reports of child abuse and neglect. Each regional manager oversees the intake workers in the region.

Findings

OCS outspends almost all states to address child abuse and neglect, and yet falls behind all states in its response time to reports of child abuse and neglect. The OCS response time of 241 hours in 2013 represented the longest response time of all states, but has improved over the last few years.[50] In 2012, Alaska had the third highest spending to address child abuse and neglect per 1,000 children out of all states.[51]

Alaska also has a disproportionally high rate of Alaska Native and American Indian children in the child welfare system relative to the Alaska Native and American Indian child population. Sixty percent of children in OCS custody are of Alaska Native or American Indian heritage, while children of Alaska Native or American Indian heritage make up only 17.3 percent of the child population in Alaska.[52] There are also disparities among regions in the state in the percentage of cases that are "screened out" (meaning no further action is taken) after a report has been made. These disparities exist in spite of clear policies related to intake and assessment. According to data from OCS, the Protective Service Report (PSR) screen-out rate in the five regions varied from 5 to 30 percent in 2013, with an average of 52 percent of reports screened-out, with no further action taken.[53]

While phones are indeed answered 24 hours a day, seven days a week, a call service takes intake calls after regular business hours and on weekends. The call service makes the initial referral decision. If the call service operators determine that the call is an emergency, they contact the on-call supervisor or law enforcement in the area where the call was received. The call service is not staffed by trained child welfare workers. OCS has identified concerns related to after-hour calls answered by the three outsourced switchboard services (one is based in Louisiana; the other two are located in Alaska). According to OCS, the operators are not familiar with the population, geographical area, resources, or OCS services, yet they make critical decisions on whether a report requires immediate action.[54] Given the lack of expertise of these operators and the lack of access to the OCS data system, the on-call OCS workers who respond to cases in the field often are provided inadequate information on the cases which have been determined by the operators to require a response.[55]

By 2017, OCS plans to centralize intake at one location where trained intake staff will receive calls 24 hours a day, seven days a week.[56]

The Alaska Adult Protective Services (APS) office recently began operation of a centralized intake system for receiving and responding to reports of elder abuse and neglect. Data were not available at the time of the publication of this performance review on the impact of the newly instituted APS centralized intake system.

Recommendation

Recommendation 3.2.J.1.

Prioritize and accelerate plans to shift OCS intake from a regional intake system to a centralized intake system comprised of a distinct unit of trained CPS workers who receive reports of child abuse and neglect 24 hours a day, 7 days a week.

Preliminary estimates for equipping a 24/7 centralized intake call center in Anchorage are between $50,000 and $130,000; additional information is needed to determine a more precise estimate.

The current OCS implementation plan envisions that all intake staff will work together in one office in Anchorage. While working with stakeholders and staff to coordinate the transition to centralized intake over the next few months, the department should immediately create a virtual centralized intake system by:

- Creating a centralized intake manager, with all intake workers reporting to this position. Use the centralized intake framework to streamline training and supervision of intake workers to increase consistency of assessments, focusing particular attention on disproportionality issues in response to reports.

- Creating a virtual statewide hotline number that rings to existing intake worker phones. Existing phone numbers can continue to remain in use.

K. Direct Service Administrative Support

DHSS operates three sets of institutions that provide residential care: the Alaska Psychiatric Institute (API) consisting of one 80-bed facility, eight juvenile justice facilities overseen by DJJ across the state, and the Alaska Pioneer Homes, which consist of six facilities across Alaska. These facilities each manage similar institutional administrative support functions, such as food service, facility maintenance, pharmaceutical purchasing and dispensing, recruitment and retention of direct service workers, and invoicing and billing.

Findings

Currently, these institutional administrative support functions are not comprehensively coordinated. For example, DJJ and API purchase pharmaceuticals through the same contract as the Alaska Department of Corrections (DOC) and API manages the medications for DJJ. The Pioneer Homes purchase pharmaceuticals separately and employees two pharmacists to dispense medications for residents of all six homes. Contracts for meal and nutrition services

are negotiated separately by each institution; facility maintenance is also managed at the institutional level DHSS has begun to review these administrative functions and is looking for opportunities to coordinate with DOC. Any merger would necessitate maintaining adherence to the unique needs of each institution in some instances, such as meeting the varying nutritional needs of the populations served.

Recommendations

Recommendation 3.2.K.1.

Designate an existing Deputy Commissioner to oversee the programs within DHSS that operate institutions to create standardized administrative functions and realize efficiencies that can be achieved by consolidating many of the support functions.

Recommendation 3.2.K.2.

Redirect the oversight and management of API to a Deputy Commissioner designated to oversee institutions. This will allow API to be managed together with the other institutions within DHSS by one Deputy Commissioner.

Recommendation 3.2.K.3.

Move all of the institutional administrative functions currently managed by DJJ and Pioneer Homes under the designated Deputy Commissioner.

Recommendation 3.2.K.4.

Establish an administrative office under the Deputy Commissioner that would provide all administrative support functions such as purchasing, human resources, billing, and other services to operate facilities for all 13 institutions.

3.3. Medicaid Program

The Alaska Medicaid program is administered through four divisions in DHSS:

- HCS is responsible for Medicaid provider enrollment and claims processing.
- SDS is responsible for administration of the four Medicaid waiver programs.
- DBH is responsible for administration of Medicaid behavioral health services.
- DPA is responsible for eligibility determination for the Medicaid program.

Each of these divisions has responsibility for:

- Maintaining existing and writing new regulations pertaining to the component of Medicaid that they administer.
- Identifying and investigating misuse of Medicaid funds by providers and recipients.
- Conducting quality assessments of the components each administers.

While Medicaid expenditures are budgeted through HCS, other divisions have responsibility for developing policies and procedures that may impact Medicaid expenditures.

Currently, each division takes the lead for the components of the Medicaid program assigned to their division. While each division reports good working relationships and extensive collaboration with the other divisions, some difficulties are experienced among divisions when questions arise from enrollees or providers. According to staff, employees in the division receiving a question may not know who to contact in another division to get an answer.

A bi-weekly Medicaid Director's meeting brings key individuals from each division, plus FMS, together to discuss program and policy issues within the Medicaid program. The Deputy Commissioner for Medicaid and Health Care Policy resolves any issues encountered among divisions.

A. Medicaid Administration and Structure

Findings

Analysis and comparison of the Alaska Medicaid program to other states reveals 10 other states similar in their delivery of services through the Medicaid program. Alaska is one of 11 states that serve Medicaid enrollees through fee-for-service (FFS) reimbursement rather than through managed care. Under FFS, medical providers are reimbursed by the state Medicaid program for services provided to members based on a fee schedule established by the state. Under managed care, one or more managed care organizations receive a capitated (per member per month) payment from the state and the managed care organization coordinates the medical care of Medicaid members enrolled in their plan. Other states have a mix of FFS and managed care or provide Medicaid services exclusively through managed care contracts. Table 3-9 shows the number of enrollees, expenditures, and staffing for each of the 11 FFS states sorted by the number of Medicaid enrollees.

Table 3-9: States with Fee-for-Service Medicaid Programs

FFS State[57]	Location of Medicaid Program	Total Population (Census 2014 Estimate)[58]	January 2015 Medicaid Enrollment[59]	FY 2013 Total Medicaid Spending[60]	Percent Rural Population (Census 2010)[61]	Percent Native Population (2013 ACS Estimates)[62]
Alabama	Stand alone agency - Alabama Medicaid Agency	4,849,377	843,250	$5,038,553,636	41	0.5
Alaska	**Department of Health and Social Services**	**736,732**	**125,747**	**$1,356,288,090**	**34**	**14.1**
Arkansas	Department of Human Services	2,966,369	824,529	$4,206,830,398	43.8	0.6
Idaho	Health and Welfare Organization	1,634,464	273,329	$1,672,080,653	29.4	1.3
Maine	Department of Health and Human Services	1,330,089	286, 917	$2,887,138,817	61.3	0.6
Montana	Department of Public Health and Human Services	1,023,579	170,740	$1,007,145,361	44.1	6.5

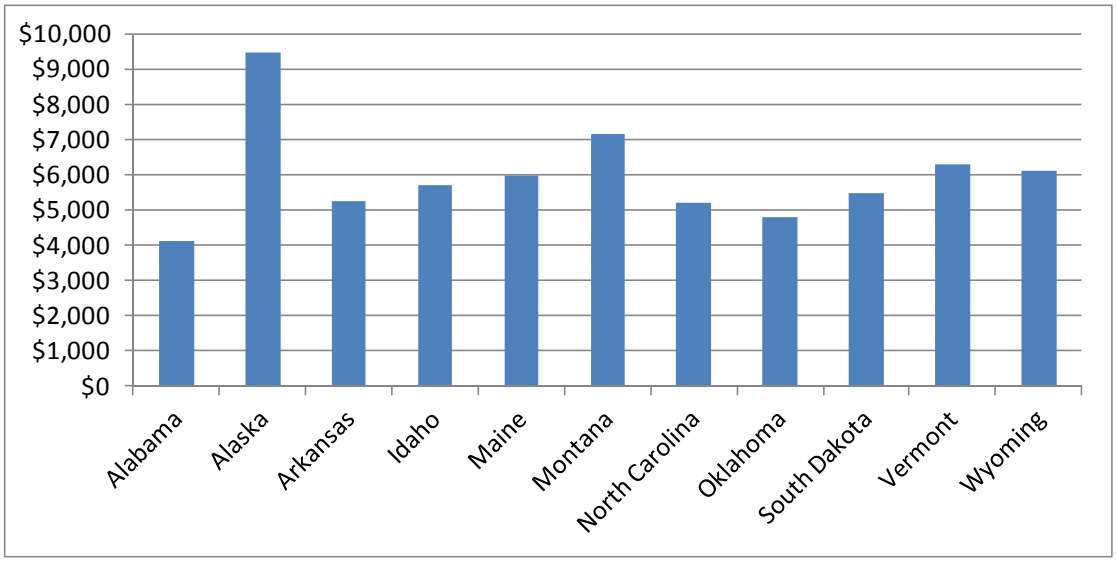
FFS State[57]	Location of Medicaid Program	Total Population (Census 2014 Estimate)[58]	January 2015 Medicaid Enrollment[59]	FY 2013 Total Medicaid Spending[60]	Percent Rural Population (Census 2010)[61]	Percent Native Population (2013 ACS Estimates)[62]
North Carolina	Department of Health and Human Services	9,943,964	1,844,304	$11,915,039,901	33.9	1.2
Oklahoma	Health Care Authority	3,878,051	808,807	$4,795,886,340	33.8	7
South Dakota	Department of Social Services	853,175	117,687	$766,382,971	43.3	8.7
Vermont	Agency of Human Services, Department of Vermont Health Access	626,562	179,862	$1,473,569,964	61.1	0.3
Wyoming	Department of Health, Financing Division	584,153	68,577	$554,122,142	35.2	2.3

Source: See references to data in each column

A.1 Spending Per Enrollee

The Alaska Medicaid program has higher costs per enrollee than the other 10 Medicaid FFS states, as shown in Chart 3-1.

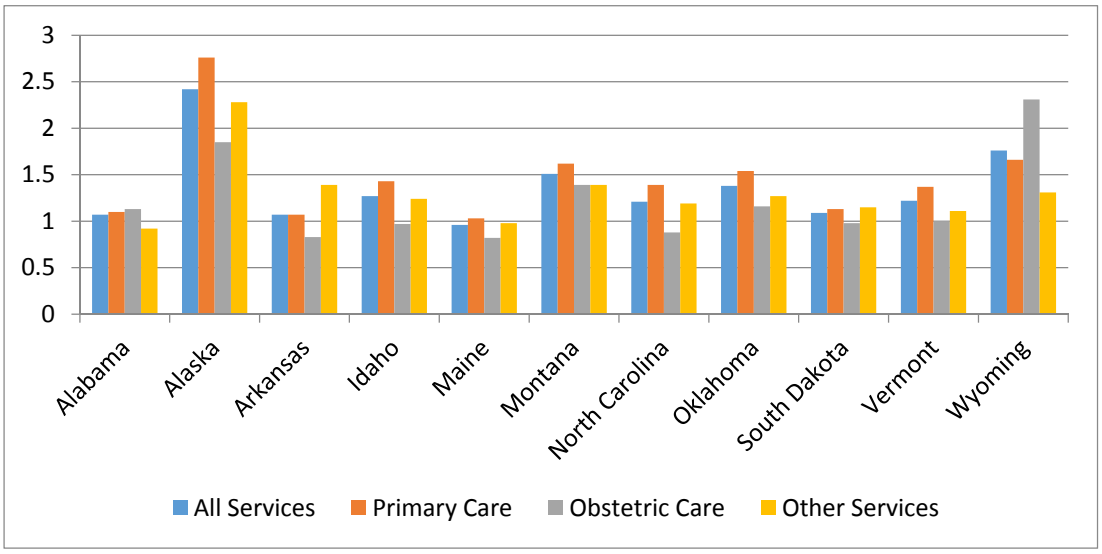
Chart 3-1: Medicaid Spending Per Enrollee



Source: Medicaid Spending per Enrollee (Full or Partial Benefit) [Data Set]. The Henry J. Kaiser Family Foundation, 2011. Web. http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/. Accessed June 24, 2015.

Several factors contribute to the higher costs of the Medicaid program in Alaska. While travel is certainly a high cost in Alaska, accounting for about nine percent of all Medicaid expenditures in FY 2013,[63] it does not fully account for the higher costs per enrollee. Another factor contributing to higher costs is reimbursements for physician fees, which are higher compared to other states and higher compared to the Medicare program, as shown in the charts below.

Chart 3-2: Medicaid Physician Fees Compared to Other FFS States

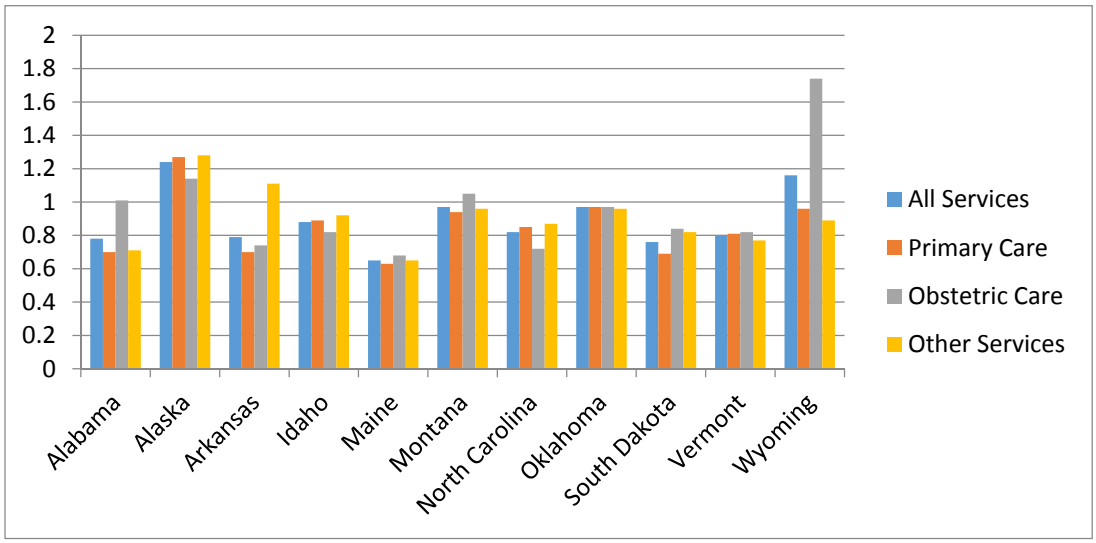


Source: Medicaid Physician Fee Index [Data Set]. The Henry J. Kaiser Family Foundation, 2012. Web. http://kff.org/medicaid/state-indicator/medicaid-fee-index/. Accessed June 24, 2015.

On Chart 3-2, a value of "1" equals the national average. All FFS states except Maine have higher than average physician fees for all services, however Alaska is the highest of these states, with over double the national average in all areas except obstetrics.

When comparing Medicare reimbursement rates to Medicaid, many FFS states have higher physician reimbursement rates for Medicare than Medicaid; Alaska is the only FFS state that spends more on Medicaid physician fees compared to Medicare in every service category (a ratio greater than one indicates that Medicaid reimbursement rates are higher than Medicare rates.). In addition, Alaska is one of only three states out of all fifty (along with Wyoming and North Dakota) where Medicaid rates are, on average, higher than Medicare rates.

Chart 3-3: Medicaid to Medicare Fee Ratio



Source: Medicaid to Medicaid Fee Index [Data Set]. The Henry J. Kaiser Family Foundation, 2012. Web. http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/. Accessed June 24, 2015.

Physician fees are higher in Alaska because all public and private health care costs are higher overall in Alaska than in other states for the following reasons:

- Insurance payments are about 35 percent higher than national average.
- Average per day hospital expenses are 56 percent higher than national average.
- Alaskan health care practitioners receive on average higher wages and more benefits than in other states.[64]

Alaska has several unique characteristics that make health care considerably more expensive than the rest of the United States:

- 30 percent higher cost of living than comparable states.
- Higher average incomes, which correlate with higher health care expenditures.
- Difficulty attracting physicians and health-care professionals.
- Higher staffing levels per patient in small, isolated, Alaska hospitals.
- Reduced competition among providers and fewer economies of scale.[65]

A.2 Medicaid Staffing

Comparing staffing among the 11 FFS Medicaid states is difficult due to a number of factors: differences in what components of Medicaid administration and services are contracted out, in the number and types of waiver programs, and in how Medicaid staff are counted. In addition,

the organization of the Medicaid function in each state may include one or more divisions, each with staff supporting the Medicaid program to varying degrees and eligible for varying levels of reimbursement from the federal government. In states where counties provide the staff that determine Medicaid eligibility, the comparisons become even more challenging.

While data were collected from other states, the ability to compare staff among the states was ultimately not possible. A national source of information on Medicaid staffing was not identified, nor was research found on this topic. While DHSS suggests the Medicaid staffing levels in the department are lower than other states, the data is not available to verify that.

Because the Medicaid program in Alaska is split among three divisions (four if eligibility is considered), some duplication among functions likely exists in order to support each self-contained division. In Section 3.3 of this report are recommendations to consolidate Medicaid functions in two areas: program integrity and continuous quality improvement.

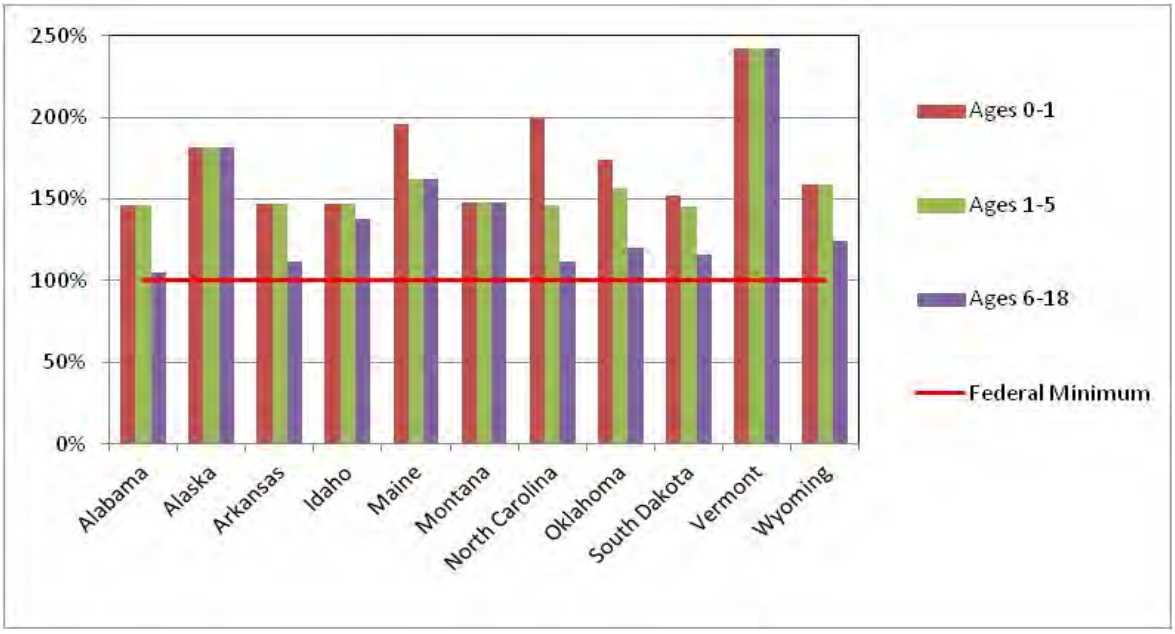
A.3 Provider Tax

A provider tax can be used as a match to draw down federal funds for the Medicaid program. Alaska is the only state that does not have any type of provider tax to help fund Medicaid.[66] Considerable research on the benefits of assessing provider taxes in Alaska has recently been completed.[67] The state issued an RFP in May 2015 for a consultant to further explore the implementation of provider taxes.

A.4 Eligibility

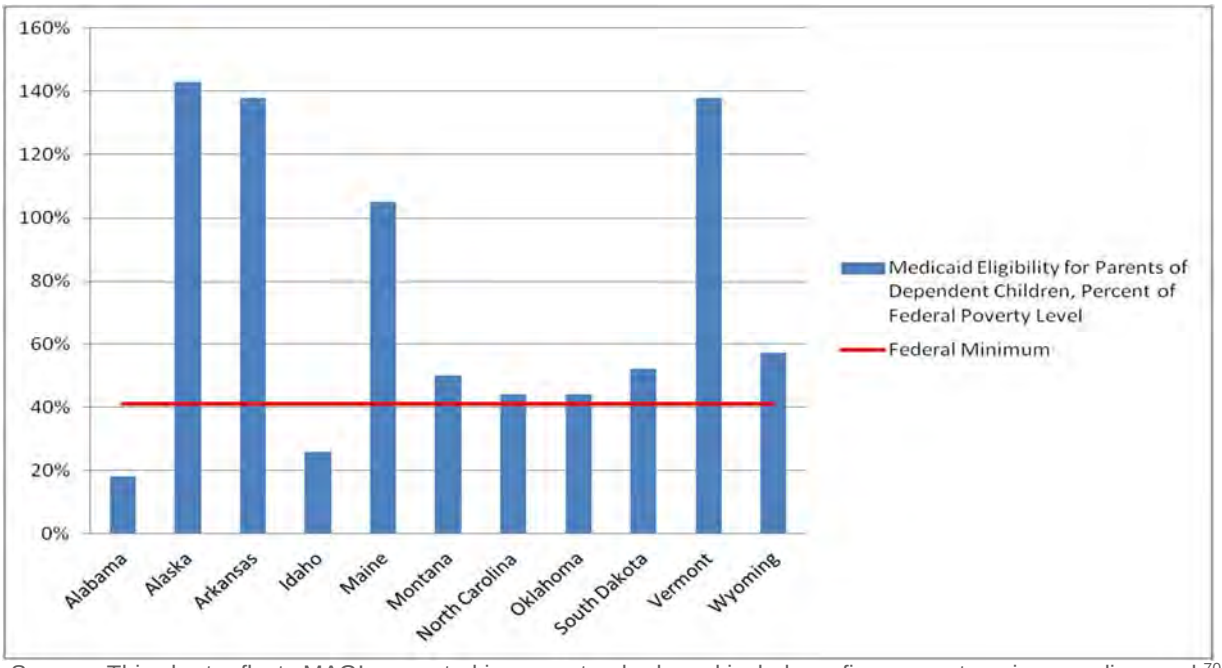
Eligibility limits for Medicaid benefits in Alaska tend to be higher than other FFS states. For example, as shown in Chart 3-4 and Chart 3-5, Alaska has the second-highest eligibility limit behind Vermont for children ages 1-5 and 6-18 (182 percent of the Federal Poverty Level (FPL) for both age groups) along with the highest eligibility limit for parents with dependent children (143 percent of the FPL).

Chart 3-4: Medicaid Eligibility for Children, Percent of Federal Poverty Level



Source: Many states provide Medicaid to children with family incomes above the minimum of 100% of the Federal Poverty Level.[68] This chart lists data from the Kaiser Family Foundation, which uses January 2015 income limits with MAGI-converted income standards and an income disregard equal to five percentage points of the Federal Poverty Level.[69] The amounts listed are thresholds for children covered under Medicaid (Title XIX).

Chart 3-5: Medicaid Eligibility for Parents of Dependent Children, Percent of Federal Poverty Level



Source: This chart reflects MAGI-converted income standards and includes a five percentage income disregard.[70] Parents and caretaker relatives in low-income families with dependent children are eligible for Medicaid if household income meets minimum eligibility levels established in 1996, which averages 41 percent of the Federal Poverty Level.[71]

In the eligibility tables above, the federal poverty guidelines for Alaska and Hawaii are adjusted by the federal government to reflect the higher cost of living in those two states. For Alaska, the federal poverty guidelines are about 25 percent higher compared to the 48 contiguous states and the District of Colombia.[72] However, research suggests that this adjustment may be too high. Using indices such as the Supplemental Poverty Measure or Regional Price Parities, the adjustment for Alaska would be substantially less than the current adjustment to the poverty guidelines.[73]

A.5 Managed Care

Most states have implemented Medicaid managed care. National research comparing managed care savings over FFS programs have produced mixed results. An extensive 2012 research report by the Robert Wood Johnson Foundation (RWJF) reviewed managed care research going back to the 1990s and concluded, "It is hard to generalize with any certainty about the impact of Medicaid managed care on costs, access, or quality. The uncertainty is due in large part to the extraordinary variation in Medicaid managed care initiatives."[74] The unique characteristics in every state, such as demographics, geography, health care market, and many

other factors produce different results from managed care. In addition, managed care plans are not identical and take a variety of forms from state to state.

On a state-by-state level, results are also mixed. According to the RWJF report, "the peer-reviewed literature finds some success by particular states in controlling costs through Medicaid managed care. The successful states appear to be those with relatively high provider reimbursement rates in their fee-for-service program. The cost savings are due primarily to reductions in provider reimbursement rates rather than managed care techniques, though reductions in emergency room utilization and inpatient hospital care also contribute." [75] The report goes on to say that the majority of studies that did find cost savings were not peer-reviewed, but rather were conducted by consulting firms on behalf of interested parties, thus creating at least a perceived bias.

A 2014 GAO report found that on a national level, managed care does not likely result in costs savings and managed care may be slightly more expensive than FFS.[76] Another 2014 GAO report found that managed care payments are growing at a faster rate than FFS payments.[77]

There is no conclusive evidence that managed care improves health outcomes over FFS. The RWJF study concluded that, “we know very little about why certain states and certain programs seem to achieve good results, while others do not. There are remarkably few studies that compare and contrast outcomes in programs with different approaches to Medicaid managed care.”[78] However, it should be noted that managed care does provide incentives to develop prevention programs for chronic diseases and other measures designed not just to reduce expenses but also to improve health outcomes.

Managed care may also simplify the administration of the Medicaid program for state governments. Rather than managing a health program, state staff members manage three to five managed care contracts with health plans which have considerable experience and expertise in managing health care. Managed care also makes budget projections more predictable since the state is paying the same cost per member per month – eliminating the variable expenditures of an FFS program that cannot always predict utilization rates, and therefore expenditures.

A.6 Medicaid Expansion

Many states have expanded their Medicaid programs to reduce the general fund commitment to the Medicaid program and to increase the number of people receiving benefits. While there are ideological objections to the federal law allowing Medicaid expansion, the increase in federal revenue would reduce the general fund expenditures for the Medicaid program. In collaboration with the Alaska Mental Health Trust Authority, DHSS issued a request for proposals in April

2015 for consulting and technical assistance services to "develop recommendations for alternative Medicaid expansion models and for Medicaid reform initiatives" (RFP 2015-0600-3077).[79] A February 2015 report by DHSS, *The Healthy Alaska Plan: A Catalyst for Reform*, outlined the following results of expanding Medicaid: expanding health coverage to an additional 41,000 Alaskans and halving the number of uninsured Alaskans.[80] The report states that over the next seven years the state could receive $1.1 billion in federal revenue, create 4,000 jobs, increase wages and salaries by $1.2 billion, and increase statewide economic activity by $2.5 billion. The report projects that in FY 2016, Medicaid expansion would save the state general fund $6.1 million, with $38 million saved from 2016 to 2021.[81] Medicaid expansion efforts are controversial and expansion in Alaska had not occurred at the time the review for this report was conducted.

Recommendations

Recommendation 3.3.A.1.

Further integrate Medicaid functions across the department to achieve cost savings and create a more streamlined authority for Medicaid policy, programming, budget, and oversight. Specific integration examples for program integrity and quality improvement are discussed in Section 3.3.B of this report.

Recommendation 3.3.A.2.

Increase the pace at which coordinated care for Medicaid enrollees and cost saving opportunities are identified within the Medicaid program through a focused and concerted efforts across all divisions. While the question of whether the full or partial implementation of managed care in Alaska would result in costs savings requires further research, managed care would simplify the administration of the Medicaid program and would likely result in a reduction in state administrative costs. Some of the ways that cost-savings may be realized in the Medicaid program include the following:

- Create a pilot managed care initiative in the Anchorage area.

- Explore the creation of Medicaid Accountable Care Organizations (ACOs), which are becoming increasingly prevalent in state Medicaid delivery systems. According to the Centers for Medicare and Medicaid Services (CMS), Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who voluntarily coordinate to provide high quality care to their patients. Many states have found ACOs to be an effective way to improve patient outcomes and control costs by shifting accountability for quality and risk to providers.[82]

- Identify additional opportunities to coordinate care and manage significant cost drivers in the Medicaid program by:

    - Identifying ways to reduce the volume of physician visits.
    - Providing incentives to providers for prenatal care to reduce pregnancy complications and improve birth outcomes.
    - Providing incentives to providers for the provision of preventive care and screenings.
    - Developing disease management programs to reduce physician visits and hospital inpatient stays.
    - Creating incentives for high-volume Medicaid providers to improve health outcomes for their patients.
    - Limiting reimbursement for hospital pharmacies that receive federal discounted 340B pricing on pharmaceuticals to the cost of acquisition plus a dispensing fee. Currently, the Alaska Medicaid program reimburses hospital pharmacies based on a fee schedule that is higher than the 340B pricing paid by the hospitals; the hospitals pocket the difference.

- Move forward with current efforts to create a Medicaid waiver program for patient travel, which allows for alternative methods of arranging transportation and is designed to reduce transportation costs.

- Combine quality programs into a single unit (this is addressed in Section 3.3.C of this report).

- Combine fraud, waste, and abuse investigations into a single unit (this is addressed in Section 3.3.B).

- Create a combined Medicaid policy office under the Deputy Commissioner for Medicaid and Health Care Policy that oversees the development of regulations for all divisions that have a role in Medicaid and ties together the programmatic components of the Medicaid program and assesses the cost implications of regulatory and programmatic changes.

- Create a working group to address the issues related to implementing a provider tax.

B. Program Integrity and Compliance

Multiple department divisions are involved in DHSS program integrity and compliance work, including: inspections; data analysis; and other activities related to federal and state benefit programs, such as reviewing provider and recipient activities, auditing claims, identifying

overpayments, reviewing utilization, and educating providers and others on program integrity and compliance issues. The staff and funding commitment to program integrity across DHSS is shown in Table 3-10.

Table 3-10: Staffing and Expenditures for Program Integrity

Division/Office	Staff	Funding
DBH	3.25	$463,439
DPA	16	$2,116,600
HCS	66	$7,875,201
Program Integrity	7	$1,112,200
SDS	4	$400,630
Total	96.25	$11,968,070

Source: Data provided by DHSS.

Findings

Investigation and program integrity efforts vary widely across the divisions. Information from focus groups and interviews conducted for this review indicate that some of these functions are duplicative. Many staff members are analyzing similar data sets to identify areas for investigation within their division. While staff members report good working relationships and some coordination among the divisions on these activities, there is no department-wide coordination to make the best use of staff resources. Investigation staff and efforts vary widely by division and staffing levels within each division may not reflect the level of effort needed to mitigate fraud, waste, and abuse.

A review by the federal Centers for Medicare and Medicaid Services (CMS) in 2011 identified the lack of a centralized program integrity function as a continuing vulnerability for the Alaska Medicaid program.[83] The 2011 review noted that Medicaid program integrity functions were spread among three separate entities": HCS, SDS, and the Program Integrity office. This issue was identified by CMS in earlier reviews and CMS noted that Alaska "has failed to address the recommendations of any of these reviews, and continues to run a program integrity function that is less effective than it could be if it were consolidated under a single unit."[84]

This separation of functions may be one of the reasons that Alaska had among the highest Medicaid integrity expenditures per enrollee from FY 2007-FY 2010 (the most recent data available for all 50 states). Alaska was by far the highest in 2007, spending $26.01 per enrollee

compared to an average of $9.89 for Medicaid fee-for-service (FFS) states (excluding North Carolina, Arkansas, Vermont, and Wyoming, which had no data). From 2008-2010, Alaska was second highest in spending of the FFS states behind South Dakota; Alaska spent about $16 per enrollee compared to an average of about $8 per enrollee.[85]

Comparing the effectiveness of these expenditures is difficult due to the differences in overpayment reporting and collection procedures from state to state. While the amount recovered from provider audits and overpayments collected are reported by each state on an annual basis, comparisons between states are not useful. For example, if a state identifies fewer overpayments, it could be either because it is less effective at identifying them or because it had fewer overpayments in the first place. Recovery of funds is equally problematic given that the recovery process can take years. Low recovery rates in one year may be offset by much higher rates the next.

Beyond CMS' recommendation for integrated program integrity functions for Medicaid, many states have combined compliance activities for all federal benefit programs. Of 20 public integrity programs reviewed for this report, 10 have combined program integrity offices/divisions for federal and state benefit programs (such as Medicaid, SNAP, and TANF): Idaho, Illinois, Maine, Minnesota, Montana, New Mexico, Oklahoma, Oregon, South Dakota, and Texas.

Six of the states reviewed (four of which combine Medicaid and other state and federal benefit programs) have created an Inspector General position, typically appointed by the Governor, to oversee program integrity functions. The benefits and costs of creating an independent Inspector General position in Alaska can be determined by DHSS, however it does not preclude the combination of the program integrity functions within DHSS.

A recent memo from the DHSS Fraud Task Force to the Commissioner delineates several recommendations for coordinating and strengthening fraud activities to address inconsistencies and redundancies across the divisions in computer systems, training, fraud hotlines, and investigations, but stops short of recommending consolidation of these functions.[86]

Recommendation

Recommendation 3.3.B.1.

Combine all program integrity and compliance units across the department, including provider enrollment and the surveillance and utilization review subsystem (SURS).

Combining units will allow DHSS to conduct risk analyses to best deploy resources to prevent, detect, and investigate fraud, waste and abuse for all department programs and services. This

analysis should identify the most effective use of resources allocated to provider versus recipient investigations. A consolidated office would also be able to review programs that do not currently have a dedicated program compliance function, such as Pioneer Homes. Licensing functions, discussed in Section 3.2.C of this report, also could be included in the expanded office. When determining which functions to incorporate into the office, DHSS should identify the maximum potential for the most effective and efficient structure.

Overall, the benefits of combining these functions include the opportunity to consolidate analytical capabilities and systems to conduct risk assessments. In addition, overhead can be reduced, and travel can be coordinated. Assuming a modest savings in travel of $50,000 (the elimination of 33 field visits each year, assuming $1,500 per trip) and the elimination of at least two of the 92 positions as a result of consolidating these programs, the estimated annual savings would be $250,000. Additional savings can be achieved by cross-training program integrity staff (cost calculations of additional savings would need to include the cost of additional training).

Alaska would also benefit from the state share of increased recoveries and/or avoidance of fraudulent or incorrect payments.

C. Medicaid Continuous Quality Improvement

While DHSS has staff and infrastructure throughout the department focused on ensuring the quality of programs and services, two divisions have quality improvement programs related to the Medicaid program.

SDS has a long-standing and nationally recognized quality improvement strategy originally developed from federal requirements for home and community-based waivers. SDS quality improvement efforts are led by a quality improvement steering committee, a quality improvement workgroup, and task committees. This strategy has grown to include all services and programs in the division.

HCS recently has created a Quality Management office that is developing bylaws and an annual work plan to implement a continuous quality improvement (CQI) process within the division.

Findings

Developing a CQI process is an integral and required component of Medicaid managed care plans. In 2014, the National Committee on Quality Assurance (NCQA) established best practices for the structure and role of CQI processes.[87] NCQA recommended standards for managed care health plans that should be incorporated into state contracts for managed care

organizations providing health care services to Medicaid recipients. In a managed care environment, the Quality Manager is considered a key staff person who must be identified in a state managed care contract. The credentials of a Quality Manager are evaluated during the managed care proposal evaluation process.

Although Alaska is a Medicaid fee-for-service state, implementing these practices will create a culture of continuous improvement within the Alaska Medicaid program and serve to identify areas where care coordination can improve health outcomes and reduce costs. Some of the key features of the NCQA quality management and improvement process include:

- A quality committee that includes Medicaid providers.
- Involvement of the Medical Director.
- Integration of behavioral health.
- Development of an annual work plan.
- Development of annual performance improvement plans (PIPs).

Having two parallel CQI efforts within DHSS focused on Medicaid duplicates efforts and resources. In addition, when quality issues originate in areas of the Medicaid program that are not overseen by the SDS or HCS division director, they may not be easily resolved because one division may lack authority to execute change in another division.

Recommendations

Recommendation 3.3.C.1.

Elevate the Medicaid CQI function within DHSS. This function should report directly to the Deputy Commissioner for Medicaid and Health Care Policy and should include the entire Medicaid program, including behavioral health and long-term care services.

Recommendation 3.3.C.2.

Create a Quality Committee whose membership includes the DHSS Chief Medical Officer and external stakeholders, such as providers. Membership on the Quality Committee should include providers or clinicians familiar with behavioral health, long-term care, children's health, and tribal health. The Quality Management Office should develop an annual work plan and develop at least two performance improvement projects annually.

4. OBJECTIVE 4: BOARDS AND COMMISSIONS

Objective 4: Determine whether DHSS' advisory groups are effective and efficient in advising and overseeing services, and recommend changes based on national best practices to better utilize resources including consolidation or elimination of groups as determined appropriate. The review team should exclude behavioral health and long-term care related advisory groups from this review. This should address the following:

a) Are the department's advisory groups effectively advising and guiding the delivery and administration of services?

b) Are the department's advisory groups efficiently advising and guiding the delivery and administration of services?

c) Are all of the department's advisory groups necessary for effective and efficient delivery and administration of programs and services?

d) Are there changes that could be made to improve the effectiveness or efficiency of the department's advisory entities?

Findings

This review evaluated 14 advisory groups responsible for working with DHSS to shape public policy. The list of membership bodies evaluated in this review was determined by DLA and does not include advisory groups related to behavioral health or long-term care covered in a separate component of the DHSS performance review (conducted by PCG), or informal department task forces and stakeholder groups.

These membership bodies evaluated in this report can be divided generally into five categories:

- **Advisory groups** – Charged with advising the department and policymakers (the Commissioner, Governor and/or Legislature) in the design and implementation of programs to address specific concerns.
    - Alaska Council on Emergency Medical Services
    - Alaska Early Childhood Coordinating Council
    - Alaska Health Care Commission
    - Alaska Pioneer Homes Advisory Board
    - Governor's Council on Disabilities and Special Education
    - Juvenile Justice Advisory Committee
    - Medical Care Advisory Committee
    - Trauma System Review Committee

- **Professional review** – Review services provided by the department.
    - Drug Utilization Review Committee
    - Pharmacy and Therapeutics Committee

- **Funds administration** – Determine fund administration related to state assessments or state loan program administration.
    - Alaska Vaccine Assessment Council
    - SHARP Advisory Council

- **Review authority over catastrophic events** – Reviews deaths in certain instances and provides recommendations to law enforcement and social service professionals for investigations.
    - Child Fatality Review Committee

- **Citizen review** – Provides citizen examination of state and local agency policies, procedures, and practices.
    - Alaska Citizen Review Panel

Table 4-1 lists the purpose and authority of each of the 14 groups evaluated in this review.

Table 4-1: Select DHSS Boards and Commissions
Purpose and Authority

Advisory Board or Commission	Purpose	Authority Source
Alaska Citizen Review Panel	**Citizen review:** examines the policies, procedures, and practices of state and local agencies and where appropriate, specific cases, to evaluate the extent to which state and local child protection system agencies are effectively discharging their protection responsibilities.	AS §47.14.205
Alaska Council on Emergency Medical Services	**Advisory group:** assists with planning and implementing a statewide EMS system; distribution of funding; and policy development.	AS §18.08.020
Alaska Early Childhood Coordinating Council	**Advisory group:** promotes positive development, improved health outcomes, and school readiness for children, prenatal through age eight by facilitating the integration and alignment of services, planning efforts, resources, policy development, and funding connections between health, mental health, education and family support systems, and public and private partners.	Federal Head Start Act of 2007, Sec. 642 B
Alaska Health Care Commission	**Advisory group:** serves as the state health planning and coordinating body, providing recommendations for a comprehensive statewide health care policy and strategies for improving the health of Alaskans.	AS §§18.09.010 and 18.09.020
Alaska Pioneer Homes Advisory Board	**Advisory group:** conducts annual inspections of property and procedures of the Alaska Pioneer Homes and recommends changes and improvements to the governor.	AS §44.29.500
Alaska Vaccine Assessment Council	**Funds administration:** determines the amount of vaccine assessments and oversees programmatic activities of the Alaska Vaccine Assessment Program.	AS §18.09.210
Child Fatality Review Committee	**Review authority over catastrophic events:** assists the State Medical Examiner in determining the cause and manner of the deaths of children under 18 years of age and provides recommendations, suggestions, and advice to state/municipal law enforcement and social service agencies in the investigation of deaths of children.	AS §12.65.120
Drug Utilization Review Committee	**Professional review:** reviews the use of medications by Medicaid recipients, identifies regimens that do not meet predetermined clinical criteria, and when an aberrant pattern of prescribing and/or utilization is identified, sends an educational letter to the prescriber and/or dispensing pharmacist informing them of the potential problem, requesting a reply which explains how the issue will be addressed.	42 CFR 456.703 42 CFR 456.705 42 CFR 456.709 42 CFR 456.711

Advisory Board or Commission	Purpose	Authority Source
Governor's Council on Disabilities and Special Education	**Advisory group:** provides advocacy, capacity building and systems change activities for Alaskans with disabilities. Council acts as the State Council on Developmental Disabilities, the Special Education Advisory Panel, and the Interagency Coordinating Council for Infants and Toddlers with Disabilities, as required by federal law.	AS §§47.80, 14.30.231, 14.30.600, 47.20.060, 47.30.031
Juvenile Justice Advisory Committee	**Advisory group:** counsels on all planning, administrative, and funding functions related to the federal Juvenile Justice and Delinquency Prevention Act; oversight in the development, approval and implementation of the state's juvenile justice plan.	42 U.S.C. §§5601-5780 Administrative Order 137
Medical Care Advisory Committee	**Advisory group:** advises department on Medicaid policy and program changes, as required by federal law.	Social Security Act (Title XIX) §1902 (a) (4)
Pharmacy and Therapeutics Committee	**Professional review:** advises on the development of the Preferred Drug List; reviews drug classes for the Alaska department's Medicaid program, identifying which drugs are safe and effective, and which drugs cost less than others in the same class.	N/A
SHARP Advisory Council	**Funds administration:** provides recommendations for policies, oversight and evaluation of all aspects of the SHARP program to enhance health care access in Alaska.	AS §18.29.015(c)
Trauma System Review Committee	**Advisory group:** issues recommendations to the commissioner for allocations from the Alaska Trauma Care Fund; oversight of the Alaska Trauma Registry; provides advice re: trauma center levels, evaluation of trauma center criteria, and development and implementation of a comprehensive trauma system plan and quality improvement processes.	7 AAC 26.745

Four factors were considered when determining the *effectiveness* of these public policy advisory bodies:

1. **Federal mandate** – Is the advisory body mandated by federal law or required as a condition for federal funding?

2. **Public health and safety** – Does the entity regulate or provide direct oversight of programs or services affecting the health and safety of Alaskans?

3. **Current relevance** – Is the entity addressing a current or continuing state/department priority (compared to ones that have declined in importance over time)?

4. **Stakeholder/Public involvement** – Does the group provide an effective avenue for stakeholder involvement and/or public input for department programs and services?

Similarly, the following criteria were used to evaluate the *efficiency* of these bodies:

- **Productivity** – Does the group produce a tangible work product that directly influences public policy (e.g., annual policy reports, legislative recommendations, budget evaluations/approval)?

- **Suitability** – Does the advisory body best fit within DHSS rather than in another state agency? Is the group better equipped to perform its assigned responsibilities than other available alternatives such as internal agency workgroups, subject matter experts from academia or the public/private sectors?

- **Avoids redundancy** – Does the body perform unique duties that do not overlap with or duplicate those of other advisory groups or state personnel?

- **Cost** – Are the costs to support the groups reasonable for the duties discharged?

Table 4-2 applies the above criteria to the existing advisory bodies within DHSS. Checkmarks indicate where criteria have been met.

Table 4-2: Effectiveness and Efficiency Criteria

	Effectiveness				Efficiency			
	Federal Mandate	Public Health and Safety	Current Relevance	Stakeholder/ Public Involvement	Productivity	Suitability	Avoids Redundancy	Cost
Alaska Citizen Review Panel	✓	✓	✓	✓	✓	✓	✓	✓
Alaska Council on Emergency Medical Services		✓	✓	✓			✓	
Alaska Early Childhood Coordinating Council	✓	✓	✓	✓	✓		✓	✓
Alaska Health Care Commission			✓	✓	✓		✓	
Alaska Pioneer Homes Advisory Board				✓				
Alaska Vaccine Assessment Council		✓	✓	✓	✓	✓	✓	✓
Child Fatality Review Committee		✓	✓	✓	✓	✓	✓	✓
Drug Utilization Review Committee	✓	✓	✓	✓	✓	✓	✓	✓
Governor's Council on Disabilities and Special Education	✓		✓	✓	✓	✓	✓	
Juvenile Justice Advisory Committee	✓	✓	✓	✓	✓	✓	✓	✓
Medical Care Advisory Committee	✓	✓	✓	✓	✓	✓	✓	✓
Pharmacy and Therapeutics Committee		✓	✓	✓	✓	✓	✓	✓
SHARP Advisory Council		✓	✓	✓	✓	✓	✓	✓
Trauma System Review Committee		✓	✓	✓	✓	✓	✓	✓

Based on this analysis and data collected during interviews for this project, the following observations are made for specific advisory groups:

- The Alaska Health Care Commission budget was eliminated by the state legislature during the 2015 session. While the Commission is very productive, its work is not focused on the administration of DHSS programs and services.

- The Governor's Council on Disabilities and Special Education is funded almost entirely with federal funds. This Council efficiently combines three separate responsibilities into one board.

- Two committees are federally mandated to oversee the provision of services for the Medicaid program: the Drug Utilization Review Committee and the Medical Care Advisory Committee. While the Pharmacy and Therapeutics Committee is not mandatory, this group is a subcommittee of the Drug Utilization Review Committee and advises the Division of Health Care Services (HCS) on the Preferred Drug List, which is an essential, cost-saving measure for the Medicaid program. The Drug Utilization Review and Pharmacy and Therapeutics committees have overlap in membership and the meetings are held on the same day to minimize time and expenses.

- The current mission articulated by the Alaska Council on Emergency Medical Services to "support and strengthen the existing system of emergency medical services and promote the full integration of EMS into the larger system of healthcare delivery"[88] is markedly different from the original statutory charge to "advise the commissioner and the governor with regard to the planning and implementation of a statewide emergency medical services system."[89] Many of the group's current priorities are focused on advocacy for the profession.

Recommendations

In reviewing each advisory body against the criteria noted in this analysis for effectiveness and efficiency, the following specific recommendations are made:

Recommendation 4.1.

The efforts of the Alaska Council on Emergency Medical Services should be refocused from professional advocacy to providing more formalized policy and budget advice to the DHSS commissioner and governor.

Recommendation 4.2.

The travel budget for the Alaska Pioneer Homes Advisory Board should be eliminated. Travel and annual reports from the Alaska Pioneer Homes Advisory Board duplicate the work of Finance Management and Services (FMS). The board can continue its advisory role via teleconference. This is discussed in more detail in Section 8.1.G of this report.

Recommendation 4.3.

Evaluate opportunities for savings in advisory body travel by:

Scheduling concurrent meetings of groups with considerable membership overlap (such as the Drug Utilization Review Committee and the Pharmacy and Therapeutic Committee).

1. Using videoconference or teleconference meetings when these can achieve the same outcomes as in-person meetings.

Recommendation 4.4.

To maintain and augment the effectiveness and efficiency of all DHSS advisory bodies, policymakers should:

1. Review periodically, beyond traditional sunset audits, whether each membership body is better equipped to determine policies/oversee programs than other available alternatives such as internal agency workgroups or subject matter experts from academia or the public/private sectors.

2. Establish and enforce expectations regarding the use of performance management tools by agency councils, boards and commissions.

3. Use the criteria developed in this analysis when considering the creation of any new advisory bodies.

5. OBJECTIVE 5: BEST PRACTICES

Objective 5: Determine whether organizational management best practices can be utilized to more effectively organize the department and reduce funds spent on department and program administration. Compare overall organizational structure of DHSS with similar public or private organizations. This should address the following:

a) ***Is the number of staff devoted to administration in the department's varying divisions commensurate with or disproportionate to the level of services overseen by the department?***

b) ***Are there national best practices that could reduce administrative expenses?***

c) ***Are there national best practices for department organization that could increase department effectiveness?***

Best practices are practices that are deemed effective through experience or research by a well-known, respected organization. There is no consensus on what criteria or indicators qualify as "best" practice. However, based on a review of department staffing, administrative expenses, and organization, a number of practices were identified during this performance review that have been deemed a best practice by a reputable organization. Table 5-1 lists the best practices that have been recommended for consideration or implementation by DHSS throughout this report to more effectively organize the department or to reduce costs. Adjacent to each cited best practice is the page number in this report where they are discussed in more detail.

Table 5-1: Best Practices Identified

Best Practice	Objective	Page Number
Budget Presentations	Objective 1	13
Licensing Foster Care Homes	Objective 2	52
Consolidate Program Integrity	Objective 2	71
Continuous Quality Improvement	Objective 2	74
Juvenile Justice Organizational Placement	Objective 6	87
IT Security	Objective 7	111
Protocol for Setting Fees	Objective 8	127
Billing Insurance for Public Health	Objective 8	134

Described throughout this report are a number of other practices in place in other states that have not been deemed a best practice by any organization. However, these practices indicate an emerging trend or a common practice that may be appropriate for implementation in Alaska.

6. OBJECTIVE 6: DEPARTMENT STRUCTURE

Objective 6: Recommend changes to DHSS' organizational and administrative structure that may lead to a more effective and efficient use of the state's limited resources.

As part of the evaluation of Objective 6, this performance review considered the benefits and challenges of the current comprehensive structure of DHSS as the single state agency for health and social services. In addition, two related components of Objectives 2 and 3 were also evaluated:

- Identify strengths and weaknesses of the current organizational structure.
- Identify changes to the organizational structure that would improve the efficiency and effectiveness of service delivery and administration

As a result of the performance review, the following conclusions are discussed in more detail in this section:

1. DHSS should be maintained as a single state agency for health and social services.
2. Privatization or an alternative, called managed competition, should be considered for the Alaska Pioneer Homes.
3. Re-locate early childhood prevention and early intervention programs, both inside and outside the department.

Additional recommendations for organizational changes within the department are made throughout this report. At the conclusion of this section, all of the recommendations for changes to the organizational structure of the department are summarized in a revised organizational chart for the department.

6.1. Maintain Single State Agency for Health and Social Services

The scope of work developed by the Division of Legislative Audit (DLA) for this performance review emphasized the administrative complexity of DHSS, a department of more than 3,000 employees and a budget of nearly $2.7 billion providing all of the health and social service functions for the State of Alaska. The scope of work seeks to determine whether the DHSS organizational design contributes to the administrative complexity of the department. According to the scope of work, the purpose of the DHSS performance review is to gain "a more focused picture of the department's organization and an understanding of whether the department's

organizational design is perpetuating problems or otherwise inhibiting a more effective means of delivering essential services [that] could help provide more clarity about resource needs."[90]

Findings

A number of issues related to streamlining and consolidating agency operations have been proposed throughout this report. However, based on the information collected for this review, there is no compelling evidence to show that separating DHSS into multiple smaller departments would yield significant benefits.

Interviews and focus groups with staff in DHSS indicated strong support and appreciation for the administrative resources available to divisions.

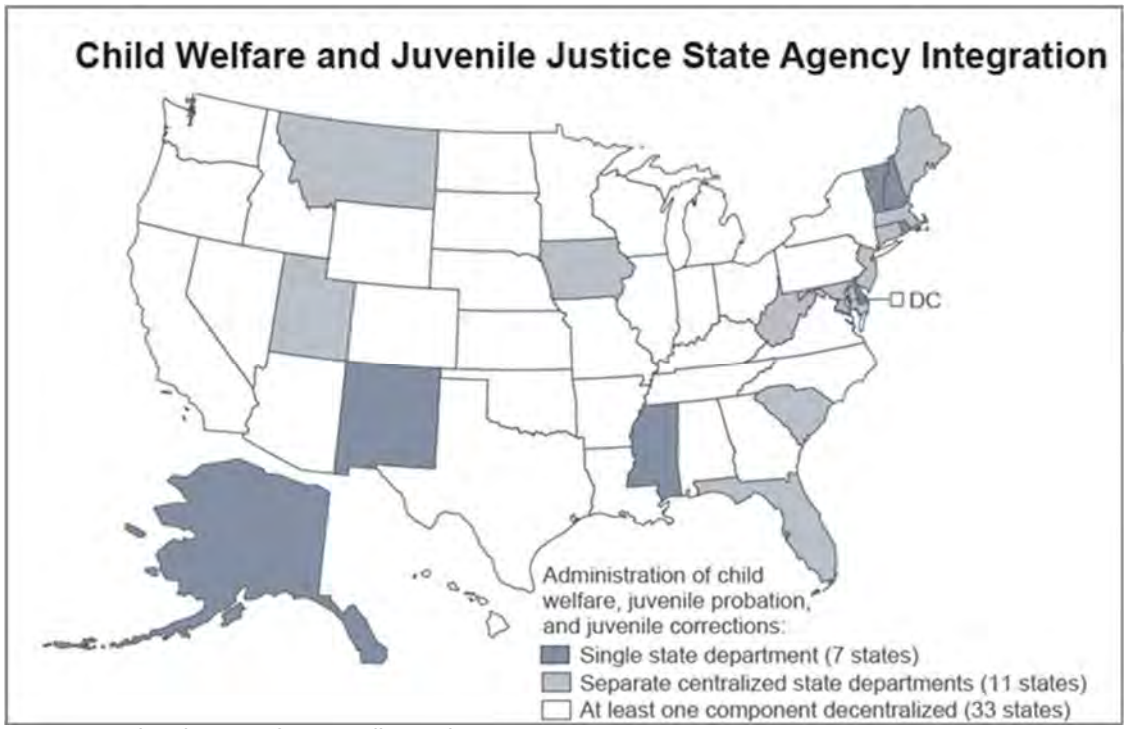
Of the 10 peer states reviewed for this performance review, Montana has the most similar structure to Alaska, housing all of its health and human services in a single department, with the exception of juvenile justice, which is part of the Montana Department of Corrections.

Of the states reviewed, Montana, along with North Dakota and South Dakota include juvenile justice in the Department of Corrections. Three other states – Idaho, Georgia, and Oklahoma – have a separate department for juvenile corrections. Four of the states reviewed – Arkansas, Hawaii, New Mexico, and Wyoming – include juvenile justice in a family or human services department, as is done in Alaska.

While most states have not incorporated juvenile justice into a health and human services agency, child welfare and juvenile justice integration has emerged as a leading reform trend. As states review the growing body of research establishing the correlation between adverse childhood experiences (ACEs) and subsequent delinquency, policymakers are searching for tools to improve outcomes for "dual status" juveniles, those children involved in both the child welfare and juvenile justice systems.

As shown in Exhibit 6-1, Alaska was one of only seven states nationwide to have child welfare and juvenile justice administration in a single state agency. Others are considering this model as a way to remove structural barriers to coordination and improve data sharing for youth in both systems.[91]

Exhibit 6-1: Juvenile Justice Integration with Child Welfare



Source: National Center for Juvenile Justice, 2014.

Six of the peer states reviewed separate health and human functions into two departments: Arkansas, Hawaii, Idaho, North Dakota, South Dakota and Wyoming. Georgia, Oklahoma, and New Mexico have multiple departments providing the services housed within Alaska DHSS. Of the states reviewed, only Georgia has Medicaid in a stand-alone department.

While Alaska is unique in supporting health and social services functions within a single department, there are several advantages to this arrangement including:

- Economies of scale can be achieved in the administrative infrastructure needed to support the department. Multiple departments each require an administrative infrastructure, including purchasing, human resources, IT support, budgeting, accounting, and auditing, among many others.

- DHSS has made significant progress in developing an enterprise approach that allows oversight and integration of administrative functions as well as programs and services.

Coordinated efforts can be facilitated among divisions that serve the same individuals. For example, an upcoming software application, the Master Client Index, will allow staff to access client data from programs throughout the department.

Recommendation

Recommendation 6.1.1.

Alaska should maintain a single state agency for health and social services. This performance review found no compelling reasons to separate any of the functions within DHSS into independent departments. In the current fiscal climate in Alaska, separating the department would be a complex, expensive, and protracted effort.

6.2. Privatization or Managed Competition for Alaska Pioneer Homes

During the 2015 Alaska legislative session, HB 190/SB 74 (introduced, but not passed) included the following directive that DHSS study privatization options:

> The department shall conduct a study analyzing the feasibility of privatizing services delivered at Alaska Pioneers' Homes, the Alaska Psychiatric Institute (API), and select facilities of the division of juvenile justice. The department shall deliver a report summarizing the department's conclusions to the senate secretary and the chief clerk of the House of Representatives and notify the legislature that the report is available within 10 days after the convening of the Second Regular Session of the Twenty-Ninth Alaska State Legislature.[92]

When evaluating Alaska Pioneer Homes, the January 2015 Indirect Expenditure Report from the Legislative Finance Division suggests that "the legislature may wish to consider getting out of the business of operating homes for seniors."[93]

Findings

While it is beyond the scope of this performance review to analyze the costs and benefits of privatizing state services, the research for this review indicates that there may be some merit to exploring the privatization of the Alaska Pioneer Homes.

Only two other examples of state-owned assisted living homes were identified during research for this project: Arizona and Wyoming each own and operate one assisted living facility. In Wyoming, a Joint Executive and Legislative Task Force studying state-owned health facilities recommended in November 2014 that privatization of the Wyoming Pioneer Home be considered: "The Task Force recommends that the Legislature convene a study of the Wyoming Pioneer Home to examine the potential for privatization or long-term lease of the

facility. The Task Force does not believe that the Pioneer Home, as an Assisted Living Facility, serves as part of the 'safety net."[94]

In addition to owning and operating the six Alaska Pioneer Homes, DHSS, through the Division of Senior and Disabilities Services (SDS), provides general fund benefits to support low-income seniors living in non-DHSS assisted living facilities. SDS also provides general fund grants that support three privately owned assisted living facilities in rural areas.

An alternative to privatization is a process called *managed competition*. Many public agencies contract for services with private firms without considering whether a job can be done cheaper and better in-house by public employees. Layers of bureaucracy often prevent such efficiency assessments. Managed competition analyzes the real cost of an operation or service and then designs a competitive bidding process that is open to in-house bidding by governmental agencies/workers, as well as outside, private bidders. This open competition is used to determine the best service provider – whether governmental or private sector – and the best price.

Managed competition has been used by numerous public agencies to reduce inefficiencies, save money, and reduce unnecessary bureaucracy. For example, in a competitive bidding process in Tulsa, Oklahoma, in 2011, city employees won a contract against 12 other private firms to provide City Hall maintenance services. The in-house contract saved the City 10.5 percent or approximately $123,000.[95] In San Diego, California, in 2011, an independent advisory board chose an in-house bid by city workers to run the City print shop over five other bids from private firms. The in-house contract lowered costs by 30 percent.[96] An example from Indianapolis, Indiana shows the significant potential cost savings of managed competition over time. A 2005 study conducted by the School of International and Public Affairs at Columbia University found that the City of Indianapolis saved $230 million from 1992 to 1997 by utilizing competitive bidding for over 70 diverse City services.[97]

Recommendation

Recommendation 6.2.1.

The State of Alaska should consider managed competition or privatization for the Alaska Pioneer Homes, the costs of which are discussed more fully in Sections 8.1.G and 8.1.I of this report.

6.3. Prevention and Early Intervention

The mission of OCS, which houses the Alaska child welfare program, is to "enhance families' capacities to give their children a healthy start, to provide them with safe and permanent homes, to maintain cultural connections and to help them realize their potential."[98]

Findings

Generally speaking, prevention and early intervention programs have a low profile in DHSS. The department does not have an office dedicated to these issues. DHSS FY 2015 *Budget Alignment and Core Service Alignment* documents do not include prevention and early intervention as a priority or core service, although prevention activities are noted in the continuum of care graphics developed by each division for presentation to the legislature. Several comments from the DHSS public hearing on May 13, 2015, related to concerns that the department is not focusing on the lower cost activities related to prevention and early intervention in a number of programs, including Medicaid and behavioral health. The return on investment from prevention and early intervention programs has been well documented in the fields of health care, public health, and early childhood programs.

This performance review evaluated four early childhood programs located within OCS: the Early Intervention Infant Learning Program (ILP), the Alaska Early Childhood Coordinating Council (AECCC), the Early Childhood Comprehensive Systems Planning Project, and the Strengthening Families initiative.

Three of the current OCS early childhood programs fit well under the OCS mission to enhance families and promote the health and well-being of children.

- The Alaska Early Childhood Coordinating Council (AECCC) is designed to facilitate the integration and alignment of services, planning efforts, resources, policy development, and funding, and establish connections among health, mental health, education and family support systems, and public and private partners.

- The Early Childhood Comprehensive Systems Planning Project, funded by the federal Health Resources and Services Administration (HRSA), is designed to mitigate toxic stress and trauma in infancy and early childhood, which fits well with the mission of OCS.

- The Strengthening Families initiative focuses on building protective supports for children, which helps strengthen families. This program also fits well with the OCS mission.

The Early Intervention Infant Learning Program (ILP), is currently under consideration to be moved to the Department of Education and Early Development (DEED). This program may be better suited for DEED for the following reasons:

- Traditional early education programs like Head Start, Early Learning, and Pre-Kindergarten programs are already housed in the DEED Division of Teaching and Learning Support.

- OCS is a crisis-driven organization and ILP is not getting the priority attention that it could receive in a less triage-focused environment.

- OCS suffers from negative perceptions in the community, which impacts perceptions of ILP.

Recommendations

Recommendation 6.3.1.

Elevate prevention issues within DHSS. This may be achieved by creating a prevention and early intervention office or by clearly identifying and tracking in budget documents, including the *Budget Alignment and Core Service Alignment* documents, the return on investment of prevention and early intervention programs that are in place throughout the department.

Recommendation 6.3.2.

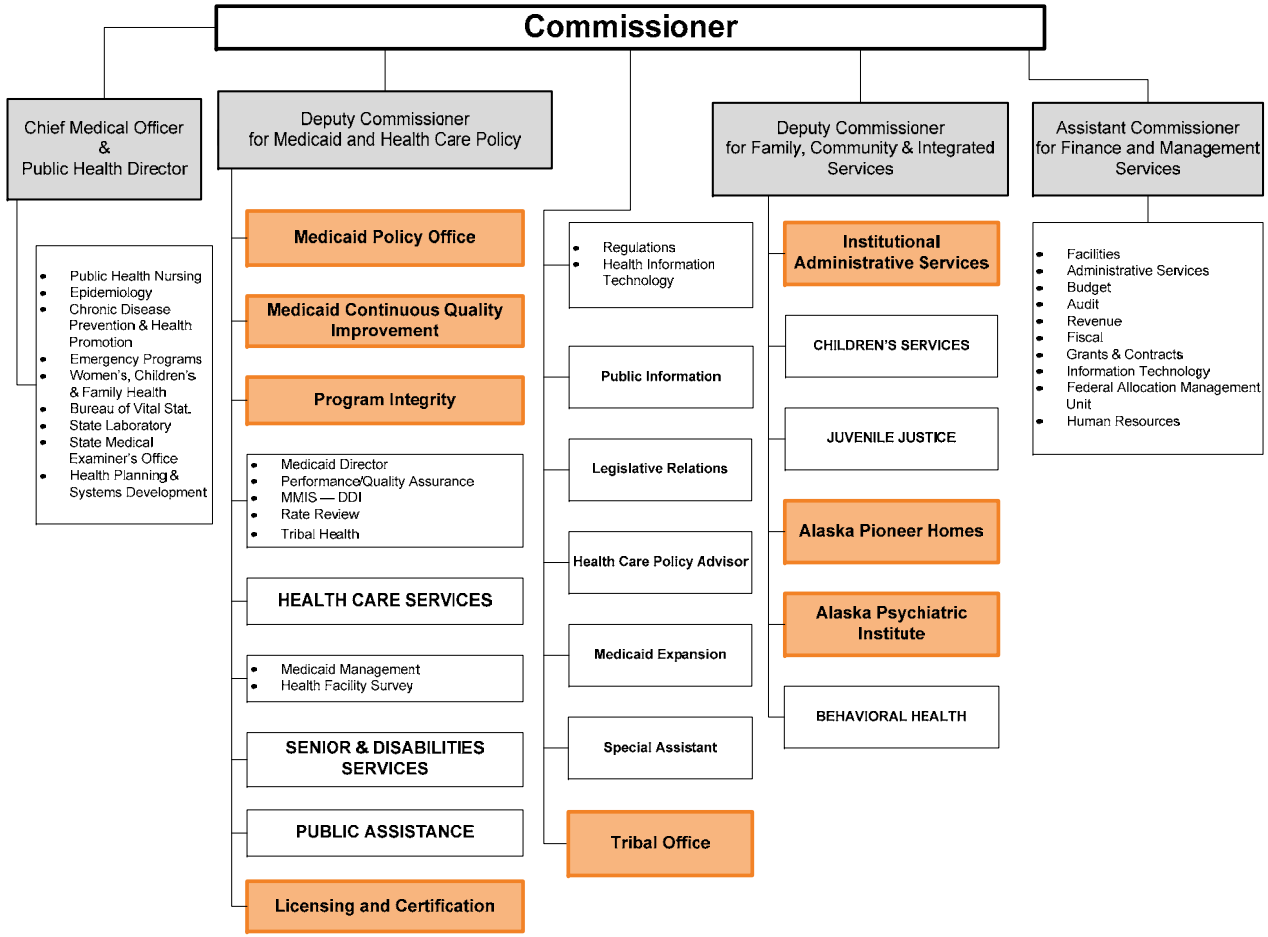
Move forward with the transfer of the ILP program to DEED.

6.4. Changes to the Department Organization

Several recommendations in this report impact the structure of the department. The following organizational chart, Exhibit 6-2, summarizes the changes discussed throughout this report; changes are highlighted in orange.

Exhibit 6-2

Alaska Department of Health and Social Services
Organization Chart



7. OBJECTIVE 7: INFORMATION TECHNOLOGY

Objective 7: Evaluate whether DHSS' organization and administration of information technology effectively supports its programs and services. The evaluation should recommend new types and uses of technology to improve agency efficiency and effectiveness in line with recognized best practices. Recommendations should include the estimated long-term maintenance costs for the technology or best practice identified. The review team will exclude the recently implemented Medicaid Information System.

In order to evaluate the organization and administration of DHSS information technology (IT) and whether it is effectively supporting departmental programs and services, this performance review focused on the DHSS consolidation of divisional IT services into one department-wide IT services section. This consolidated approach focuses on enterprise-wide solutions, including a shared-services approach, designed to reduce duplication and redundancies, and improve efficiencies.

Specifically, this performance review examined:

- The overall vision and goals of the department as they related to information technology, and how these are being implemented;
- The goals of the centralized Information Technology Services (ITS) section and how they are aligned with the services and programs they support;
- Any gaps between the vision and the realization of the enterprise approach to managing department technology;
- The ITS organizational structure, management team, and financial and other resources to determine how effectively they are deployed to achieve enterprise objectives;
- Whether the DHSS enterprise vision is being effectively guided by the creation and usage of an Information Technology Governance (ITG) process;
- When and how critical components of information technology are being provided by other state agencies and by business associates;
- How technology and needed policies, procedures, and training offerings are being developed and used to minimize security and privacy risk issues;

- How effectively video conferencing and other technologies are being deployed in the efforts of the department to save resources while providing essential services, especially in remote parts the state; and

- How needed technology is funded, and the process for divisions to request funding for IT projects.

7.1. Information Technology Governance Process

The Information Technology Governance (ITG) process in DHSS is an effort to improve how technology projects are approved, prioritized, funded and aligned with the department-wide vision. The ITG process is supported by the staff and resources in the following offices:

- Information Technology Services (ITS), including the Project Management Office (PMO) and the ITS director;

- The director of the Office of IT Planning, who also serves as the State Health Information Technology Coordinator (State HIT Coordinator);

- The ITG Committee; and

- The Project and Portfolio Management Review (PPMR) team.

Efforts to coordinate IT at the enterprise level have led to the development of tools, such as the Enterprise IT Roadmap (the vision of technology deployment across the department) and the Alignment Framework Form (AFF), a form used by a division to request new or enhanced technology projects, and training to help ensure projects are aligned with the DHSS vision and mission, and are approved and prioritized based on an objective scoring system. The ITG process is also designed to ensure that: resources are secured before projects move forward; there is a life-cycle approach to embarking on new technology; agile software development methods are employed; and where possible, systems are designed to reduce redundancies and leverage shared technologies and business components across division lines.

The role of the Office of IT Planning includes:[99]

- Preparing status reports on projects managed by IT Planning (some projects are managed by divisions);

- Monitoring status reports on all ongoing IT projects and recommending projects that should be more closely reviewed by the ITG Committee;
- Assisting divisions with preparing AFFs and identifying their IT alignment business needs with the assistance of the ITS PMO;
- Maintaining the Master IT Prioritization list;
- Assessing at-risk IT projects and recommending actions to the ITG Committee;
- Assessing and prioritizing the status of existing systems and maintaining documentation;
- Acting as the business owner of some enterprise-wide projects; and
- Preparing status reports on IT Plans.

The ITS PMO tasks include:

- Conducting meetings to discuss requirements and estimates for all submitted AFFs;
- Supporting project managers;
- Providing process tools, such as templates, standards, metrics, best practices and other aides to help project managers manage their projects consistently, efficiently, and effectively;
- Assessing at-risk projects;
- Reviewing adherence and alignment with IT policy, procedures, and staffing;
- Providing project management expertise;
- Coordinating with key IT staff; and
- Reviewing all monthly IT project status reports.

The ITG Committee evolved out of a committee established to steer development of a new healthcare services information system (MMIS). Because the federal government requires governance oversight of federally-funded IT projects, and because state and department leaders determined IT spending needed to align with department priorities, the ITG Committee was established. Its responsibilities include:

- Annually approving the IT Roadmap;
- Prioritizing spending on IT projects;
- Reviewing requests for new IT business needs, and for changes to current systems;
- Analyzing and discussing IT opportunities and risks; and
- Approving funding for department-wide (Enterprise) projects.

The DHSS IT Roadmap envisions modernized technology infrastructure, standardized business processes, streamlined functions and reduced or eliminated redundancy.[100]

According to the ITG Committee Charter and DHSS staff, the ITG Committee is composed of 12 senior department leaders, representing each division within DHSS: two deputy commissioners, the Assistant Commissioner for Finance and Management Services (FMS), the PMO Manager, the Director of ITS, and the division or deputy division directors of all eight functional divisions. Non-voting members include some PPMR team members, the State HIT Coordinator, and invited project managers from divisions. According to two other DHSS documents, *IT Governance 101 & Alignment Framework Training* and the *IT Governance 101 Refresher*, ITG Committee membership also includes the Office of IT Planning Director and IT PMO. Because the State HIT Coordinator is also the director of the Office of IT Planning, this review assumes these documents are referring to the same positions.

Division Business Alignment Liaisons support the ITG Committee by assisting division staff in completing the AFFs and reviewing all AFFs for alignment to division and department priorities.

The PPMR team is charged with:

- Evaluating IT spending for opportunities for savings;
- Monitoring and reporting on IT project status;
- Assessing at-risk projects and making recommendation to the ITG committee; and
- Standardizing IT policy, procedures, staffing and documents throughout the department.

In document review for this report, the acronym PPMR was defined by five different names in various (and in one case the same) department documents: Portfolio and Project Management

Review; Project and Portfolio Management Review; Project/Program Management Review; Project and Program Management Review; and Project Plan and Management Review team.

Findings

Research for the performance review raised concerns about IT staffing and spending levels for DHSS. In addition, there are a number of challenges to the current ITG approach, including the process for prioritizing projects, communications about project status, the overlap between the various units and staff that comprise the ITG process, and the demands on the ITG Committee, all of which are discussed in more detail on the following pages.

A. IT Staffing

The status of the staffing of the DHSS IT unit compared to other Alaskan agencies' IT units is illustrated in Table 7-1. DHSS had 128 staff positions in 2012, which equated to nearly 3.5 IT staff persons for every 100 department staff, compared to the statewide average of nearly four positions per 100 employees. DHSS has more than 4,000 CPUs (laptops, desktops, and servers), including nearly 500 at its data centers, that have to be maintained, networked, updated, and repaired. DHSS also has more than 3,600 staff, working in 35 communities with 128 facilities, including some that operate 24 hours, seven days a week. These staff need help with computer networking, hardware, and software problems in an environment that has several of its components operating around the clock in high-security, high-risk environments with federally imposed confidentiality mandates.

For comparative purposes, the following table excludes the Department of Administration (DOA) Division of Enterprise Technology Services (ETS) because it provides core information technology to all state agencies, so nearly all of its employees are considered IT staff. Based on the complexity of many of the DHSS functions, such as health services, children services, and behavioral health services; the diversity of the services it provides; and the wide geographic distribution of services it provides, IT staffing for DHSS should be more aligned with similarly complex, diverse, and dispersed departments such as the Department of Fish and Game, the Department of Natural Resources and the Department of Commerce, Community, and Economic Development.

Table 7-1: By State Agency for 2012 (Excluding DOA ETS)

Proposed FY 2014 IT Operational Summary for All Departments	FTE	IT Positions	Contractor	Shadow	Total IT FTE and Shadow Staff as Percent of Total FTE	IT-FTE as Percent of Total FTE
Department of Health and Social Services	**3,690**	**128**			**3.47%**	**3.47%**
Department of Transportation	3,187	62		4.8	2.10%	1.95%
Department of Corrections	1,708	17			1.00%	1.00%
Department of Fish and Game	1,176	65			5.53%	5.53%
Department of Public Safety	969	26			2.68%	2.68%
Department of Administration	962	62		11.5	7.64%	6.44%
Department of Labor and Workforce Development	910	42		3.5	5.00%	4.62%
Department of Revenue	881	63		1.0	7.26%	7.15%
Department of Natural Resources	745	45		13.0	7.79%	6.04%
Department of Law	570	9			1.58%	1.58%
Department of Environmental Conservation	541	39		1.0	7.39%	7.21%
Department of Commerce, Community, and Economic Development	514	29			5.64%	5.64%
Department of Education and Early Development	335	25		1.0	7.75%	7.46%
Department of Military and Veteran Affairs	285	9			3.16%	3.16%
Office of the Governor	156	7			4.49%	4.49%
TOTAL	**16,629**	**628**		**35.8**	**3.99%**	**3.78%**

Source: Calculations based on "State of Alaska Consolidated IT Report: Fiscal Year 2014." Alaska Department of Administration, *2014*

DHSS spending on information technology has dropped significantly in the past several years and recent proposed budget cuts continue that decline. At the same time, there is a need for enhancements to information technology security and confidentiality capabilities driven by an audit by the U.S. Department of Health and Human Services and subsequent Corrective Action Plan. Agreements with the federal government require Alaska to increase spending for third-party monitoring and pay fines imposed for failures in security. At the same time, the department must provide additional remediation projects with major system enhancements to increase efficiency and create the infrastructure needed for a support shared-services model of functionality. These system enhancements will build an enterprise-level, service-oriented architecture that could support expansion of Medicaid in the state.

B. Prioritization of Projects

The prioritization of projects is tracked in two reports prepared by the IT Planning Office. At the time of this review, the *Prioritized Initiatives Report* showed 58 projects. The *IT Governance Prioritization Summary* report listed 66 projects and included individual ITG Committee member scores and the average of combined scores. The results-based alignment (RBA) scores of 1, 3, 5, or 7 are based on how well the proposed project aligns with department core services and the return on investment anticipated. The total score used to rank project priority is based on a formula using a combination of weighted factors including scores based on a business impact score (number and type of users and number of user divisions); the Roadmap Alignment Score (RAS); and the RBA score.

The final score on the *IT Governance Prioritization Summary* is used to rank projects in the *Prioritized Initiatives Report.* The maximum total final score could be as high as 35 points. At the time of this review, only three projects had scores in excess of 30 points: the Payment Card Industry Data Security Standard (PCI DSS) Compliance replacement project (a mandatory requirement for all DHSS transactions involving credit card vendors, online merchants and service providers); the Shared Services Integration, also known as Master Client Index project (which would allow divisions to access information about their clients served by other divisions); and the benefit eligibility system replacement (ARIES).

This review noted several problems or irregularities in the IT project prioritization process, including:

- The *Prioritized Initiatives Report* does not include a begin date or AFF date or some other date to indicate how long projects have been under ITG oversight.

- One major project (the Shared Services Integration, also called the Master Client Index) was not shown as approved on the ITG *Prioritized Initiatives Report*, although it is ranked number two in the priority list. This is a critical component to department-wide system integration efforts that, according to DHSS staff, is making only incremental steps toward implementation. This project would create a common view of individual clients served across DHSS programs and systems. Sharing client information across divisions would allow for closer coordination of benefits, understanding of costs, and the ability to share information about client needs, conditions, potential risks, and issues.

- Eleven projects in one prioritization document that had no scores or zeroes for their Results-Based Alignment (RBA) score (which evaluates alignment with department core services and return on investment) or Roadmap Alignment Score (RAS).

- Report notations that at least one project (and possibly others) was considered out of alignment with the IT Roadmap because it was an IT-only project and should be treated separately.

- Some projects that predated the ITG process received no score, even though they are existing projects. The exclusion of points in a scoring system may diminish the benefits of ranking projects and could undermine the credibility of the prioritization ranking.

Weaknesses identified in the current scoring process are listed below. These items may be considered in ITG Committee discussions, but are not included in the formal scoring methodology:

- No consideration for whether a project is mandated by the state legislature or a federal government oversight agency.

- No consideration for whether project implementation will help avoid payment of fines for non-compliance with agreements.

- No allowance for projects that may impact only the IT infrastructure and are, therefore, not “aligned” with the department-wide performance measures. These projects may be scored by committee members and by PPMR, however they are not specifically included in an objectively scored factor. As important as alignment is, other relevant metrics should be used as an objective method to provide a fair and credible prioritization process.

- Natural bias in scoring that can unfairly elevate projects that are well aligned or have many users across the department, but are not as critical as others.

When evaluating scoring methodologies, DHSS policymakers should ask:

- What is the right mix of scoring factors to be included?
- What factors should be weighed more heavily than others?
- What weight should be given to mandated projects?
- What factors should be used to compensate for very small but important projects with few users and in only one division?
- Should scoring be modified for projects proposed prior to the ITG process or those dealing only with IT infrastructure?

C. Communication of Project Status

A key component of project management is communication, which is often accomplished using project status reports. The IT *Application Development Status Report* includes comments to help understand project issues and concerns. A review of this report identified that two important columns are not consistently completed on many projects: "Planned Percent Complete To Date" and "Actual Percent Complete To Date." One or both of these columns were blank on 19 of 37 projects. Also, it is difficult for readers to see which projects are at risk without reading all comments – there are no dashboard indicators or color-coding to assist stakeholders in understanding the status of projects.

D. Staff Overlap

One person serves three roles in the ITG process: as the IT Planning Office Director, member of the PPMR team, and as the State HIT Coordinator. Multiple roles may place a burden on this individual who has other duties in addition to ITG roles. This may also reduce the number of collaborators and limit objectivity.

E. Demands on the ITG Committee

Currently, the ITG Committee must review every IT project. Because the Committee only has one-hour meetings once a month, the agenda is full and there may not be sufficient time to fully vet projects on the agenda. If a project is not accepted for review at a meeting, the request must wait another month for an opportunity to address Committee questions or concerns.

Interviews conducted for this review evidenced great frustration among department employees regarding the ITG process. Specifically, employees noted significant delays in the ITG approval

process and commented that they have foregone using specific IT tools (and often accompanying grant funding) if it would require engagement of the ITG process.

Recommendations

Recommendation 7.1.1.

Revise the prioritization scoring system to address the concerns, weaknesses and unintended consequences identified in this review.

Recommendation 7.1.2.

Revise the ITG process to limit the number of projects that must be vetted by the ITG Committee. This may include developing a "fast-track" process for relatively small projects that are grant-funded, federally mandated, or do not significantly impact the IT infrastructure. Alternatively, DHSS can consider an interim approval process between ITG Committee meetings.

Recommendation 7.1.3.

Require the completion of all information on the Application Development Project Status Report. This can be a valuable tool if it is completed as designed. Information showing project plans and to-date completion can provide IT managers, division managers and agency leadership vital information on project status. Using "green, yellow, red" color-coding to illustrate project status can also help management and stakeholders to quickly focus on problem areas. Projects in red should require more than the casual comments evidenced in a recent review of the report.

Recommendation 7.1.4.

Identify and correct inconsistencies in IT policy, procedures, terminology, and titles throughout the department noted in the discussion. For example, acronyms, position titles, and membership on the ITG Committee need clarification.

7.2. Video Conferencing Technology

Despite numerous strategic, operational, and financial benefits, video conferencing (VC) technology remains underutilized by DHSS. Causes for the underutilization include technological limitations in several remote parts of the state, infrastructure limitations (which creates VC room booking delays), and other limited resources. Although not fully utilized, DHSS has been implementing VC technology for the past several years for many purposes

including: staff meetings, mental and medical healthcare interviews and diagnostics, family visitations, and judicial proceedings. All DHSS divisions can benefit from expanded VC usage.

Findings

Several divisions are reviewing projects that use VC to improve efficiencies. According to DHSS, the IT Governance Committee is considering:

- A Division of Behavioral Health (DBH) project using iPads to connect patients in their homes with providers at a DBH tele-health clinical location via secure HIPAA compliant VC.

- A Senior and Disabilities Services Division (SDS) project to use Polycom VC services for SDS tele-health to complete plans of care sessions.

The Division of Juvenile Justice (DJJ) reports its conferencing sites are often fully booked and it would benefit from additional VC sites. Significant savings could likely be realized by using VC for events such as family visits, medical appointments, court appearances, and attorney visits and staff meetings. Savings could be achieved in most, if not all DHSS divisions, as a result of reduced transportation costs and, in some cases, eliminating the need for staff escort time.

Examples of savings are noted in the National Center for State Courts 2010 survey of correctional system use of VC for courts. That report highlights and quantifies numerous benefits, including:[101]

- Savings resulting from reduced time, staff, and fuel usage.

- Streamlining and more efficient administration of the entire court process.

- Providing 24/7 magistrate coverage (Virginia).

- Savings identified by some respondents included:
    - $31 million in total savings since inception (Pennsylvania Department of Corrections).
    - 30 percent reduction in travel expenses (Utah Department of Corrections).
    - $500 to $7,500 per hearing (cited by multiple respondents).

California reported that medically related guarding and transportation costs for one inmate can exceed $2,000 per day.[102] Therefore, reductions in the number of such trips can produce significant cost savings.

A 2011 survey conducted in Pennsylvania estimated that annual savings from the use of video conferencing technology not only saved jurisdictions an estimated $21 million annually, but also enhanced security by reducing the risk of escapes or assaults.[103]

The Alaska Department of Corrections (DOC) provides examples of how VC technology is used in the corrections system. VC technology is currently being used at several DOC facilities for court appearances, public attorney visits, and at most facilities for medical evaluations. With a few exceptions at smaller facilities, DOC correctional facilities housing pre-trial offenders have video links to courts and the necessary video and audio equipment for arraignments and other legal proceedings. The DOC IT manager works closely with the IT manager from the state court system to help ensure conference technology is deployed in a manner acceptable to judges and other members of the state legal system (prosecutors and public defenders).

Skype technology is being used in Santa Clara County, California to allow minors housed in juvenile justice facilities in other counties to attend semi-annual permanency placement hearings. This allows minors to attend while avoiding transportation costs and risks.[104]

Although in-person visits are generally preferred by families and in most cases more beneficial for children, there are numerous benefits of VC for visitation in corrections and detentions facilities including: [105]

- Reduces the number of staff required for the visitation process, leaving staff to perform traditional security duties.
- Eliminates the need for infrastructure dedicated to the traditional visitation process.
- Promotes visitation by reducing or eliminating the need for families to travel to visit family members, which can be time-consuming for families who live far from the facility.
- Reduces the possibility of incidents among and between family members.
- Increases the frequency of visits.
- Increases visitation hours, which reduces stress on visitors, children and staff.

- Reduces travel costs for families.

DHSS has made progress implementing VC technology as funds become available; however, there are additional advantages to the department if it can fully implement such a system. Once fully implemented in all DHSS offices and facilities throughout the state, and court acceptance is gained, there will be savings as well as improved public safety since fewer transfers of juvenile offender to and from courts will be required.

DHSS spends nearly $4 million per year on travel. By increasing the use of VC and decreasing the need for travel, the department could target savings in this area. The full cost of implementing an expanded VC system is not known; however, conservatively targeting a net savings of 10 percent in the first year to account for start-up costs, the department would save $400,000. Savings targets can be increased in subsequent years.

Recommendations

Recommendation 7.2.1.

Elevate the priority of current and future VC projects to expand VC capabilities of the department, increase efficiency, and reduce travel-related expenses across all divisions. Certain court-related usage of VC technology may require legislative changes and would require partnering with the judicial branch. VC use for health care is expensive and should be considered as funds are available.

Recommendation 7.2.2.

As new video conferencing capabilities come on-line, the Commissioner should establish a target reduction in travel of 10 percent for the first year and 20 percent in the second year.

7.3. Project Management and Project Management Training

According to some DHSS officials there is a shortage of project management skills across the agency. Often divisions do not fully understand the cost of developing, owning, and maintaining technology systems. Staff members with project management skills not only communicate, facilitate and manage projects, they can also educate others about enterprise alignment, costs, risks, opportunities for strategic sourcing or partnering, and other information important to efficient and effective usage of technology.

Findings

Benefits derived from project management are undervalued in many divisions, including some with significant investments in new or upcoming technology projects. Good project management is critical to delivering on-time, on-budget and high-value services to the department.

The Information Technology Section (ITS) has a Project Management Office (PMO) which manages several IT projects in development and the IT Governance process. The PMO also offers project management training and mentoring to division staff throughout the department.

In addition to PMO project management support, divisions with large technology projects need to have member(s) of their staff with project management training and experience on development and procurement/integration teams. A Division Business Alignment Liaison, as the name implies, should serve as a business-oriented project support staffer and a liaison to the divisions.

Recommendations

Recommendation 7.3.1.

Implement mandatory project management training and mentoring for IT and division staff, including Division Business Alignment Liaisons and project managers, who are tasked with responsibilities concerning development, integration and implementation of technology systems.

This training and mentoring can be completed with little or no additional cost since the ITS PMO has a Project Management Institute (PMI)-certified professional (considered a project management master); this individual also teaches project management courses at the local university.

7.4. Information Technology Section Organization and Management

Information systems security and privacy issues are, and will continue to be, a high priority in the current world of internet security breaches, cyber hacking, and the vulnerability of mobile computing devices. The Health Insurance Portability and Accountability Act (HIPAA) Security Rule established a national set of standards for protecting all electronic personal health

information (ePHI) that organizations create, receive, maintain, or transmit.[106] The Security Rule describes administrative, physical, and technical safeguards that are required to secure ePHI.

Findings

A 2012 audit of DHSS' system by the U.S. Department of Health and Human Services, Office of Civil Rights (OCR) resulted in a fine, Resolution Agreement (RA) and Corrective Action Plan (CAP) based on findings of significant security and privacy issues in the DHSS system. Two units within DHSS' Information Technology Services (ITS) section – the Security Office and Technology Office – are working very closely to remediate technology security and privacy issues and ensure the department has the necessary security safeguards to meet all federal requirements and address specific concerns noted in the OCR audit and a Risk Management Plan.

DHSS formed an Information Technology and Security workgroup that developed and implemented a security plan for the DHSS Eligibility Information System (EIS). DHSS directed the Security Office and Technology Office to work together to address the findings. As a result of these collaborative efforts, the two offices have been effectively combined. They are not, however, organizationally combined and remain separate offices each with a Data Processing Manager III.

Recommendation

Recommendation 7.4.1.

Combine the Office of Security and Office of Technology and appoint one manager to oversee all IT operations. The elimination of one manager will reduce the span of control to 1:6 and produce an estimated savings of $143,000 per year.

A. Information Technology Security

In light of the Office of Civil Rights Audit, Resolution Agreement (RA) and Corrective Action Plan (CAP), IT security must be a higher priority for the department. DHSS IT officials do not believe full compliance will be achieved by the March 2016 deadline agreed to in the CAP, in part, because resources are being directed to other necessary improvements.

Findings

Organizationally, IT Security is placed at a low level within the department. It is within the Information Technology Services (ITS) section, which is in FMS, thus three levels below the Commissioner's office.

Additionally, the Prioritization Report prepared by the IT Governance Committee ranks projects such as SharePoint Hardening and OCR remediation, both components of the security plan, as low priorities. Of 58 listed projects on the IT Governance Prioritized Initiatives list, SharePoint Hardening is number 15 and OCR Remediation is number 23. The Prioritization Report shows that SharePoint Hardening received a score of 1 for one of the factors (having only internal users) while Column F of the Report indicates it would have internal and external users. If Column F is accurate, it should have received a score of 5. This would have raised the total score to a level where it would have been tied for eighth in the prioritization list.

As part of its agreement with OCR, DHSS had an IT Risk Assessment and Risk Mitigation Plan prepared in 2012. The security projects agreed to in the Risk Mitigation plan do not appear at the top of the prioritization list since they received a score of "0" regarding alignment with the IT Roadmap. This is despite the fact that IT Governance officials recognize that many infrastructure projects that are required to maintain the day-to-day operations of DHSS do not align with the department vision or performance goals.

The estimated cost to implement all recommended controls in the Risk Mitigation Plan is more than $5.3 million in initial costs with another $2.4 million per year in on-going costs. The initial implementation would require 16,425 person hours of labor, which exceeds what 10 full-time employees or contractors generally work in one year. In addition, on-going hours would require at least eight full-time equivalents (FTEs). This is well beyond the capacity of the current three-person DHSS IT Security Office, even with the DOA providing some support.

Some of the recommended controls have been implemented, including changes to governance and oversight, training, and some enhancements to physical security. However, the vast majority of controls have not been implemented despite the known risk of cyber security breaches and cyber attacks. Security staff are beginning to show signs of reduced morale because they are overwhelmed with the amount of work that needs to be done with few resources. It is not feasible to implement all of the recommended controls and risk reductions expected by the federal government without a large infusion of resources. The level of commitment, not only from DHSS, but also from other state agencies and the legislature, must be elevated dramatically to accomplish these goals.

There is a lack of consensus between DHSS users and IT security staff on the need and level of IT system security features. Department staff see IT security efforts as overreaching while, at the same time, they struggle with a system that does not fully support their direct services work or provide adequate customer interface for applications. IT Security, on the other hand, recognizes the shortcomings of security features and the need to implement the risk mitigation plan. There is a natural conflict between security needs and business needs for the IT Governance Committee that is primarily composed of division directors who must focus on what is needed to provide more effective and efficient services to their clients.

Security issues will be exacerbated as DHSS develops a new application that will allow it to accept credit cards for payments. Credit card data is a frequent target of cyber thieves, which gives rise to a new set of security concerns facing the department.

IT security best practices highlight the need to monitor and detect security breaches by having firewalls, gateway antivirus software, intrusion detection devices, and intrusion testing to help protect network-based systems. DHSS and DOA have some of these tools in place, though not all of them. Additionally, these tools need constant monitoring and updating, which requires resources.

Another IT security best practice is to restrict the use of devises that can facilitate security breaches into and out of networks.[107] DHSS has policies that restrict such usage; however, waivers based on business needs are requested and granted, which reduces the impact of the policies and increases risk exposure. Restricting and better enforcement of restrictions on USB drives, external hard disks, thumb drives, and social media should be paramount, and the granting of waivers should be more closely scrutinized and limited by the IT Security Office and requesting divisions. Educating division leaders and users regarding risks due to mobile computing and social media would clarify the need for restrictions, why waivers should be more closely monitored and restricted, and would help reduce the number of mishaps.

A low-tech, and therefore lower cost IT security best practice, is to educate users about security concerns and how they can avoid risky behaviors when handling valuable and often private data. A best practice followed by DHSS is security awareness training that is offered to new employees. The training is not repeated, however, so experienced employees may develop complacency about these issues. This can be mitigated with periodic refresher courses in security awareness.

Recommendations

Recommendation 7.4.A.1.

Allocate resources to IT security systems and other tools to ensure critical concerns cited in the OCR Audit and the Risk Mitigation Plan are addressed.

Recommendation 7.4.A.2.

Educate division leaders and system users on the risks of mobile computing and social media, and obtain agreement on policies concerning need for restrictions and why waivers from security requirements should be more closely monitored and restricted.

Recommendation 7.4.A.3.

Develop and offer on-line security awareness training programs. Security awareness refresher training should be required of all DHSS employees every few years or more frequently, if resources permit.

Recommendation 7.4.A.4.

Restrict and closely scrutinize requests for IT security waivers that may facilitate security breaches. DHSS has policies that restrict such usage; however, waivers based on business needs are often requested, and granted, that may increase agency risk exposure. Education of users is needed to reduce the number of waivers requested.

Recommendation 7.4.A.5.

Implement strict enforcement policies and procedures regarding the use of USB drives, external hard drives, social media, and other possible points of entry for cyber attacks.

Restrictions and enforcement of restrictions on the use of USB drives, external hard drives, and social media should be paramount, with waivers closely scrutinized and limited by the IT Security Office and requesting divisions.

B. Direct Secure Messaging

According to the DHSS website, Direct Secure Messaging (DSM) is "a HIPAA-compliant, encrypted email system that…is intended to facilitate sending personal health information (PHI) between HIPAA-covered entities."[108]

Findings

In nearly every meeting and focus group with program staff across the department, a high level of frustration was found with the use of the DSM system. Complaints included limits on the size of attachment, the fact that the system runs parallel to Outlook, the need to log into and monitor two separate email systems, the lack of knowledge about whether attached files were sent, and the slow speed of the system. Reported work-arounds include using an older version of DSM, which apparently works better, and faxing documents, which was reported to be faster than using DSM.

DSM was repeatedly identified as a significant productivity issue, slowing down work production across the department.

Recommendations

Recommendation 7.4.B.1.

Develop a plan to address the significant shortcomings and productivity issues identified by operational staff using DSM. As this review was concluding, DHSS reported making progress toward resolving the issues with DSM. Feedback from line staff is needed to ensure that the significant productivity issues are resolved.

Recommendation 7.4.B.2.

Expedite the execution of this plan. Significant productivity issues related to DSM need to be addressed across DHSS.

Recommendation 7.4.B.3.

Communicate progress on the plan and how problems are being addressed to all DHSS staff at regular intervals.

7.5. Public Health Nursing Technology Limitations

Due to budget limitations, the Division of Public Health (DPH) Section of Public Health Nursing (SOPHN) has limited technological tools in its public health centers.

Findings

In the clinics, SOPHN uses the Resource and Patient Management System (RPMS), the legacy electronic health record still used in many parts of the Alaska Tribal Health System. RPMS offers an integrated solution for the management of clinical, business practice and administrative information for healthcare facilities. While SOPHN has all four components of RPMS (hardware, software, network, and database), the Section has not been able to purchase the most recent updates because of budget constraints. DPH currently has several RPMS projects on the DHSS IT Governance Master Prioritization List.

Due to its technology limitations, SOPHN still maintains a paper charting system in all of its health centers. Section leaders report that they are required to train all new nurses on paper charting protocols because nursing schools today utilize only electronic records in their teaching.

According to a 2010 health care worker retention survey, "limited access to technology" is a serious concern in today's health care arena, with 29 percent of nurse respondents citing this as a significant challenge.[109] In the employee questionnaire conducted as part of this review, several SOPHN employees pointed to limited technology resources as a great source of frustration.

In September 2014, SOPHN formed a workgroup of staff and management team members to review suggested changes to the Public Health Nursing website based on feedback from staff, patients, and community partners. Several improvements have come out of this group's work:

- According to SOPHN staff, the public health nursing website is now much easier to find and navigate. Also, registration and health assessment forms are now available online, allowing patients to complete these prior to their appointments.

- The public health center in Fairbanks is working within its community to pilot the MyIR (My Immunization Record) patient portal to the state VacTrAK immunization information system. MyIR allow patients or parents to access current immunization records from anywhere in the state.

Recommendations

Recommendation 7.5.1.

Continue to expand the use and availability of technology in SOPHN to improve patient communications, improve services and maximize efficiency.

Recommendation 7.5.2.

Prioritize migration to electronic health records (EHRs) for all divisions – particularly SOPHN – to reduce medical errors, maximize operational efficiency, and minimize redundant training. Projects related to electronic health records before the IT Governance Committee should be prioritized.

8. OBJECTIVE 8: EVALUATE BUDGET REDUCTIONS

Objective 8: Determine if DHSS' proposed budget reductions related to administration are supported by the performance review including whether DHSS complied with AS 44.66.020(c)(2) when proposing cuts to such services. This should address the following:

(a) Do the proposed reductions represent a good faith effort by the department to identify areas that can be reduced without compromising the department's ability to meet its mission?

(b) Are the reductions recommended by the department in response to AS 44.66.020(c)(2) consistent with results derived from the review of each applicable objective within this Scope of Work?

(c) Did work on any of the objectives within this Scope of Work reveal other potential areas that could be subject to a budget reduction without inhibiting the ability of the department to fulfill its mission?

8.1. Methodology

In order to evaluate the budget items in Objective 8, the proposed budget reductions submitted by DHSS to the Division of Legislative Audit (DLA) on February 25, 2015, were reviewed.

The reductions proposed by the department are included in Table 8-1. The row highlighted in orange indicates a reduction inconsistent with the findings of the performance review and should not be included in the suggested reductions.

Table 8-1: Reductions Submitted by DHSS to DLA
February 25, 2015

Assigned Number	Division	Program	Description	Unrestricted General Fund Reduction	Personnel Reduction [110]
Note: The row highlighted in orange indicates a reduction inconsistent with the findings of the performance review					
1-APH1	APH	Alaska Pioneer Homes Management	Reduce Pioneer Homes' administrative staff and support	($240,700)	(2) PFT
2-APH2	APH	Pioneer Homes	Reduce Pioneer Homes' direct service staff, non-essential services, and supplies	($1,673,400)	(10) PFT (3) PPT (4) TMP
3-BH1	DBH	Behavioral Health Treatment and Recovery Grants	Reduce grants through grant equitable distribution; shift clients to Medicaid	($1,558,700)	None
4-BH2	DBH	Alaska Psychiatric Institute	Delete Alaska Psychiatric Institute Medical Director	($347,300)	(1) PFT
5-CS1	OCS	Family Preservation	Reduce funding for Family Preservation Services grants	($169,500)	None
6-CS2	OCS	Early Childhood Services	Reduce funding for the Early Childhood Services grants	($237,300)	None
7-HCS1	HCS	Catastrophic and Chronic Illness Assistance	Reduce individual benefits in the Catastrophic and Chronic Illness Assistance Program for clients eligible for Medicaid	($1,000,000)	None
8-JJ1	DJJ	McLaughlin Youth Center	Reduce Community Detention Program and eliminate recreational therapist position	($261,600)	(2) PFT
9-JJ2	DJJ	Nome Youth Facility	Delete office assistant III position	($92,800)	(1) PFT
10-JJ3	DJJ	Probation Services	Delete probation staff	($482,400)	(5) PFT (1) TMP
11-PA1	DPA	Alaska Temporary Assistance Program	Reduce Alaska Temporary Assistance Program due to excess authorization	($1,072,600)	None
12-PA2	DPA	Adult Public Assistance	Reduce Adult Public Assistance due to excess authorization	($237,400))	None
13-PA3	DPA	Tribal Assistance Program	Reduce Tribal Assistance Program due to excess authorization	($681,800)	None
14-PA4	DPA	Senior Benefits Payment Program	Reduce Senior Benefits to lower payment categories	($5,091,600)	None
15-PA5	DPA	Energy Assistance Program	Reduce Energy Assistance Program commensurate with declining caseload,	($3,500,000)	None

Assigned Number	Division	Program	Description	Unrestricted General Fund Reduction	Personnel Reduction [110]
16-PH1	DPH	Health Planning and Systems Development	Reduce Health Care Providers' Loan Repayment Program and Community Health Center Senior Access Grants	($136,600)	None
17-PH2	DPH	Nursing	Close 1 public health center, reduce Public Health Nursing Grants, delete staffing	($1,400,100)	(8) PFT (1) PPT
18-PH3	DPH	Women, Children, and Family Health	Hold Public Health Specialist II position vacant	($113,800)	None
19-PH4	DPH	Public Health Administrative Services	Delete administrative assistant II	($92,000)	(1) PFT
20-PH5	DPH	Emergency Programs	Reduce Emergency Medical Services grants and travel	($211,600)	None
21-PH6	DPH	Chronic Disease Prevention and Health Promotion	Reduce school districts' grants for obesity prevention, reduce travel, hold positions vacant	($157,500)	None
22-PH7	DPH	Epidemiology	Eliminate certain supplies to low-risk schools for tuberculosis screening, and reduce travel	($198,200)	None
23-PH8	DPH	Public Health Laboratories	Reduce viral immunology testing	($264,300)	None
24-PH9	DPH	Community Health Grants	Reduce Community Health Aide Training and Supervision Grants	($82,700)	None
25-SDS1	SDS	SDS Administration	Reduce overtime due to implementation of Automated Service Plan	($579,600)	(3) TMP
26-SDS2	SDS	General Relief / Temporary Assistance	Reduce individual benefits under the General Relief Assistance Program	($789,800)	None
27-SDS3	SDS	Senior Community Based Grants	Reduce grants for senior in-home services, adult day services, and traumatic and acquired brain injury management	($33,600)	None
28-SDS4	SDS	Community Developmental Disabilities Grants	Reduce Community Developmental Disabilities Grants Program addressing habitation needs	($506,700)	None
29-SDS5	SDS	Senior Residential Services	Reduce Senior Residential Services Grants supporting elders' residential services	($200,000)	None
30-DSS	DSS	Agency-wide	FY 2016 Target Reduction	(4,800,000)	None
31-DSS1	DSS	Commissioner's Office	Travel reduction due to multimedia meeting space enhancements in core areas	($19,000)	None
32-DSS2	DSS	Commissioner's Office	Delete project coordinator	($93,000)	(1) PFT
33-DSS3	DSS	Commissioner's	Delete office assistant II	($41,100)	(1) PFT

Assigned Number	Division	Program	Description	Unrestricted General Fund Reduction	Personnel Reduction [110]
		Office			
34-DSS4	DSS	Administrative Support Services	Delete accounting technician I	($37,200)	(1) PFT
35-DSS5	DSS	Administrative Support Services	Delete grants administrator II	($51,900)	(1) PFT
36-DSS6	DSS	Administrative Support Services	Delete grants administrator II	($57,400)	(1) PFT
37-DSS7	DSS	Administrative Support Services	Delete accounting technician II	($41,800)	(1) PFT
38-DSS8	DSS	Administrative Support Services	Delete administrative assistant III	($47,500)	(1) PFT
39-DSS9	DSS	Administrative Support Services	Delete economist IV	($65,600)	(1) PFT
40-DSS10	DSS	Information Technology Services	Delete seven college intern and two student intern positions	($177,300)	(9) TMP
41-DSS11	DSS	Information Technology Services	Reduce hardware support program due to expansion of the department computer refresh program	($362,500)	None
42-DSS12	DSS	Information Technology Services	Reduce personal services for support to the Automated Services Plan System	($145,000)	None
43-HSCMG1	Human Services Community Matching Grant		Reduce municipalities' grants for essential human services	($370,000)	None
44-CIMG1	Community Initiative Matching Grants		Align authority and reduce travel	($2,300)	None
45-MS1	Medicaid Services	Health Care Medicaid Services	Medicaid cost containment initiative	($20,000,000)	None
TOTAL				($49,860,200)	(38) FTP (4) PPT (17) TMP

Source: DHSS proposed budget reductions submitted to the Legislative Budget and Audit Committee on February 25, 2015.

Objective 8 requires determining whether DHSS complied with AS 44.66.020(c)(2) when proposing cuts to departmental services. AS 44.66.020(c)(2) states:

> *Sec. 44.66.020. Agency programs.*
>
> *(c) In the year before the year designated as the year for review in (a) of this section, the agency shall provide to the review team, before November 1,*
>
> *(2) a list of programs or elements of programs that compose at least 10 percent of the general funds in the agency's budget appropriated from the general fund that could be reduced or eliminated; the agency shall consider first those programs or elements of programs that*
>
> *(A) do not serve a current need;*
>
> *(B) are not authorized by the Constitution of the State of Alaska or the Alaska Statutes; or*
>
> *(C) are not essential to the agency mission or delivery of the agency's core services.*

To evaluate the proposed cuts, selected staff in each affected division and program were interviewed. Where applicable, we also reviewed program documents and conducted cost-benefit analyses and best practices research.

Findings – Objective 8(a)

Objective 8 and 8(a) evaluate whether the reductions proposed by the department: (1) comply with AS 44.66.020(c)(2); and (2) represent a good faith effort by the department to identify areas that can be reduced without compromising the ability of the department to meet its mission.

- The reductions were not submitted in time to meet the statutory due date; they were due before November 1, 2014, and were submitted by the department on February 25, 2015. Additionally, the cuts do not total at least 10 percent of the general fund dollars in the department budget that could be reduced or eliminated. The unrestricted and designated general fund appropriation in the Governor's FY 2015 Operating Budget for DHSS totals $1.3 billion. The reductions submitted total $48.9 million, or 3.7 percent of the total.

- While it is likely that the reductions proposed by the department will not impact its overall mission, many of the cuts will reduce its ability to serve vulnerable Alaskans. The reductions in staffing will impact remaining staff, making it more difficult to meet program

requirements, timeliness measures, and perhaps outcome measures. Reducing staffing, grants, benefits, and services for programs may in fact be considered cutting funding for current needs even though the programs themselves are not entirely eliminated. For example, reducing the probation staff in the Division of Juvenile Justice (DJJ) will reduce supervision and could increase the risk of recidivism. Similarly, closing a public health center could result in gaps in coverage for needy Alaskans.

- The department made a good faith effort to minimize the impact of budget reductions across programs and services. However, the proposed reductions appear to be an effort to minimize repercussions by distributing them widely, but perhaps not strategically. When confronted with sizable budget reductions, it is often better (and more strategic) to downscale the scope and mission of the department and eliminate entire programs or service lines rather than derive cuts from smaller parts of programs or personnel vacancies that happen to exist at the time of budget reductions. The department must focus on "strategic reductions" or jeopardize its ability to meet the needs of Alaskans, retain staff, and meet federal and state performance expectations.

Specific observations on the proposed DHSS reductions include:

- Of the 45 reductions, 21 involve cutting positions or holding vacancies open and 19 include a reduction in grants or benefits. Cutting positions or holding vacancies open negatively impacts the remaining staff members who must add responsibilities to their already full workload. Cutting grants or benefits – when need for these exists – negatively impacts the most vulnerable populations. While these types of cuts are sometimes called for to address inefficiencies (such as overstaffing or overfunding a program); based on the research for this performance review and the widespread use of this type of cut indicate that this was not the purpose of the majority of these cuts. For example, the cuts to grants for seniors are especially concerning because of the growing population of seniors in the state, often described in DHSS documents as the "silver tsunami."

- Two of the cuts are based on the assumption that the state will expand Medicaid, which is risky because Medicaid expansion has not been approved by the legislature. Several other cuts are based on the assumption that Medicaid waivers will be put in place to serve the individuals who will no longer be served through these general fund reductions.

- Two cuts, totaling $24.8 million, are placeholders that contain little detail. The department later provided information indicating that $4.8 million of the "unallocated"

cuts will be reductions in benefits provided through the Public Assistance programs in addition to benefit reductions already included in the reductions (the APA benefit program and the Public Assistance Energy Program). The largest cut, $20 million in "Medicaid cost containment initiatives" contains little detail. However, the Medicaid program has made strides with cost containment efforts and this amount represents slightly more than 1 percent of the Medicaid budget, so this placeholder seems reasonable.

- If enacted, at least nine of the cuts would reduce federal funding drawn down by the state, reducing the ability of DHSS to take advantage of a significant return on investment of general fund expenditures.

More desirable alternatives to these reductions would have been to find entire programs to eliminate, leaving other programs and services intact, or to find efficiencies or revenue sources that would have mitigated the need for reductions.

Findings – Objective 8(b)

In Table 8-1, the row highlighted in orange is a reduction that is inconsistent with the findings of the performance review and should not be included in the proposed reductions. All other proposed reductions are consistent with the review.

The one reduction that is not recommended is for funding for interns in the Office of Information Technology (OIT). OIT has nine interns in this program deployed in various ways, but mainly to provide staffing for the help desk. In addition to providing an avenue for recruiting and assessing potential employees, the internship program allows experienced help desk staff to perform other, more complex tasks, thereby increasing productivity within OIT. This program provides significant value at a lower cost than full-time salaried positions; the average savings by eliminating the funding for the program is less than $31,000 per year, which would be less than half of the fully loaded cost of most positions. The general fund amount saved would be less than $20,000.

Findings – Objective 8(c)

This performance review identified additional options for budget reductions or revenue enhancement that could be implemented without impeding the mission of DHSS. Table 8-2 summarizes these additional possible reductions and revenue enhancements and the total

impact on the state general fund. For more information about each recommendation and the associated cost reduction, please see the discussion in the related section of the report.

Table 8-2: Additional Reductions and Revenue Enhancement Measures Identified During the Performance Review

Division	Description	Estimated Year One Unrestricted General Fund Net Savings
Department Wide	Recommendation 3.2.C.1. Combine the DPA, HCS, and SDS facility licensing and certification functions into a single office or new division.	$250,000
Department Wide	Recommendation 3.3.B.1. Combine all program integrity and compliance units across the department, including provider enrollment and the surveillance and utilization review subsystem (SURS).	$250,000
Department Wide	Recommendation 7.2.2. As new video conferencing capabilities come on-line, the Commissioner should establish a target reduction in travel of 10 percent for the first year and 20 percent in the second year.	$400,000
Department Wide	Recommendation 8.1.A.2. Implement nominal annual child care facilities licensing fees.	$7,488
Department Wide	Recommendation 8.1.A.3. Establish a minimum license fee for smaller residential care facilities.	$24,250
Department Wide	Recommendation 8.1.A.4. Establish an application fee for all licensing services provided by DHSS.	$45,000
Department Wide	Recommendation 8.1.C.1. Increase the billing capacity at DHSS.	$281,666
APH	Recommendation 8.1.G.1. Increase revenue and reduce general fund expenditures by developing a fee schedule for Pioneer Homes.	$60,750
APH	Recommendation 8.1.G.2. Require a denial letter from Medicaid before a resident may move into a Pioneer Home.	$926,983
APH	Recommendation 8.1.G.4. Increase rates for Pioneer Homes to market rates.	$3,448,260

Division	Description	Estimated Year One Unrestricted General Fund Net Savings
APH	Recommendation 8.1.G.5. Eliminate the travel budget for the Pioneer Homes Board and remove the facility inspection requirement from statute.	$15,000
APH	Recommendation 8.1.G.6. Reduce the amount of information materials produced and distributed, and limit printing to black and white forms.	$12,500
APH	Recommendation 8.1.H.1. Negotiate rates for the lease of space at the Pioneer Homes and any other state-owned facility. [Note: this revenue mostly likely would be received in the state general fund, not in the DHSS budget.]	$40,000
APH	Recommendation 8.1.I.2. Evaluate the reasons for higher monthly costs per resident, including administrative overhead, maintenance staffing, travel, and other expenses	$5,460,000
OCS	Recommendation 3.1.E.1. Reduce the caseloads for new child welfare workers to meet the enhanced federal Title IV-E reimbursement rate requirements for workers in training, as well as during the first six months of employment.	$768,000
OCS	Recommendation 3.2.I.1. Maintain sufficient staffing by hiring caseworkers and providing all workers with manageable caseloads. Recommendation 3.2.I.2. Separate foster care licensing statutes and regulations from other residential care facilities. Recommendation 3.2.I.3. Clarify the waiver and variance process for kinship placements in department regulations. Recommendation 3.2.I.4. Develop a template or checklist for OCS workers and/or eligibility technicians to assist in correctly documenting the components of Title IV-E eligibility within the appropriate timeframes. Recommendation 3.2.I.5.	$4,653,600

Division	Description	Estimated Year One Unrestricted General Fund Net Savings
	Prioritize technology purchases and implementation to assist OCS workers.	
DPA	Recommendation 3.1.D.1. Create a master trainer program in DPA modeled after the DJJ program and allow eligibility workers who have low error rates (comparable to experienced employees) to take on greater caseloads as early as possible.	$692,091
DPA	Recommendation 8.1.D.1. Expedite the implementation of electronic document imaging throughout DPA and eliminate the courier budget.	$23,288
DPA	Recommendation 8.1.E.1. To the extent allowed by statute, require direct deposit or the issuance of EBT cards for benefit checks from DHSS.	$63,700
DPH	Recommendation 8.1.B.1. Reestablish a fee system to help cover the state's cost for laboratory testing.	$2,000,000
FMS	Recommendation 7.4.1. Combine the Office of Security and Office of Technology and appoint one manager to oversee all IT operations.	$143,000
	TOTAL	$19,565,576

The remainder of this section of the report discusses areas of potential budget reductions or revenue enhancement.

A. Licensing Fees

Like virtually all state health and human services agencies, DHSS licenses and certifies a number of facilities and individuals.

Findings

In many cases, DHSS does not charge fees for these services. Where fees are charged, the amounts are so small that the revenue generated falls far short of covering the department's

costs in issuing the license or certification. The DHSS fee structure has not been comprehensively reviewed, and there has been no formal effort to determine whether the current fees support the actual cost to the state in providing the license/certificate. In other words, the state and Alaska taxpayers are subsidizing many licensures.

While establishing new fees can be challenging, ad hoc adjustments of fees present additional issues. Often changes in fees without substantial justification face resistance from affected communities, and hide the underlying subsidies and cross-subsidies (use of higher fees for one license to offset the costs of others). In recent years, governments at every level have begun to review fee structures to bring them in line with the actual cost of performing services, and to provide for recoupment of costs in the future. The Government Finance Officers Association has established a best practice protocol for establishing government charges and the fee-setting process, which includes:[111]

- Adopting formal policies for reviewing and setting fees.
- Calculating the full cost of providing a service in order to provide a basis for setting the charge or fee.
- Reviewing and updating charges and fees periodically based on factors such as the impact of inflation, other cost increases, adequacy of cost recovery, use of services, and the competitiveness of current rates.

The Southern Legislative Conference also recommends and provides examples of states that have developed state-wide, blanket policies for fee adjustments for government services.[112]

The most commonly used automatic-adjustment measurement is the Consumer Price Index (CPI), which uses the cost of a "basket" of goods and services typically purchased by the average consumer. The CPI is widely used by both the public and private sectors for "indexing" salaries, benefits, contracts, taxes, and sometimes even prices. There is widespread public acceptance of the CPI as a measurement of the "cost of living." This makes it a convenient indexing device for ensuring that costs do not ever-increasingly outstrip receipts. Medical costs are part of the CPI "basket," as are other costs germane to government services such as transportation, education, and communications.

The absence of any indexing feature increases the need for frequent cost and subsidy assessments, adding to the cost and complexity of the fee-setting process.

Research for the DHSS performance review examined two facility licensing functions to determine current fees and potential for fee increases: child care facilities and residential care facilities.

A.1 Child Care Facilities Licensure

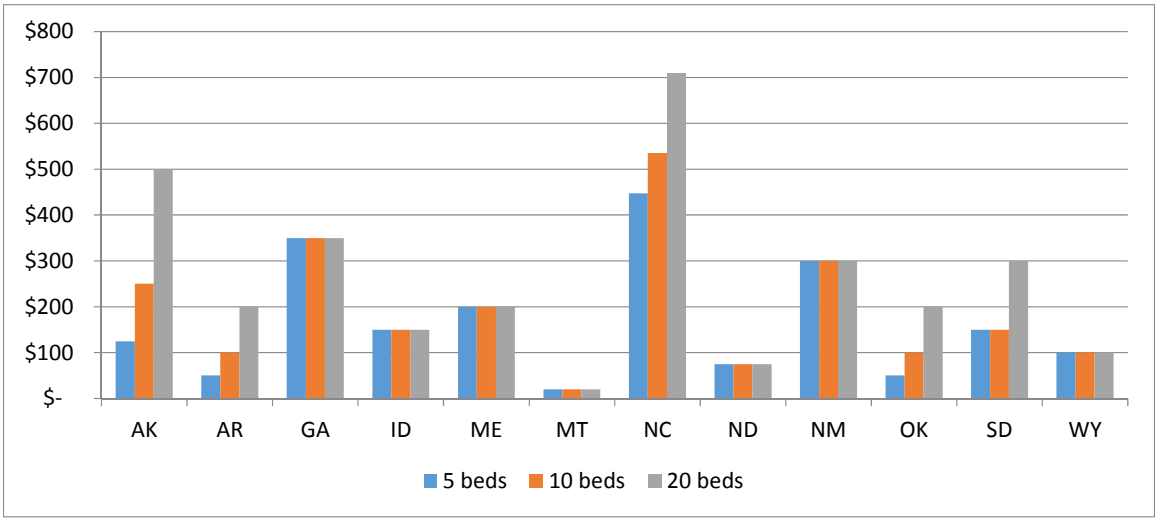
The Child Care Program Office (CCPO) is responsible for child care licensing statewide in Alaska, with the exception of the Municipality of Anchorage, which conducts child care licensing activities within Anchorage. The Municipality of Anchorage charges $25 per child care license. CCPO has not established a licensing fee for the 287 child care facilities located outside of Anchorage.

While Alaska is not the only state providing child care licenses free of charge (a review of child care licensing fees found at least three other states that have no licensing fee, including South Dakota, Oklahoma, and Montana), many states do charge licensing fees. Of the states reviewed that charge child care licensing fees, the fees range from $15 to more than $500, based on the number of children served or the type of facility (home, group, or child care center).

A.2 Residential Care Facilities Licensure

Alaska has an established license fee for residential care facilities of $25 per bed. Most of the residential care facilities are assisted living facilities. In January 2013, DHSS determined that the cost of licensing these facilities is $1.8 million annually.[113] A review of peer states found a range of fees, from no fees (Hawaii and Vermont), to flat fees for all facilities ranging from $75 to $500, to fees based on the size of the facility. Fees were compared for facilities of various sizes based on the number of beds. As shown in Chart 8-1, for a five-bed assisted living facility, Alaska would have a comparably low fee of $125. For a 10-bed facility, Alaska would still have a comparatively moderate fee of $250. For a 20-bed facility, however, Alaska would have one of the highest fees at $500 per facility.

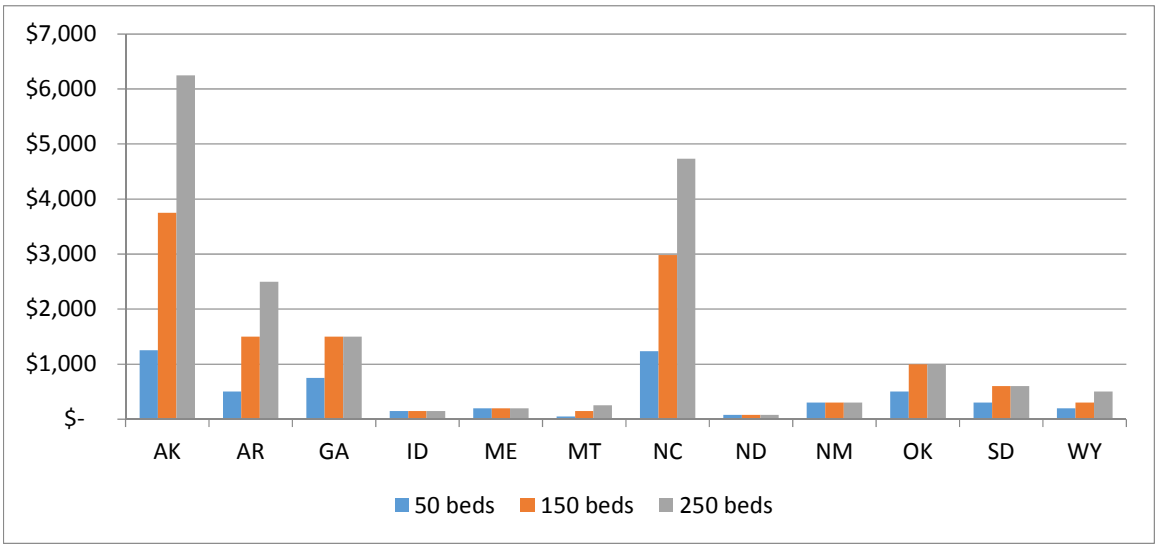
Chart 8-1: Assisted Living Licensing Fees Based on 55 to 20 Beds



Source: Calculations based on data available from other states.

For larger facilities with 50, 150, or 250 beds, Alaska would have the highest fees, as shown in Chart 8-2.

Chart 8-2: Assisted Living Licensing Fees Based on 50 to 250250 Beds



Source: Calculations based on data available from other states.

These state comparisons do not consider the cost to the state of providing the licensing services which may be higher in Alaska due to higher salaries and the high cost of travel to inspect sites for licensing.

In January 2013, the DHSS Office of Rate Review conducted an analysis of fees for residential facilities with scenarios for recouping 100 percent, 50 percent, and 25 percent of the costs of licensing residential facilities.[114] With a fee of about $500 per bed, the 100 percent cost recoupment scenario would result in an annual fee of $25,000 for a facility with 50 beds.

The analysis by the Office of Rate Review also addressed the collection of application fees, which are not currently assessed for either child care facilities or residential care facilities.

Recommendations

Recommendation 8.1.A.1.

Conduct a comprehensive review of the fee structure for all licensing and certification functions, with the goal of establishing fees equal to costs, accompanied by indexing to provide automatic adjustments of fees as costs change. While the state may deem that fee subsidies are necessary as a matter of public policy (meaning the state decides to continue to subsidize some or all of the cost of providing a license or service), any fee structure that is developed should be rationalized to minimize wide variations. The Consumer Price Index (CPI) should be used to index fees to provide for regular automatic adjustments, with some study given to the possibility of utilizing a more accurate health care inflation index in the future for health facility-related fees.

Because of the low number of child care facilities in the state, charging fees comparable to other states for these services does not generate a significant amount of revenue. And, setting fees to recoup costs would likely be prohibitively high. However, because DHSS already has the infrastructure in place to assess and collect the fees, the new revenue can be collected with little or no additional administrative overhead. A comprehensive review of cost recovery for other services within DHSS will yield additional fee revenue opportunities.

Recommendation 8.1.A.2.

Implement nominal annual child care facilities licensing fees, as shown in Table 8-3, **resulting in total biennial revenue of $14,975.**

Table 8-3: Child Care Facility Licensing Revenue

Type of Facility	Number of Facilities	Proposed Fee	Revenue
Licensed child care homes	107	$25	$2,675
Licensed child care group homes	76	$25	$1,900
Licensed child care centers	104	$100	$10,400
Total biennial revenue			$14,975

Source: Data provided by DHSS Child Care Program Office

Recommendation 8.1.A.3.

Establish a minimum license fee for smaller residential care facilities. In FY 2014, residential care facilities serving between three and five residents were assessed 194 times. If, instead of $25 per bed, all facilities with fewer than 10 beds paid a minimum fee of $250, an additional $24,250 would be collected annually.

Recommendation 8.1.A.4.

Establish an application fee for all licensing services provided by DHSS. According to the January 2013 analysis by the Office of Rate Review, an application fee of $1,000 for assisted living facilities would generate an additional $45,000 in annual revenue.

B. Fees for State Lab Tests

The Alaska State Public Health Laboratories (ASPHL) provide lab testing and analysis for a variety of public health concerns ranging from communicable diseases to toxic exposure. ASPHL also conducts tests to evaluate the safety of radiation-producing equipment; to analyze sources of biological, nuclear, incendiary, chemical, and explosive hazards; and to determine the cause of death in many cases in Alaska.

Findings

Each year, the ASPHL conducts approximately 181,000 tests with a commercial testing value of over $20 million.[115] There are currently no fees associated with the lab's testing.

In the early 1990s, ASPHL instituted a fee-for-service system for its lab work. The fee-for-service system was later rescinded in 2001 when ASPHL compared the cost of billing operations to the fees they were able to collect From 1996-2001, ASPHL billed $1,990,792 for lab services, however only collected $371,250 (less than 19 percent).[116]

ASPHL provides a significant amount of laboratory testing free of charge for the Department of Corrections and other state agencies. This generates substantial savings for the agencies over laboratory services from the private sector.

ASPHL has a small number of contracts with Alaska medical entities to provide reference and esoteric testing that is not available within the state's private sector.

According to ASPHL, current regulations limit the amounts charged for contractual work to 50 percent of the published Medicare/Medicaid rate for Alaska. (It should be noted that even the Medicaid/Medicare rates fail to cover the full cost of most tests.)

States across the nation are evaluating ways to maintain the long-term financial stability of their public health laboratories. Minnesota enacted legislation in 2013 that authorizes the state's infectious diseases laboratory to charge for the full cost of performing tests (with exemptions for tests for mandated disease reporting). An earlier law had allowed only a handling fee of $25 per test. Minnesota's legislation stipulated that the income from the test fees will be deposited into a fund for use by the laboratory.[117] In late 2014, the Oregon State Public Health Laboratory (OSPHL) instituted a new billing system (that included several fee updates) and contracted with a billing vendor in an effort to improve the timeliness and accuracy of their billing invoices, increase Medicaid billing, and ultimately bill private insurers.[118] With the new fees and billing vendor in place, Oregon projects a positive impact of $1,585,948 on the lab's 2015-17 budgets with a total of $2,764,734 in revenue.[119]

An in-depth fiscal analysis is necessary to determine exact revenue projections for an ASPHL fee reinstatement. But, if ASPHL could collect just 10 percent of its estimated $20 million in commercial testing value each year that could generate $2 million annually.

Recommendations

Recommendation 8.1.B.1.

Reestablish a fee system to help cover the state's cost for laboratory testing. In determining appropriate fee amounts and exceptions, ASPHL should be mindful of market pricing factors and the negative impact fees may have on certain public health concerns (e.g., STD testing).

While practicable fee levels may not generate enough revenue to cover the full cost of laboratory operations, it can help reduce the demand on general fund dollars. In establishing a laboratory fee system, ASPHL should focus on increased Medicaid and private insurance billing.

Recommendation 8.1.B.2.

Update current charges to reflect the true cost of testing for ASPHL's contractual work with other health entities. Any regulations limiting ASPHL's charges should be reviewed and updated as necessary to reduce losses.

Recommendation 8.1.B.3.

Consider an external billing vendor (whose contract costs should be borne by the new fee revenue) if ASPHL does not have internal capacity to support the personnel and technology needs of a billing program.

Recommendation 8.1.B.4.

Maintain services for state agencies currently receiving laboratory work from ASPHL when instituting a fee-for-service system. Fees should be assessed to other state agencies only when doing so can reduce the overall use of state general fund dollars (i.e., if other non-state dollars can be used).

C. Insurance Billing

Three divisions within DHSS provide services to clients who may be eligible for Medicaid, other public health insurance programs, or may be privately insured: Alaska Psychiatric Institute (API), Pioneer Homes, and the Division of Public Health (DPH).

Findings

DHSS is not taking advantage of all of the opportunities available to bill individuals and third party insurance to recover a portion of the costs of the services currently supported by the general fund.

API has a medical claims and billing unit in place consisting of seven accounting staff. API bills public and private insurance providers and individuals using the Alaska State Accounting System (AKSAS) interface for expenditure accounting and revenue accounting. DHSS has discussed the possibility of contracting out this function.

The DPH public health clinics are providing services that may be covered by private insurance; however, instead of filing insurance claims, the clinics provide services on a sliding fee scale and miss the opportunity to recover a higher percentage of the costs for providing services. Services that may be covered by private insurance include immunizations, well child exams, STD screening, and family planning. The clinics request payment from patients at the time of services and collected $132,159 in FY 2012, $230,561 in FY 2013, and $204,974 in FY 2014.[120]

At least two professional associations have recognized the need for public health clinics to consider billing individuals and third party insurance for a number of reasons, including shrinking budgets, the increased costs of providing services, and the increase in insurance coverage through Affordable Care Act (ACA) exchange health plans. Both the National Association of County and City Health Officials (NACCHO) and the National Coalition of STD Directors (NCSD) have detailed information and toolkits on their websites to assist local public health clinics in implementing a process for billing private insurance.[121]

A review of the services at DPH health centers in FY 2014 compared to the Medicaid reimbursement rate for those services suggests that considerable additional revenue can be realized by billing insurance. Seven services were chosen to illustrate the revenue that could be received if DPH billed insurance at Medicaid rates. Table 8-4 shows the revenue that would be received.

Table 8-4: Estimated Revenue for a Sample of Procedures

Service	Number Administered by DPH Health Centers	Code	Rate Applied	Total	25% of Total
Immunization	28,139	90472	$20.43	$574,880	$143,720
Pregnancy Testing	3,257	81025	$8.70	$28,336	$7,084
Prenatal Counseling (15 min)	1,122	99401	$59.49	$66,748	$16,687
Well-Child Exam (Infant)	1,132	99381	$181.85	$205,854	$51,464
Tuberculosis Screening	12,348	86580	$11.30	$139,532	$34,883
HIV Screening	3,541	86703	$18.85	$66,748	$16,687
STI Screening (syphilis)	7,592	86592	$5.87	$44,564	$11,141
Total				$1,126,662	$281,666

Source: Analysis of data available from DHSS and selected procedure (CPT) codes.

If just 25 percent of the services provided are for individuals insured through Medicaid or private insurance, the annual revenue would be $281,666 for the seven services shown compared to the sliding fee scale revenue that was received in FY 2014 of $204,974 for all services performed. The opportunity exists for DPH to significantly increase revenue from the services provided.

Pioneer Homes bills third party insurance for pharmacy costs, but is missing opportunities to work with residents to take advantage of long-term care insurance policies. Residents could receive assistance in submitting claims to their long-term care insurance carrier and pay the reimbursement to Pioneer Homes. Counseling all potential residents before they are offered residency about options for paying for assisted living, including converting life insurance policies and using reverse mortgages may also provide additional sources of revenue. QuickBooks is used at Pioneer Homes to track and bill self-pay patients.

Recommendations

Recommendation 8.1.C.1.

Increase the billing capacity at DHSS. By expanding billing capacity for the public health clinics and Pioneer Homes, additional revenue will be generated to offset the costs of services funded through the general fund.

This can be accomplished either by expanding the billing unit at API to include the public health clinics and Pioneer Homes or by contracting out billing functions altogether. The API billing unit already has the expertise and infrastructure to bill private insurance and other insurance programs. An expanded unit should report directly to the Deputy Commissioner overseeing institutions (recommended in Section 3.2.K of this report).

Recommendation 8.1.C.2.

Explore whether the contract for third party billing in the Division of Health Care Services (HCS) could be expanded to include billing for API, DPH, and Pioneer Homes.

D. Electronic Data Imaging

Findings

The Division of Public Assistance (DPA) has a workload management process that allows any available staff to work any pending application from anywhere in the state. This practice helps to address the backlog and keep all offices busy, especially the rural offices. The drawback to this process is that files are not routinely scanned, requiring paper applications to be physically transported between offices.

The DPA Field Offices budget includes over $800,000 for delivery services. DPA indicates that $23,288 of this amount is for courier services among the field offices.

According to the department, there are plans to implement a shared system of imaging and document retrieval via the MMIS document imaging and storage systems. The majority of this work is contained within the existing scope of the ARIES system implementation, although the timeline is unknown.

Recommendation

Recommendation 8.1.D.1.

Expedite the implementation of electronic document imaging throughout DPA and eliminate the courier budget.

E. Paper Checks

Findings

DPA issues 9,694 paper checks annually to recipients. Alaska contracts with JPMorgan Electronic Financial Services (EFS) to maintain EBT cards, called the Quest Card, for distribution of SNAP and TANF benefits. Many states also provide direct deposit and some continue to allow certain recipients to receive paper checks. Research indicates that some states no longer issue any paper checks for TANF benefits: Indiana,[122] Mississippi,[123,] and South Dakota,[124] for example.

Recommendation

Recommendation 8.1.E.1.

To the extent allowed by statute and feasible in the remote areas of the state, require direct deposit or the issuance of EBT cards for benefit checks from DHSS. This will result in savings of $63,700 in DPA. Additional savings may be generated in DBH and Division of Senior and Disabilities Services (SDS) by converting from paper checks for general fund benefit programs in these divisions.

F. Federal Meal Program Assistance at Division of Juvenile Justice Facilities

The National School Lunch Program (NSLP) and School Breakfast Program (SBP) are federally assisted meal programs operating in schools and residential child care institutions, including juvenile detention centers.

Findings

In juvenile detention centers, all residents qualify for free meals each school day, including weekends and holidays. Last year, working in conjunction with the Alaska Department of Education and Early Development, DJJ received $452,874 from federal school meal programs.[125] Based on family income, youth may remain eligible for free or reduced meals after release from juvenile detention centers.

To qualify for federal meal program funding, meals must meet current nutritional guidelines governing the National School Lunch Program. The Alaska Department of Corrections (DOC) provides meal service for many of the state's youth centers. During interviews for this project, DJJ divisional leaders expressed concern that the meals provided by DOC do not meet all of the nutritional requirements established by the NSLP.

Other states have implemented strategies to ensure that all meals served in juvenile detention centers, including those provided by adult correctional systems, qualify for NSLP standards. The Florida Department of Juvenile Justice and Department of Corrections participate in the National School Lunch and Breakfast Programs under the Florida Department of Agriculture. Meals served in both venues meet the same requirements as schools. Both juvenile justice and corrections facilities are classified as residential child care institutions under USDA child nutrition programs. The Florida Department of Corrections also receives federal reimbursement and commodities for juvenile offenders in the adult corrections system.

Recommendations

Recommendation 8.1.F.1.

Ensure that DJJ draws down all eligible federal funding from the National School Lunch Program (NSLP), School Breakfast Program (SBP), Special Milk Program, and After School Snack Program by supplementing meals provided by the Department of Corrections with other foods that will meet minimum USDA nutritional standards.

Recommendation 8.1.F.2.

Provide information to youth and their families regarding continued eligibility for free or reduced cost meals in schools as youth are released from DJJ facilities.

G. Pioneer Homes Revenue Opportunities

Findings

There are a number of opportunities to increase revenue and reduce general fund expenditures for the Alaska Pioneer Homes:

- Pioneer Homes does not charge application or waiting list fees, although it is common practice for assisted living facilities to require an application fee,[126] deposits to be included on waiting lists,[127] and community or entrance fees[128] to move into a facility.

- The Alaska Administrative Code (7 AAC 74.040(d)(1) states that a person applying for payment assistance for residency in the Pioneer Homes "shall" apply for Medicaid, However, Pioneer Homes does not enforce this requirement and does not require a Medicaid denial letter prior to admission. This means that the general fund could be supporting residents who are eligible for the Alaskans Living Independently (ALI) Medicaid waiver. Residents of Pioneer Homes are assigned a level of care based on a resident's abilities and needs, and monthly charges are based on the service level. Level I includes housing, meals, emergency assistance, and recreation. Level II adds additional assistance throughout the day but not at night, and Level III care adds assistance throughout the day and night; Level III residents may be eligible for the waiver. Currently, 68 residents are enrolled in the Medicaid waiver program. In 2014, 69 residents received general fund payment assistance for Level III care at Pioneer Homes. Based on observations by Pioneer Home administrators, 32 of these 69 residents may be eligible for the ALI Medicaid waiver.

- Although the Pioneer Homes do receive insurance payments when a resident is covered by long-term care insurance, the Pioneer Homes do not aggressively pursue long-term care insurance payments or other forms of payment for residents. The pharmacy does bill insurance directly, but private insurance is not billed for other services.

- Fifty percent of the residents of Pioneer Homes are private pay. Pioneer Homes charges below market rates. A rate increase of 8.5 percent was proposed by the DHSS in FY 2015, but was not implemented. According to the department, a rate increase is expected to occur in the FY 2016 budget.

- The Pioneer Homes Board travels each year to each of the six Pioneer Homes to review the condition of the homes and prepare a letter to the Governor. According to AS 44.29.510, the stated purpose of the board is to "conduct annual inspections of the property and procedures" of the Pioneer Homes. This effort duplicates the Deferred Maintenance program in Finance and Management Services (FMS), which conducts a physical inspection of each home every two years and conducts a telephone conference with each home in the interim year to discuss the maintenance needs of each home. In addition, each home has dedicated maintenance staff.

- Pioneer Homes has a budget of $25,000 for informational materials, despite the long waiting list. Several different color brochures are produced.

Recommendations

Recommendation 8.1.G.1.

Increase revenue and reduce general fund expenditures by developing a fee schedule for Pioneer Homes.

Table 8-5 shows nominal application and deposit fees that could be levied by Pioneer Homes. Approximately half of applicants are considered low-income, so the table shows the impact of collecting half of the fees, thus allowing fees to be waived for low-income applicants. Table 8-5 shows estimated annual fee revenue:

Table 8-5: Impact of Fees for Pioneer Homes

Fee	Number	Annual Revenue	50%Collection of Fees
Application Fee $20	700	$14,000	$7,000
Deposit for Inactive Waiting List $100	700	$70,000	$35,000
Deposit for Active Waiting List $250	150	$37,500	$18,750
ESTIMATED TOTAL		$121,500	$60,750

Recommendation 8.1.G.2.

Require a denial letter from Medicaid before a resident may move into a Pioneer Home. In addition, require an annual application for waiver services for all residents. Pioneer Homes may assist current residents in applying for Medicaid (this activity is reimbursable from Medicaid). Table 8-6 shows the Medicaid revenue that would be generated if half or all of the 32 Level III residents on general fund payment assistance were determined eligible for the ALI Medicaid waiver.

Table 8-6: Impact of Medicaid Waiver Revenue on the General Fund

Potential ALI Waiver Recipients	Annual Waiver Payment = $158.73/day*	Total Projected Savings to General Fund
50% of current Level III residents (16)	$57,936	$926,983
100% of current Level III residents (32)	$57,936	$1,853,966

*Lowest base rate. Higher rates are received at some Pioneer Homes and enrollees may qualify for higher payments.

Recommendation 8.1.G.3.

Centralize billing functions within DHSS to consistently and aggressively pursue payment from private sources. This recommendation is discussed in detail in Section 8.1.C of this report. To support this recommendation, require disclosure of long-term care insurance, life insurance policies, and other assets by Pioneer Homes applicants that can be converted into cash to pay for residency.

Recommendation 8.1.G.4.

Increase rates for Pioneer Homes to private market rates. Table 8-7 shows the impact of raising rates to market rates. This calculation only includes residents who pay the full charges, not residents who pay a portion of their expenses.

Table 8-7: Impact of Increasing Rates

	Current Monthly Charge	Market Rate[129]	Difference	Number of Residents	Annual Increase in Revenue *(If half of residents in each category are private pay)*
Level 1 Services	$2,350	$3,390	$1,040	64	$399,360
Level 2 Services	$4,260	$5,500	$1,240	132	$982,080
Level 3 Services	$6,170	$7,500	$1,330	115	$1,835,400
Total					$3,448,260

Source: See references to data in market rate column.

Recommendation 8.1.G.5.

Eliminate the travel budget for the Pioneer Homes Board and remove the facility inspection requirement from statute. This would result in at least $15,000 in general fund savings annually.

Recommendation 8.1.G.6.

Reduce the amount of information materials produced and distributed, and limit printing to black and white forms. Reducing the printed materials budget by half would result in a savings of $12,500 to the general fund.

H. Lease of State Buildings

Findings

Four of the six Pioneer Homes have a no-cost lease agreement with an organization to use space at their facility. Three of the organizations that occupy space in the state-owned facilities are a Head Start Program, a private preschool, and a school district pre-school program. The fourth no-cost lease is with GCI, a local, private cell phone service provider that has a cell phone tower on the roof of the Anchorage Pioneer Home. In exchange for the cell phone tower, GCI provides 16 parking spaces for employees and free wireless internet service for residents. The parking spaces allow staff and visitors closer parking to the building during inclement weather and icy conditions. The parking spaces are valued at $25 per space per month and the internet services to the residents is valued at $300 per month; these items would otherwise cost approximately $8,400.

The Pioneer Homes includes child care programs in its facilities in adherence to a tenant of the Eden Alternative model of senior living, to which the Pioneer Homes subscribe. The Pioneer Homes are heavily dependent on state general funds for their maintenance and operations. High costs, including deferred maintenance costs of $11 million, and low rates for private pay residents may dictate that excess space at any of the assisted living homes should be considered as revenue generation opportunities to offset the costs of operating and maintaining the facilities.

While the Pioneer Homes indicate that the child care space is shared with the residents (a common room is used by both the child care provider and the residents), the costs for maintenance, janitorial, and liability issues are not recouped from the child care providers and the lease agreements are not reviewed by the Alaska Department of Administration (DOA), which oversees the use of state facilities.

Additionally, for Head Start programs, facility lease costs are reimbursable by the federal government if certain conditions are met, such as rates are reasonable compared to market conditions, the leases are reviewed periodically to determine if conditions have changed, and there are no conflicts of interest in the lease agreements.[130]

Recommendation

Recommendation 8.1.H.1.

Negotiate rates for the lease of space at the Pioneer Homes and any other state-owned facility. To encourage the continuation of the multi-generational programming at the Pioneer Homes, these leases could be negotiated at below-market rates, but should be negotiated in conjunction with DOA to ensure that legal issues are addressed and the costs of utilities, janitorial services, and maintenance are recouped, at a minimum.

If each of the four lease agreements generated $10,000 in revenue per year, an additional $40,000 in revenue would be available to off-set general fund expenditures by the State of Alaska.

I. Pioneer Homes Staffing Ratios and Costs per Resident

Findings

While the State of Alaska does not prescribe statutory minimum staffing ratios for nursing homes or assisted living facilities, Pioneer Homes has substantially higher staffing ratios than state minimum standards where they exist. State-owned assisted living facilities are highly

unusual in the United States, and the Pioneer Homes "hybrid" model of care (exhibiting characteristics of both traditional nursing homes and assisted living facilities) is also unique. It is therefore difficult to make comparisons across a representative number of comparable facilities in other states. Bearing in mind the limitations of available data to make direct comparisons, Public Works observed that Pioneer Homes has significantly higher costs per resident than two other state-owned assisted living facilities examined.

A survey of all 50 states indicates that 14 have minimum staffing standards specified in state statutes, shown in Table 8-8.

Table 8-8: Statutory Minimum Staffing by State

State	Statutory Minimum Direct Staff to Client Ratio (or Equivalent Staff Hours) for Assisted Living Facilities
Arizona	1:15 (7am – 8pm) and 1:25 (8 pm – 7am)
Colorado	1:6
Florida	Minimum direct staff hours per week vary by number of residents in the facility. Direct staff: client ratio equivalents range from 1:5 to 1:30.
Georgia	1:15 (awake hours) and 1:25 (sleeping hours).
Maine[131]	1:12 (7am – 3pm), 1:18 (3pm – 11pm), 1:30 (11pm – 7am).
Michigan	1:12
Mississippi	1:15 (7am – 7pm), 1:25 (7pm – 7am).
Missouri	1:15 (day shift), 1:20 (evening shift); 1:25 (night shift).
New Mexico	1:15
New York[132]	3.75 hours personal care per resident weekly; 1:60 (overnight)
North Carolina[133]	1:20 (morning shift), 1:20 (afternoon shift), 1:30 (night shift)
Pennsylvania	7 hours personal care per resident weekly; (14 hours for those with mobility needs).
South Carolina	1:8 (7am – 7pm), 1:30 (overnight)
South Dakota	1:10 (equivalent staff hours)

Source unless otherwise noted: Polzer, Karl. *Assisted Living State Regulatory Review 2013*. National Center for Assisted Living, March 2013. PDF File. Web. http://www.ahcancal.org/ncal/resources/Documents/2013_reg_review.pdf. Accessed July 1, 2015.

Table 8-9 compares minimum standards to the average staffing ratios at Alaska Pioneer Homes, Arizona Pioneer Home, and Wyoming Pioneer Home – three states that *do not* have minimum staffing ratios specified in state statute.

Table 8-9: Staffing Ratios at State-Owned Assisted Living Facilities

	Average Staff: Client Ratio (All Staff)	Average Staff: Client Ratio (Direct Care Staff only)
Alaska Pioneer Homes (all facilities)[134]	1:2.5	1:3.8
Arizona Pioneer Homes[135]	1:2.7 to 1:4	Unknown
Wyoming Pioneer Homes[136]	1:4.5	1:11

States with minimum staffing statutes specify ratios that range from one staff per six residents to one staff per thirty residents during daytime hours, with a typical minimum staffing ratio of one direct care staff per 15 residents. The states with the highest staffing ratios are Colorado (1:6), South Carolina (1:8) and South Dakota (1:10). Alaska Pioneer Homes has an approximate, average staffing ratio of one direct care staff per 3.8 residents – significantly higher than the minimum ratios required in these three states. Costs per resident are higher for the Alaska Pioneer Homes compared to the Wyoming Pioneer Home and Arizona Pioneer Home as shown in Table 8-10 (most recent available figures):

Table 8-10: Budget Comparison for State-Owned Assisted Living Facilities

State	Number of Residents	Total Budget	Average Monthly Cost per Resident
Alaska (FY 2014)[137]	604	$62,832,200	$8,669
Wyoming (FY 2016)[138]	48	$4,360,071 (biennium)	$3,785
Arizona (FY 2011)[139]	105	$5,923,700	$4,701

Note: These calculations have not been adjusted for cost of living differences between these states.
Source: See references to data in each column.

A number of factors make direct comparisons between the Alaska Pioneer Homes and other assisted living facilities challenging and imperfect: Most of the residents living within the Alaska Pioneer Homes are receiving some form of palliative, hospice, post-acute, or specialized memory care which requires greater staffing needs than other similarly-licensed assisted living

facilities. Alaska Pioneer Homes also indicates that comparisons to the Arizona and Wyoming Pioneer Homes are limited due to differing admission criteria and the fact that facilities in Arizona and Wyoming discharge to other more skilled settings when care needs require further assistance. Alaska Pioneer Homes generally do not discharge to other care facilities when residents are unable to pay or have increasing care needs. The "aging in place" model at the Alaska Pioneer Homes benefits the well-being of the resident and is also a consequence of limited long-term care resources available in rural Alaska settings. According to the Alaska Pioneer Homes, the majority of its care is provided to individuals who require significant or total assistance due to physical or mental impairment.

Despite these challenges – and the unique "hybrid" model of care– Alaska Pioneer Homes staffing ratios and costs per resident far exceed those of the most comparable state-owned facilities available. This would suggest that reductions in staff-to-client ratios and other cost-per-resident drivers could be achieved while maintaining adequate care levels. According to Alaska Pioneer Homes, its current staffing levels would earn a five-star service level rating under The Centers for Medicare Services (CMS) rating system. Public Works acknowledges that best-in-class service is a legitimate policy choice for the State of Alaska, while observing its costs.

Recommendations

Recommendation 8.1.I.1.

Review staffing levels and identify ways to reduce staffing ratios to be more in line with other state-operated assisted living facilities, with due consideration given to variations in care models.

Recommendation 8.1.I.2.

Evaluate the reasons for higher monthly costs per resident, including administrative overhead, maintenance staffing, travel, and other expenses. Bringing costs down by $1,000 per resident (assuming 455 residents) would result in an annual savings of $5,460,000. This reduction would still leave the Alaska Pioneer Homes with monthly costs per resident that are twice the other two state-owned facilities. A discussion in Section 3.2.K of this report identifies the opportunity to share administrative functions with other institutions, such as juvenile facilities and the API, which could reduce some of these expenses, without impacting direct care. For example, the Fairbanks Pioneer Home and juvenile facility are adjacent to each other and could share maintenance staff.

9. ENDNOTES

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[40] Recommendations include: 1. Eliminate or revise the "Automatic" Juvenile Waiver statute passed in Alaska in 1996 (expand the current "discretionary waiver" statute for juveniles under the age of 16 to all juveniles under 18 for all crimes covered by the existing automatic juvenile waiver law and waive juveniles deemed not amenable to treatment to adult status), 2. Extend the age of jurisdiction in the juvenile system to the age of 21 for all offenders adjudicated of the following crimes: an unclassified or class A felony against a person, arson in the first degree, B felony against a person in which the juvenile is alleged to have used a deadly weapon and the juvenile was previously adjudicated as a delinquent or convicted as an adult as a result of an offense that involved the use of a deadly weapon against a person, misconduct involving weapons in the first degree when the offense includes felony, and misconduct involving a controlled substance or discharging a deadly weapon from a propelled vehicle, and 3) expand the use of the dual sentencing statute (adjudicated juveniles serving time in a juvenile treatment facility with satisfactory results prior to their 21st birthday would be released from DJJ jurisdiction when treatment is complete, adjudicated juveniles without satisfactory results by their 21st birthday would then be transferred to an adult facility to serve out the remainder of their sentence, and allow dual sentencing to be utilized as an option for all crimes under the current automatic waiver statute.
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ATTACHMENT A

REVISED BUDGET ALIGNMENT

RESULTS FOR ALASKANS

STATE OF ALASKA

DHSS: Alaska Pioneer Homes

FY2015
BUDGET ALIGNMENT
(dollars shown in thousands)

Total Appropriation = 2% of DHSS Budget = $62,323.1

PRIORITY 1: Health & Wellness Across the Lifespan

37% Total Budget = $23,059.6

PRIORITY 2: Health Care Access Delivery & Value

46% = $28,668.6

PRIORITY 3: Safe & Responsible Individuals, Families & Communities

17% = $10,594.9

CORE SERVICE 1.1

Protect and promote the health of Alaskans

$0

■HCS ■DBH ■DPH ■DPA ■FMS ■DJJ ■SDS

CORE SERVICE 1.2

Provide quality of life in a safe living environment for Alaskans

$23,059.6

■SDS ■HCS ■DPA ■OCS ■DBH ■APH ■FMS ■DPH

CORE SERVICE 2.1

Manage health care coverage for Alaskans in need

$28,668.6

■HCS ■APH ■DBH ■FMS ■DPA ■DPH

CORE SERVICE 2.2

Facilitate access to affordable health care for Alaskans

$0

■HCS ■DPH ■DPA ■DBH ■FMS ■SDS

CORE SERVICE 3.1

Strengthen Alaska families

$1,246.5

■DPA ■OCS ■DPH ■FMS ■DJJ ■SDS ■HCS ■APH ■DBH

CORE SERVICE 3.2

Protect vulnerable Alaskans

$9,348.4

■DPA ■OCS ■SDS ■FMS ■DJJ ■DBH ■APH ■DPH ■HCS

CORE SERVICE 3.3

Promote personal responsibility and accountable decisions by Alaskans

$0

■OCS ■DJJ ■DPA ■FMS ■SDS ■DPH ■DBH

APH — ALASKA PIONEER HOMES

DBH — DIVISION OF BEHAVIORAL HEALTH

OCS — OFFICE OF CHILDREN'S SERVICES

HCS — DIVISION OF HEALTH CARE SERVICES

DJJ — DIVISION OF JUVENILE JUSTICE

DPA — DIVISION OF PUBLIC ASSISTANCE

DPH — DIVISION OF PUBLIC HEALTH

SDS — SENIOR & DISABILITIES SERVICES

FMS — FINANCE & MANAGEMENT SERVICES

$23,059.6 spent to provide quality of life in a safe living environment for Alaskans

$28,668.6 spent to provide health care coverage for Alaskans in need

$1,246.5 spent to strengthen Alaska families

$9,348.4 spent to protect vulnerable Alaskans

TOTAL BUDGET
62,323.1

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ATTACHMENT B: DHSS RESPONSE

THE STATE of ALASKA
GOVERNOR BILL WALKER

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October 28, 2015

Ms. Kris Curtis, CPA, CISA
Legislative Auditor
Legislative Budget and Audit Committee
Division of Legislative Audit
P.O. Box 113300
Juneau, Alaska 99881-3300

Dear Ms. Curtis:

RE: Department of Health and Social Services (DHSS) response to legislative audit confidential preliminary report titled: Performance Review on the Alaska Department of Health and Social Services, Organizational and Administrative Structure received October 8, 2015.

We appreciate the opportunity to review and evaluate the confidential preliminary report pertaining to the performance review on DHSS organizational and administrative structure received October 8, 2015. DHSS has the following responses to share on the recommendations and it is worthwhile to note that while the department and its divisions may agree with the recommendations as shared in this report, the agency is facing cost constraints that may limit the necessary resources for implementation.

Recommendation 2.3.1 (p. 18)
Increase the level of detail in the *Budget Alignment and Core Services Alignment* documents.
The department concurs with this recommendation. However, due to limited resources, adding levels of electronic detail to the budget alignment documents is unlikely at this time.

Recommendation 2.3.2 (p. 18)
Use the Budget Overview Presentations to make a case.
The department concurs with this recommendation.

Recommendation 2.3.3 (p. 19)
Refine individual elements of the Budget Overview Presentations.

The department partially concurs. It should be noted that the department adjusts budget documents and presentations through a collaborative process with our Legislative (House and Senate) Finance Committees, and makes changes and edits based on their requests.

Recommendation 2.3.4 (p. 21)
Improve readability and usefulness.
The department concurs with this recommendation. Please see the response to Recommendation 2.3.3 above.

Recommendation 2.3.5 (p. 22)
Illustrate interconnectivity at fiscal analysis stage.
The department partially concurs. It should be noted that in the process of preparing fiscal notes, DHSS looks across the department to determine how proposed legislation would affect different divisions and programs.

Recommendation 2.3.6 (p.22)
Consider phasing in a zero-based budgeting process.
The department partially concurs. A fiscal analysis is needed to quantify the associated costs of agency resources needed to comply with the incremental change process, in addition to implementing the zero based budgeting process. This process could be considered on a statewide basis, but would take a significant amount of lead time to implement.

Recommendation 3.1.A.1 (p.28)
Form a multi-disciplinary work team to develop a long range plan for recruitment and retention of field workers in the department.
The department concurs with this recommendation.

Recommendation 3.1.A.2 (p. 28)
Implement the targeted strategies identified in the newly developed DHSS plan to recruit and retain field staff.
The department partially concurs. While the department concurs with the need to implement the strategies identified in the plan for recruitment and retention of field staff, the department asserts that there are still barriers that may make implementation of some strategies difficult to impossible. Because the State of Alaska is one employer with numerous departments, the department must follow statewide collective bargaining agreements, policies, and laws that may be barriers to making department-specific changes. However, the department concurs with the recommendation to implement strategies within these statewide parameters.

Recommendation 3.1.B.1 (p.32)
Evaluate positions that have been vacant more than six months to determine need.
The department concurs with this recommendation. As noted by the reviewers, it is important that there be an exception process to address needed positions for which recruitment is difficult.

Recommendation 3.1.B.2 (p.32)

Repurpose vacant positions that have never been filled.
The department concurs with this recommendation, but notes that some positions cannot be repurposed due to being supported by restricted funds.

Recommendation 3.1.B.3 (p. 32)
Develop a formal succession plan to internally cultivate future leaders and certain skilled non-management positions.
The department partially concurs. The department agrees with the need to engage in increased succession planning. However, a succession plan including all of the elements in this recommendation will require changes will the state's collective bargaining agreements and that process is managed at a statewide level outside the authority of DHSS. .

Recommendation 3.1.B.4 (p. 33)
Implement all recommendations resulting from the DHSS training needs assessment.
The department concurs with this recommendation. DHSS continues to work on implementation of these recommendations.

Recommendation 3.1.C.1 (p. 34)
Prioritize training needs based on risk to the department budget (including the direct and indirect costs of staff turnover) and to vulnerable populations.
The department partially concurs. The department is able to analyze department wide training needs based on risk to the budget and to vulnerable populations; however, division specific training should be developed and prioritized within each division. Division training should be reviewed at the department level to identify opportunities to consolidate training and best practices.

Recommendation 3.1.D.1 (p.36)
Create a master trainer program in DPA modeled after the DJJ program and allow eligibility workers who have low error rates (comparable to experienced employees) to take on greater caseloads as early as possible.
The department partially concurs. DHSS division leadership recently visited another state to observe its training model. DPA will be pursuing additional recommendations by moving the training positions into the field. These trainers will be able to provide on-site training and eliminate the need for new staff to travel for classroom training. However, the training team will also create web based training and their duties may change to include completing case reviews along with development of training on-line.

Recommendation 3.1.D.2 (p. 37)
Eliminate the additional four months of continued distance learning and reduced caseloads for DPA eligibility workers.
The department does not concur. Additional fiscal detail is needed for the reader to gain an understanding of proposed cost savings.

Recommendation 3.1.E.1 (p. 39)

Reduce the caseloads for new child welfare workers to meet the enhanced federal Title IV-E reimbursement rate requirements for workers in training, as well as during the first six months of employment.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. The recommendation does not include an analysis of workload impact on existing staff.

Recommendation 3.1.E.2 (p. 39)
Use the estimated additional revenue of $768,000 to hire additional caseworkers and supervisors in the appropriate ratio.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. It is unclear whether the addition of eight to ten caseworkers would offset the loss in productivity from new workers with a reduced caseload.

Recommendation 3.2.A.1 (p.41)
Implement a system that requires the timely completion of employee performance evaluations and holds supervisors and managers accountable for meeting this requirement.
Department response:
The department concurs with this recommendation. The department currently has processes in place to communicate the need to supervisors to complete evaluations. Human resources staff have been communicating with and offering assistance to supervisors who need to complete evaluations.

Recommendation 3.2.B.1 (p. 43)
Establish an internal audit section for the entire department.
The department concurs with this recommendation. Finance and Management Services (FMS) plans to expand the scope of the DHSS audit unit, within resource constraints, to incorporate additional review activities pertaining to internal controls and processes within the department.

Recommendation 3.2.C.1 (p.45)
Combine the DPA, HCS, and SDS facility licensing and certification functions into a single office or new division.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. The report needs to include a feasibility study identifying and quantifying existing administrative efficiencies. Since the proposed consolidation involves different programs, regulations, and standards, a one size fits all approach may increase inefficiencies and safety issues.
Recommendation 3.2.C.2 (p.46)
Foster care home licensing should remain a separate function because it is so closely integrated with the fieldwork performed by child welfare workers.
The department concurs with this recommendation.

Recommendation 3.2.D.1 (p.46)
Expand cross-training opportunities so staff can conduct multi-purpose site visits.

The department partially concurs. A cost benefit analysis including the staff training costs associated with this recommendation is needed.

Recommendation 3.2.D.2 (p. 47)
Consider creating a formal process for coordinating site visits.
The department concurs with this recommendation. Opportunities for coordination will be evaluated as appropriate.

Recommendation 3.2.D.3 (p. 47)
While maintaining needed subject matter expertise, explore opportunities for interdivisional DHSS site visit compliance teams that can evaluate multiple department grantees during limited visits to remote areas of the state.
The department concurs with this recommendation. While recognizing the need to be judicious regarding subject matter expertise, DHSS will evaluate such opportunities.

Recommendation 3.2.D.4 (p. 47)
Expand collaboration with other local and state agencies that perform site visits (such as the Fire Marshal) to alert the department to any potential issues.
The department concurs with this recommendation. DHSS will evaluate such opportunities as they may arise.

Recommendation 3.2.E.1 (p. 48)
Using the DJJ approach to "mini-grants" as a model, all DHSS divisions should explore opportunities to expand the pool of service providers in remote or hard-to-serve areas of the state.
While the department concurs that using the "mini-grant" model of services delivery could be useful to expand service delivery in rural and remote areas of the state, a cost benefit analysis identifying the cost of the proposed service delivery model is needed.

Recommendation 3.2.F.1 (p. 49)
Create an Office of Tribal Relationships in the Office of the Commissioner at DHSS.
DHSS partially concurs with the creation of an Office of Tribal Relationships in the Office of the Commissioner. This could improve cross communication with the existing tribal liaisons in each division, tribal entities, and lead to better coordination and planning across all divisions. A fiscal analysis does not appear to be provided quantifying potential cost savings.

Recommendation 3.2.G.1 (p. 51)
Continue to evaluate opportunities to update the Fairbanks Youth Facility kitchen for full-time meal service.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. The finding fails to include availability of PCNs in other locations. An analysis of available PCNs will be required due to cost containment measures implemented. If no PCNs are available the associated fiscal analysis will need to be updated as it did not include the costs associated with new PCNs.

Recommendation 3.2.G.2 (p. 51)
Pursue federal and private grant funding to help offset the cost of needed kitchen remodeling and equipment purchases.
Please see response to Recommendation 3.2.G.1.

Recommendation 3.2.G.3 (p. 51)
Review opportunities to increase DJJ Workforce Investment Act funding as vocational training opportunities – including a culinary arts program – are expanded.
Please see response to Recommendation 3.2.G.1.

Recommendation 3.2.H.1 (p. 52)
Implement juvenile prosecution and sentencing strategies that will reduce recidivism, lower costs, and improve outcomes for youth, including the following advocated by the Alaska Juvenile Justice Advisory Committee.
The department partially concurs. Under Alaska's juvenile justice statutes, juveniles who are adjudicated as delinquent are not sentenced as is the rule in the adult justice system. These cases face a disposition which may or may not involve a period of custody that is determined by law and a positive response to DJJ intervention. Changes in juvenile justice statutes, especially in regard to the transfer of sixteen and seventeen year old juveniles to the adult system when charged with specific serious offenses, cannot be unilaterally implemented by the department, and would require collaboration with other agencies.

Recommendation 3.2.I.1 (p.55)
Maintain sufficient staffing by hiring caseworkers and providing all workers with manageable caseloads.
The department partially concurs with the recommendation. While DHSS has made recent improvements by adding new positions, the OCS workload for frontline caseworkers still does not meet the CWLA recommendations. OCS is evaluating what can be extrapolated for current use from the caseload studies as well as looking nationally for what other states are finding most effective to assist the division in designing a methodology and/or strategy to more continually and accurately measure workload in comparison to recommended national standards. .

Recommendation 3.2.I.2 (p. 56)
Separate foster care licensing statutes and regulations from other residential care facilities.
The department concurs with this recommendation.

Recommendation 3.2.I.3 (p. 56)
Clarify the waiver and variance process for kinship placements in department regulations.
The department concurs with this recommendation.

Recommendation 3.2.I.4 (p. 56)
Develop a template or checklist for OCS workers and/or eligibility technicians to assist in correctly documenting the components of Title IV-E eligibility within the appropriate timeframes.
The department partially concurs. Eligibility information for children in OCS care is documented in the division's SACWIS system, ORCA. The eligibility technician fills information into an ORCA-based

template to determine eligibility. The completion date is also tracked in ORCA. Further, a technician's ability to document the eligibility determination within appropriate timeframes is dependent on many factors, including court scheduling, court orders, and availability of parental income and resources.

Recommendation 3.2.I.5 (p. 56)
Prioritize technology purchases and implementation to assist OCS workers.
The department partially concurs. While there is a need for this, there is a significant cost as well.

Recommendation 3.2.J.1 (p. 58)
Prioritize and accelerate plans to shift OCS intake from a regional intake system to a centralized intake system comprised of a distinct unit of trained CPS workers who receive reports of child abuse and neglect 24 hours a day, 7 days a week.
DHSS partially concurs. The department agrees with prioritization, but notes that acceleration of these plans needs to occur at the speed that communities can accept/tolerate.

Recommendation 3.2.K.1 (p. 59)
Designate an existing Deputy Commissioner to oversee the programs within DHSS that operate institutions to create standardized administrative functions and realize efficiencies that can be achieved by consolidating many of the support functions.
The department does not concur. The findings fail to include a cost benefit analysis to support potential savings associated with consolidation of these facilities under a designated Deputy Commissioner. Since the proposed consolidation will involve facilities governed by different accreditation agencies and managed by agency staff who are also managing other similar programs, additional analysis on existing resources is needed. There are also concerns that the unique needs of each institution would negate some or all of the financial benefit of consolidation.

Recommendation 3.2.K.2 (p. 59)
Redirect the oversight and management of API to a Deputy Commissioner designated to oversee institutions.
The department does not concur. The benefits of merging would likely be outweighed by the disruptions this would cause. Both API and DJJ facilities are part of an integrated system of care within their divisions. Removing the facilities from that organizational structure will lead to more silos and conflicts between the most restrictive and least restrictive settings. All three types of facilities have different accrediting bodies with different standards and expectations, so expertise in many areas would be required. The statutory responsibilities of the Alaska Psychiatric Hospital for Title 47 commitments make this recommendation undesirable from both a management and a client safety perspective. Additionally, the Designated Evaluation and Treatment program is closely linked to API as it "stretches" their capacity at the regional level. They are most effective when managed together.

Recommendation 3.2.K.3 (p. 59)
Move all of the institutional administrative functions currently managed by DJJ and Pioneer Homes under the designated Deputy Commissioner.
The department does not concur. The findings fail to include a cost benefit analysis to support potential savings associated with consolidation of these facilities under a designated Deputy Commissioner. Since

the proposed consolidation will involve facilities governed by different accreditation agencies and managed by agency staff who are also managing other similar programs, additional analysis on existing resources is needed. It should also be noted that at its core, AKPH differs from DJJ and API because individuals in AKPH choose to be residents. These individuals are also paying what they can for their care.

Recommendation 3.2.K.4 (p. 59)
Establish an administrative office under the Deputy Commissioner that would provide all administrative support functions such as purchasing, human resources, billing, and other services to operate facilities for all 13 institutions.
The department does not concur. The findings fail to include a cost benefit analysis to support potential savings associated with consolidation of these facilities under a designated Deputy Commissioner. Since the proposed consolidation will involve facilities governed by different accreditation agencies and managed by agency staff who are also managing other similar programs, additional analysis on existing resources is needed.

Recommendation 3.3.A.1 (p.70)
Further integrate Medicaid functions across the department to achieve cost savings and create a more streamlined authority for Medicaid policy, programming, budget, and oversight.
The department concurs. DHSS awarded a contract for Medicaid redesign and expansion assistance to Alaska firm Agnew: Beck and their national subcontractors, Health Management Associates and Miliman who are national experts in the area of Medicaid reform. A webinar was held on July 27, 2015 for stakeholders and other interested parties to explain the process by which the department and contractors will proceed to identify, analyze, and recommend Medicaid restructuring that works for the state of Alaska. The recording of the webinar can be found on the departments Medicaid Redesign page: http://dhss.alaska.gov/HealthyAlaska/Pages/Medicaid_Redesign.aspx

Recommendation 3.3.A.2 (p.70)
Increase the pace at which coordinated care for Medicaid enrollees and cost saving opportunities are identified within the Medicaid program through a focused and concerted effort across all divisions.
The department concurs with this recommendation. DHSS has contracted with state and national experts to develop recommendations and make recommendations on Medicaid redesign and reform. The contractors drafted an environmental scan that included the reforms that have already happened or are in the planning stages in Alaska and various initiatives from other states that could be investigated. This was used to begin a series of meetings with DHSS leadership and key partners to discuss and develop recommendations to make cost saving redesigns to the Medicaid program. Leadership met in August and October with the contractors and about 30 key stakeholders to have these discussions. A third and final meeting will be held in November. Public webinars follow each of these meetings where all interested parties can ask questions and provide suggestions. We would expect that many of the ideas discussed in these forums will be included in the final recommendations. A report on these opportunities will be presented to the Legislature in January 2016. If legislation is required to implement any of the chosen initiatives, it will be pursued at that time.

Recommendation 3.3.B.1 (p.73)

Combine all program integrity and compliance units across the department, including provider enrollment and the surveillance and utilization review subsystem (SURS).
The department does not concur. Additional information pertaining to how the cost savings were determined is needed. The department has had considerable success at pursuing program integrity efforts from within the operating divisions with the support of some centralized functions. Past efforts to consolidate have failed to achieve the specific program knowledge and experience necessary to operate effectively.

Recommendation 3.3.C.1 (p. 75)
Elevate the Medicaid CQI function within DHSS.
The department partially concurs. While sharing CQI knowledge is desirable, Federal Medicaid rules have very specific requirements for CQI for home and community-based waivers, targeted specifically to those services. CQI in other services may not mirror those requirements. Consequently, there may not be a great deal of efficiency gained by consolidating functions where there are different program requirements.

Recommendation 3.3.C.2 (p. 75)
Create a Quality Committee whose membership includes the DHSS Chief Medical Officer and external stakeholders, such as providers.
The department concurs with this recommendation.

Recommendation 4.1 (p.83)
The efforts of the Alaska Council on Emergency Medical Services should be refocused from professional advocacy to providing more formalized policy and budget advice to the DHSS commissioner and governor.
The department partially concurs. While the current mission of the Alaska Council on Emergency Medical Services is different from the original statutory purpose, the council should first be evaluated as suggested in Recommendation 4.4 before being refocused.

Recommendation 4.2 (p. 83)
The travel budget for the Alaska Pioneer Homes Advisory Board should be eliminated.
The department does not concur. The recommendation undervalues the Pioneer Home Advisory Board by not acknowledging that public/stakeholder feedback given to the board and its members are both (1) relevant and (2) related to health & safety within the homes. While highlighting the travel budget of the board, the reviewers have overlooked its impact.

Recommendation 4.3 (p.84)
Evaluate opportunities for savings in advisory body travel by:
1) Scheduling concurrent meetings of groups with considerable membership overlap (such as the Drug Utilization Review Committee and the Pharmacy and Therapeutics Committee)
2) Using videoconference or teleconference meetings when these can achieve the same outcomes as in-person meetings.
The department concurs with this recommendation.

Recommendation 4.4 (p. 84)
To maintain and augment the effectiveness and efficiency of all DHSS advisory bodies, policymakers should:
1) Review periodically, beyond traditional sunset audits, whether each membership body is better equipped to determine policies/oversee programs than other available alternatives such as internal agency workgroups or subject matter experts from academia or the public/private sectors.
2) Establish and enforce expectations regarding the use of performance management tools by agency councils, boards, and commissions.
3) Use the criteria developed in this analysis when considering the creation of any new advisory bodies.
The department concurs with this recommendation. Implementation will be dependent on available resources.

Recommendation 6.1.1 (p.90)
Alaska should maintain a single state agency for health and social services.
The department concurs with this recommendation.

Recommendation 6.2.1 (p. 91)
The State of Alaska should consider managed competition or privatization for the Alaska Pioneer Homes, the costs of which are discussed more fully in Sections 8.1.G and 8.1.I of this report.
The department partially concurs. A cost benefit analysis including a facility that offers level three care is missing and is needed to evaluate the findings and resulting recommendation.

Recommendation 6.3.1 (p. 93)
Elevate prevention issues within DHSS.
The department partially concurs. OCS would support a prevention focus, but questions the availability of funding to support this change. From a department perspective, elevating could include identification of discrete prevention efforts, planning and collaborating across divisions on these efforts, and generally working to reduce "silos" related to prevention work.

Recommendation 6.3.2 (p. 93)
Move forward with the transfer of the ILP program to DEED.
The department does not concur. DHSS is evaluating how to strengthen the program and determine the best placement within the department.

Recommendation 7.1.1 (p. 104)
Revise the prioritization scoring system to address the concerns, weaknesses, and unintended consequences identified in this review.
The department concurs with this recommendation. The master prioritization scoring system has already been updated to address the concerns, weaknesses, and unintended consequences that were identified in the draft report. Steps will continue to be taken to address some of the weakness areas that were highlighted but are not currently part of the scoring process to determine if these items should be included in the scoring methodology.

Recommendation 7.1.2 (p. 104)

Revise the ITG process to limit the number of projects that must be vetted by the ITG Committee.
The department partially concurs with the recommendation. IT Planning is working with the IT-PMO to develop "fast track" options for small projects or projects that do not significantly impact infrastructure. It is very difficult to develop "fast track" options since the governance processes are critical for maintaining knowledge at an enterprise or department-wide level of how IT resources are being impacted.

Recommendation 7.1.3 (p. 104)
Require the completion of all information on the Application Development Project Status Report.
The department concurs with this recommendation. Projects in the monthly status reporting that indicate red for scope, schedule, or budget are encouraged by the IT Planning Office and the IT-PMO to add relevant and detailed comments that explain why the status is red and what mitigation steps are being taken to improve the status. The department will continue to encourage division staff members to provide detailed comments.

Recommendation 7.1.4 (p. 104)
Identify and correct inconsistencies in IT policy, procedures, terminology, and titles throughout the department noted in the discussion.
The department concurs with this recommendation. An IT Governance charter is being developed to correct inconsistencies related to acronyms, position titles, and membership of the IT Governance committee.

Recommendation 7.2.1 (p. 107)
Elevate the priority of current and future VC projects to expand VC capabilities of the department, increase efficiency, and reduce travel-related expenses across all divisions.
The department concurs with the recommendation.

Recommendation 7.2.2 (p. 107)
As new video conferencing capabilities come on line, the Commissioner should establish a target reduction in travel of 10 percent for the first year and 20 percent in the second year.
The department partially concurs. The report fails to provide a cost benefit analysis with information about the cost of expanding video conferencing and appears to be making an assumption that it will be less expensive than travel and replaces some travel needs. As VC capabilities are expanded, we will analyze travel savings and reduce costs appropriately.

Recommendation 7.3.1 (p. 108)
Implement mandatory project management training and mentoring for IT and division staff, including Division Business Alignment Liaisons and project managers, who are tasked with responsibilities concerning development, integration, and implementation of technology systems.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. The report fails to provide a cost benefit analysis associated with the training, including the cost to divisions for staff to participate. There is the cost of establishing training that relates to how DHSS applies project management and the tools that it employs. There is also the

cost for the divisions to allow their staff to take time away from their regular duties in order to attend the course. Additionally, while project management is generic and the application training can use other materials that are available online or at a reduced cost it would still need to be customized for application to the DHSS roles and activities that project staff would be performing.

Recommendation 7.4.1 (p. 109)
Combine the Office of Security and Office of Technology and appoint one manager to oversee all IT operations.
The department concurs with this recommendation. This recommendation has been implemented.

Recommendation 7.4.A.1 (p. 111)
Allocate resources to IT security systems and other tools to ensure critical concerns cited in the OCR Audit and the Risk Mitigation Plan are addressed.
The department concurs with this recommendation. The contractor's Technical Definition Document details how many staff are needed per tool to be effective. There is a need for additional staffing to begin to adequately leverage the tools the department has implemented, and is in the process of purchasing to meet the OCR CAP. However, we have been hampered by funding restrictions and cost containment measures.

Recommendation 7.4.A.2 (p. 111)
Educate division leaders and system users on the risks of mobile computing and social media, and obtain agreement on policies concerning need for restrictions and why waivers from security requirements should be more closely monitored and restricted.
The department concurs with this recommendation. DHSS has a very close monitoring program and a request process for all technology and access waivers.

Recommendation 7.4.A.3 (p. 112)
Develop and offer on-line security awareness training programs.
The department concurs with the recommendation. DHSS has developed a formalized online Security/HIPAA & Privacy training for all DHSS employees that must be taken within 30 days of their start date. DHSS will be developing online training material that will be tailored and distributed to categories of employees depending on their job responsibilities. The training is part of the department's ongoing Security & Awareness Training program.

Recommendation 7.4.A.4 (p. 112)
Restrict and closely scrutinize requests for IT security waivers that may facilitate security breaches.
The department concurs with the recommendation. DHSS has a formalized waiver and exception process in place with request forms and sanction policies for violating the terms and conditions of approved waivers that require signatures and approvals.

Recommendation 7.4.A.5 (p. 112)
Implement strict enforcement policies and procedures regarding the use of USB drives, external hard drives, social media, and other possible points of entry for cyber attacks.

The department concurs with this recommendation. Prior to and during the CAP work there has been strict enforcement through policy, procedures, and strong technical controls, as well as encrypting portable media such as CDs and USB drives. In addition, there are restrictions for social media use in the department.

Recommendation 7.4.B.1 (p. 113)
Develop a plan to address the significant shortcomings and productivity issues identified by operational staff using DSM.
The department partially concurs with this recommendation. Since this review has been initiated DHSS has implemented a feedback mechanism to ensure that productivity issues are resolved in a timely manner.

Recommendation 7.4.B.2 (p. 113)
Expedite the execution of this plan.
The department partially concurs with this recommendation. Please reference response to recommendation 7.4.B.1

Recommendation 7.4.B.3 (p. 113)
Communicate progress on the plan and how problems are being addressed to all DHSS staff at regular intervals.
The department partially concurs. DHSS has developed a remediation plan for DSM that includes:

- *Working with the DSM vendor to remediate DSM specific problems*
- *Certifying the State's email system for internal secure messaging*
- *Procuring an online secure file transfer system*
  While this is communicated via department-wide forums, it is recognized that this may not be adequately communicated to all staff and the department will consider additional notification methods.

Recommendation 7.5.1 (p. 114)
Continue to expand the use and availability of technology in SOPHN to improve patient communications, improve services, and maximize efficiency.
The department concurs with this finding. Use and availability of technology for the Section of Public Health Nursing should be expanded, particularly migration to electronic health records.

Recommendation 7.5.2 (p. 114)
Prioritize migration to electronic health records (EHRs) for all divisions – particularly SOPHN – to reduce medical errors, maximize operational efficiency, and minimize redundant training.
The department partially concurs with this finding. DHSS agrees that the use and availability of technology for the Section of Public Health Nursing should be expanded, particularly migration to electronic health records. However, a cost benefit analysis will need to be completed to determine whether the department has the resources for a complete implementation across all divisions.

Recommendation 8.1.A.1 (p. 128)

Conduct a comprehensive review of the fee structure for all licensing and certification functions, with the goal of establishing fees equal to costs, accompanied by indexing to provide automatic adjustments of fees as costs change.
The department partially concurs. DHSS has concerns that fees could become a barrier to being able to provide services or develop new agencies, especially given the shortage of service providers in rural Alaska.

Recommendation 8.1.A.2 (p. 129)
Implement nominal annual child care licensing fees, as shown in Table 8-3, resulting in total biennial revenue of $14,975.
The department partially concurs, but has concerns that the impact could be detrimental to recruitment and retention of licensed child care facilities that are already struggling. The resources needed to implement these fees (relative to the amount of revenue gained) should also be considered.

Recommendation 8.1.A.3 (p. 129)
Establish a minimum license fee for smaller residential care facilities.
The department partially concurs, with the concern that fees may negatively impact providers. Additional fiscal analysis is needed to determine whether this recommendation would be cost effective to implement.

Recommendation 8.1.A.4 (p. 129)
Establish an application fee for all licensing services provided by DHSS.
The department partially concurs, with the concern that fees may negatively impact providers. DSDS points out that there are currently provider shortages for long term care services even in the Anchorage area, with severe shortages in rural Alaska. Additional costs to providers may become a barrier to providing services or developing new agencies.

Recommendation 8.1.B.1 (p. 131)
Reestablish a fee system to help cover the state's cost for laboratory testing.
The department partially concurs with the recommendation. The fees need to be evaluated with the market pricing factors and potential negative impact on public health. An in-depth cost/benefit analysis must also be completed before any decisions are made regarding reestablishing fee –for –service. The Division of Public Health is currently evaluating strategies to determine the feasibility of implementing a clinical billing system and maximizing collections. The fiscal impact on other state agencies using the lab should also be analyzed.

Recommendation 8.1.B.2 (p.131)
Update current charges to reflect the true cost of testing for ASPHL's contractual work with other health entities.
DHSS concurs that if fee for services are to be reestablished, the regulations limiting charges must reflect the true cost of the testing.

Recommendation 8.1.B.3 (p. 131)

Consider an external billing vendor (whose contract costs should be borne by the new fee revenue) if ASPHL does not have internal capacity to support the personnel and technology needs of a billing program.
DHSS concurs that an external vendor is necessary in that the lab does not have the infrastructure to bill and collect.

Recommendation 8.1.B.4 (p. 131)
Maintain Services for state agencies currently receiving laboratory work from ASPHL when instituting a fee-for-service system.
DHSS partially concurs that fees should be assessed to other state agencies when doing so can reduce the overall use of general funds. The determination on whether or not to assess fees should be based on the possible negative impact to the Lab's public health purpose and not the fund source. However, the Lab should consider waiving fees if it does not reduce the overall use of general funds. If the other state agency has non□general funds available, those funds should be used to pay for state lab testing.

Recommendation 8.1.C.1 (p. 134)
Increase the billing capacity at DHSS.
DHSS concurs that expanding billing capacity within the department provides opportunity for clinical billing. If billing were to be expanded for Public Health Clinics, market pricing factors and the negative impact on public health should be evaluated. An in depth cost/benefit analysis must be done before any decisions are made regarding fee for service. The Division of Public Health is currently evaluating strategies to determine the feasibility of implementing a clinical billing system and maximizing collections. It should also be noted that in the case of Alaska Pioneer Homes, 50% of the current resident populations are unable to pay the current monthly rate.

Recommendation 8.1.C.2 (p. 134)
Explore whether the contract for third party billing in the Division of Health Care Services (HCS) could be expanded to include billing for API, DPH, and Pioneer Homes.
The department partially concurs, but would need to verify that outsourcing billing services for Alaska Pioneer Homes under HCS would not be a conflict of interest, as HCS is responsible for oversight of Alaska Pioneer Homes.

Recommendation 8.1.D.1 (p. 135)
Expedite the implementation of electronic document imaging throughout DPA and eliminate the courier budget.
The department partially concurs. The division is unable to commit to an expedited implementation of the electronic document imaging system at this time. However, it is in the plan moving forward with ARIES Release 2.

Recommendation 8.1.E.1 (p. 135)
To the extent allowed by statute and feasible in the remote areas of the state, require direct deposit or the issuance of EBT cards for benefit checks from DHSS.
The department concurs with the recommendation. DPA conducts annual outreach for all of its programs encouraging direct deposit and, if applicable, EBT cards.

Recommendation 8.1.F.1 (p. 136)
Ensure that DJJ draws down all eligible federal funding from the National School Lunch Program (NSLP), School Breakfast Program (SBP), Special Milk Program, and After School Snack Program by supplementing meals provided by the Department of Corrections with other foods that will meet minimum USDA nutritional standards.
The department partially concurs. While DJJ agrees with the recommendation conceptually, it is difficult to implement. Of the eight facilities within DJJ, five of them participate in the NSLP. Three of those facilities purchase meals from local providers, one contracts with Department of Corrections (DOC), and our largest facility in Anchorage has its own kitchen. The three facilities that do not participate in the NSLP all have contracts with a DOC institution. DOC has made it clear to DJJ that they will provide food, but will not alter the preparation of that food. For DOC to prepare meals for DJJ that meet all of the nutritional standards for NSLP reimbursement would create a significant cost increase to DJJ (i.e. it would not be cost effective to participate in NSLP if the main purpose is to qualify for federal reimbursement.) DJJ would be willing to begin another dialogue with DOC, but from community to community, meal provider options are very limited and it is beneficial to have a relationship with DOC that allows DJJ to purchase meals even if they don't always meet the requirements of NSLP.

Recommendation 8.1.F.2 (p. 136)
Provide information to youth and their families regarding continued eligibility for free or reduced cost meals in schools as youth are released from DJJ facilities.
The department partially concurs. Providing information to families about free and reduced meals in schools is not something DJJ is opposed to. However, this is a popular program that students and families are exposed to at an early age. The free and reduced applications are part of the school enrollment package. In addition, while it is true that all DJJ facility residents are eligible for the free and reduced meal program, that is not necessarily true when youth are released back into the community, as this program is based on financial need and not all of the youth released remain eligible once they leave a DJJ facility. This is an issue that the division is willing to discuss with the school located in DJJ facilities to ensure that each family has access to that information.

Recommendation 8.1.G.1 (p. 138)
Increase revenue and reduce general fund expenditures by developing a fee schedule for Pioneer Homes.
The department partially concurs, as Alaska Pioneer Homes is open to expanding revenue collection efforts. However, this analysis does not acknowledge that 50% of the Alaska Pioneer Homes' current resident populations are unable to pay the current monthly rate. Increasing monthly rates charged to a population who is unable to pay the lower rates would reduce the estimated net gains on page 125. Also, imposition of an application fee/deposit for the Pioneer Home wait list may advantage higher income Alaskans trying to access a limited state resource.

Recommendation 8.1.G.2 (p. 138)
Require a denial letter from Medicaid before a resident may move into a Pioneer Home.
The department does not concur. Alaska Pioneer Homes questions the enforceability of this recommendation. A requirement that an applicant apply to Medicaid and be approved or rejected before

being admitted into the homes: (1) would delay necessary care to Alaskan elders; and 2) goes beyond the current statutory authority of the division.

Recommendation 8.1.G.3 (p. 139)
Centralize billing functions within DHSS to consistently and aggressively pursue payment from private sources.
The department partially concurs. Alaska Pioneer Homes adheres to the requirements for insurance companies who provide residents with long-term care insurance. Also, requiring potential residents to completely liquidate their non-cash assets so that they can pay Alaska Pioneer Homes goes beyond the current statutory authority of the division.

Recommendation 8.1.G.4 (p. 139)
Increase rates for Pioneer Homes to private market rates.
The department does not concur. Calculating a rate increase based solely on 50% of the current residents does not give a complete picture of the payer mix and revenue collection possibilities within Alaska Pioneer Homes. Further, it is not clear what the market rate for the Pioneer Homes would be, since there is no like facility.

Recommendation 8.1.G.5 (p. 140)
Eliminate the travel budget for the Pioneer Homes Board and remove the facility inspection requirement from statute.
The department does not concur. The travel budget allocated to the Pioneer Homes Advisory Board allows for board members to interact with residents. This face-to-face connection encourages residents to share their concerns in a manner that they do not usually share with Pioneer Homes' staff. Alaska Pioneer Homes' management relies on the Pioneer Home Advisory Board to connect with residents and to report on the sense/feeling of home that is expected within every Eden Alternative Model assisted living home. This sense/feeling of home is distinct from the physical inspection of the facilities which is done by the Facilities section of Finance and Management Services.

Recommendation 8.1.G.6 (p. 140)
Reduce the amount of information materials produced and distributed, and limit printing to black and white forms.
The department partially concurs. Alaska Pioneer Homes seeks to inform families and potential residents in a format that best promotes reading comprehension while inviting readers into the Alaska Pioneer Homes' community. Changing the format to black and white reduces the impact of photos used within promotional materials reducing the connection to the reader.

Recommendation 8.1.H.1 (p. 141)
Negotiate rates for the lease of space at the Pioneer Homes and any other state-owned facility.
The department partially concurs. While this recommendation may increase revenue for the State of Alaska, the revenue gained from lease negotiations would not come to DHSS and the department has no control over the rate negotiation process of state-owned facilities.

Recommendation 8.1.I.1 (p. 144)

Review staffing levels and identify ways to reduce staffing ratios to be more in line with other state-operated assisted living facilities, with due consideration given to variations in care models
The department partially concurs with the recommendation. DHSS cannot guarantee that a staffing level review will result in a finding to reduce staff levels. The Centers for Medicaid and Medicare Services (CMS) increase the service level ratings for facilities, which have higher than average staffing levels. Alaska Pioneer Homes agrees with CMS that higher staffing levels benefit residents by positively impacting the care that they receive. When Alaska Pioneer Home staff followed the CMS rating calculation guidelines for nursing facilities the division had a calculated 5-star rating, the highest rating available, with the current staffing levels. The instructions to calculate a service level rating can be found at the following link: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/usersguide.pdf.

Further, the state-operated assisted living facilities in Wyoming and Arizona do not care for the same resident mix as the Alaska Pioneer Homes. Comparing the three state-operated assisted living facilities when they do not provide the same level of care is a potential risk to the residents within the Alaska Pioneer Homes whose care would be hindered by the reduction of staff. Residents receiving Level II and Level III care would be at the most risk as the other state-operated facilities provide care to residents similar to the Alaska Pioneer Homes' Level I.

Recommendation 8.1.1.2 (p. 144)
Evaluate the reasons for higher monthly costs per resident, including administrative overhead, maintenance staffing, travel, and other expenses.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. Supporting calculations and fiscal analysis is necessary. Assuming that Alaska Pioneer Homes is spending $1,000 more per month on each resident than is necessary without enumerating where that assumption came from leaves the division without guidance on how to find this proposed savings. As this is the largest portion of the report's year one net savings in UGF, additional details are needed to support the reported savings.

Additionally, DHSS has the following clarification: Alaska does not have a codified state minimum staffing level for the Alaska Pioneer Homes to reduce their personnel. An article entitled "Effects of State Minimum Staffing Standards on Nursing Home Staffing and Quality of Care" investigates the use of staffing standards to raise the level of care, not to reduce it. The article can be found online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2669632/. Also, the state-operated assisted living facilities in Wyoming and Arizona do not care for the same resident mix as the Alaska Pioneer Homes. Comparing the three state-operated assisted living facilities when they do not provide the same level of care is a potential risk to the residents within the Alaska Pioneer Homes whose care would be hindered by the reduction of staff.

Additional Comments, Clarifications, and Technical Corrections:

DHSS Efforts and Challenges (p. 1)

Performance Evaluations
Additional Comments: *This discussion of performance evaluations does not consider the distinction between merit steps and pay increments. The statement that a performance evaluation must be completed before a merit raise is given is partially accurate. An evaluation must be completed prior to a pay increment being given, but a merit step is granted automatically, unless an unacceptable or low acceptable evaluation was completed prior to the merit step being granted. The number of evaluations that were considered past due are for pay increments only. We believe the data from Table 3-4 is based on the pay increment due report that was provided to Legislative Audit. This report shows overdue pay increment evaluations and upcoming pay increment evaluations that are due. It is used as a tool to inform supervisors of upcoming due dates and which pay increment evaluations are past due. There are thousands of performance evaluations completed in the department each year. We believe that the conclusion in the percent late column is inaccurate because it is not comparing late evaluations as a percentage of total evaluations processed. It is comparing upcoming pay increment evaluations with late evaluations, which does not create an accurate way to determine a percentage of late performance evaluations. This is not to say that late pay increment evaluations are not a problem, but the conclusion of percent late, is not accurate. Based on this incorrect analysis, the findings and recommendation may not be accurate.*

Additional Comments Findings and Table 3-4: *The analysis appears incomplete and inaccurate in that it fails to compare late evaluations as a percentage of total evaluations processed. The discussion also fails to consider the distinction between merit steps and pay increments. An evaluation must be completed prior to a pay increment but a merit step is granted automatically, unless an evaluation with the rating of unacceptable or low acceptable was completed prior to the merit step being granted. The department completes thousands of performance evaluations each year and they are not all specific to pay increments.*

Site Visits (p. 46)
Additional Comments: *The functions of licensing and certification vary and have different standards and rules. SDS benefits from the current structure as it gives the division the ability to work closely and quickly with its own investigative and quality assurance resources to minimize compliance issues and report fraud. There are opportunities now to cross train to reduce travel expenditures without removing certification from SDS.*

Mini Grants (p. 47)
Additional Comments: *The use of the "mini-grant" model of services delivery could be useful to expand service delivery in rural and remote areas of the state; however, consideration must be made for the cost of this service delivery model so that funds are not diverted from direct services to pay additional fees for administration.*

Federal Reimbursement for Foster Care (p. 52-55, p. 148)

Additional Comments (p.52): *The national downward trend in penetration rates since 2002 may be attributed to changes in the federal title IVE regulations and policies, in addition to still relying on the*

former Aid for Dependent Families (AFDC) income and resource criteria in place in the previous state plan of 1996.

Additional Comments (p. 53): *While best practices and safety are of first consideration, there are fiscal ramifications of removing emergency licenses because currently if the relative caretaker has been issued an emergency license and is in the process of becoming licensed for a child that is potentially IVE eligible, the state can claim the associated administrative costs through the IVE administrative penetration rate for 272 days (approximately 3 quarters). Currently the maintenance portion of the Title IVE foster care claim only makes up approximately 20% of the IVE quarterly claim. Since the IVE administrative penetration rate is heavily relied upon for direct and indirect reimbursement by the largest cost centers, including the front line social worker component and management, any reduction to the numerator may adversely impact federal participation.*

Additional Comments (p. 54): *Child Trends is an association and calculates the IV-E maintenance penetration rate, while the state relies on an administrative IV-E penetration rate defined in the US DHHS ACF Child Welfare Manual (8.1.C #8) and in the department's federally approved public assistance cost allocation plan. The administrative IV-E penetration rate is always higher by several percentage points because it currently includes clients who are IV-E eligible for administrative costs but for whom the state has opted to accept a higher rate of social security benefits instead of IV-E maintenance and for IV-E eligible clients placed with relatives in the process of becoming fully licensed. Increasing the number of fully licensed relative placements will benefit both the IV-E maintenance and IV-E administrative penetration rates. However, the IV-E administrative rate will always be higher due to the IV-E eligible clients for whom the state does not claim IV-E maintenance. Additionally, other sources do exist that provide Title IV-E comparative data, such as Casey Family Program.*

Additional Comments (p. 54): *The maintenance penetration rate and administrative penetration rates shown do not match actual statistics. Also, the explanation of the difference between the two rates is inaccurate. Actual numbers are as shown in the following table:*

	Average Maintenance Penetration Rate	Average Administration Penetration Rate
FFY 2008	28.50%	47.75%
FFY 2012	38.50%	50.28%

OCS provides definitions as shown below:
Maintenance penetration rate: *The percentage of Title IV-E children placed in a fully licensed home and eligible for IV-E maintenance (i.e. room/board) reimbursement at 50%.*

Administrative penetration rate: *The children in the maintenance penetration rate* ***PLUS*** *children placed with a relative in a licensed home that does not meet Title IVE requirements (not to exceed 272 days).*

Correction Needed - Footnote #49 (p.148): *The first sentence is inaccurate. There is no Title IV-E reimbursement for either maintenance or administrative expenditures associated with unlicensed foster*

homes. This sentence should read: "...but are placed in a licensed home that does not meet title IVE requirements, the state is only reimbursed for 50 percent of the administrative component of the Title IV-E rate". This is different from "unlicensed", as DHSS does not pay unlicensed homes.

Medicaid Administration and Structure (p. 63-69)
Additional Comment: Chart 3-1: *It would be helpful to add Arizona as it will add consistency and a comparison when talking about the cost per resident of the Pioneer Homes on page 146.*

Additional Comment (p. 63) *It would be helpful to add the cost of Medicare to provide those services also to show that Medicare also pays more in Alaska for those services.*

Additional Comment (p. 63) *DHSS continues to be concerned that a "managed care" solution is recommended in a state where we do not have a sufficient number of people to make this work. The basic model is to spread the high costs of a small portion of covered lives over the less expensive majority. Therein lays the opportunity of covering the medical needs at a lower cost. From the perspective of behavioral health this is particularly risky with our Medicaid population.*

Objective 4: Boards and Commissions (p. 82)
Additional Comment Table 4-2: *This table contains a conclusion that the Alaska Pioneer Home Advisory Board meets only one criteria utilized by the reviewer for their analysis. The reviewer appears to undervalue the Pioneer Home Advisory Board by not acknowledging that public/stakeholder feedback given to the board and its members are both (1) relevant and (2) related to health & safety within the homes. While highlighting the travel budget of the board, the report fails to include its impact.*

Demands on the ITG Committee (p. 103)
Additional Clarification: *The State HIT Coordinator and the IT Planning Office Director are one and not two positions, as stated in the report. The title State Health Information Technology Coordinator was developed by a federal agency, Office of the National Coordinator, as a result of ARRA.*

Video Conferencing Technology (p. 104-107)
Additional Comments: *DHSS has the additional requirements of complying with HIPAA. Organizations that would otherwise not be required to comply with HIPAA must comply in Alaska because they are part of a single covered entity (HSS). Comparing HSS with organizations that may or may not be exempt from HIPAA is comparing apples to oranges. HIPAA compliant solutions are available, but they tend to be more expensive than free solutions such as Skype.*

Information Technology Security (p. 109-111)
Additional Clarification (p.109): *While the security office structurally is placed in the Assistant Commissioner's Office within Information technology organization, both the IT Manager responsible for all DHSS IT, and the Assistant Commissioner, sit on the Commissioner's leadership team, which meet weekly and include security and high priority issues briefings.*

Additional Clarification (p. 109): *Information security and compliance with the OCR CAP has been well defined. The key issue continues to be resources. The Risk Management Program requires high visibility*

of both the risk and risk mitigation solutions, to ensure privacy and security compliance is developed and maintained.

Additional Clarification (p. 110): *While resources are spread very thin, internal funding and resources have been brought in to assist with the compliance requirements in the CAP, however, DHSS is focused on meeting this deadline.*

Additional Comment (p. 111): *The finding seems to be inaccurate, for removable storage risk. DHSS has excellent tools and processes in place to encrypt our removable storage and limit social media to the minimum necessary, and exceptions are carefully reviewed through a waiver request, and only approved when the justification and agreements are signed. Centralized, recurring and required training in IT policies and secure computing practices are absolutely necessary to minimize misinformation and misunderstanding of department's policies and procedures. The challenge is in being resourced so we can provide targeted, role-based training.*

Objective 8: Evaluate Budget Reductions (p. 119)
Additional Comment: *The value of such retroactive assessment and judgment, when the proposed budget actions have long come and gone, is questionable. The reviewer both criticized DHSS for not submitting data timely and not identifying the requested 10% UGF reduction, and at the same time judging our smaller 3.7% UGF reduction as likely to impact our ability to serve vulnerable Alaskans. This may point out the obvious – that DHSS did not have 10% of excess UGF that we could eliminate without repercussion to our clients and achievement of our mission. Staff reductions stress those employees remaining onboard through increased workload, and cutting needed benefits hurts our priority populations. A number of the UGF reductions in turn caused a multifold reduction in DHSS's ability to draw down federal revenues.*

Table 8-2 (p. 122-124): Titled Additional Reductions and Revenue Enhancement Measures Identified During the Performance Review
Additional Comment: *The report needs to provide additional information as to how it determined the reported cost savings. Some of the numbers do not appear realistic, such as those for the division of Alaska Pioneer Homes and will require additional analysis by the department prior to being able to provide comments.*

ATTACHMENT C: PUBLIC WORKS REBUTTAL

November 12, 2015

Members of the Legislative Budget and Audit Committee:

Public Works has reviewed the comments received from the Department of Health and Human Services (DHSS) on October 28, 2015, regarding the findings and recommendations included in our Performance Review of the Alaska Department of Health and Social Services Organizational and Administrative Structure, September 29, 2015.

DHSS has concurred with a number of the recommendations in the report and we have not included those comments here. The remaining DHSS responses warrant further comments and we have provided our responses directly below the verbatim responses provided by DHSS in the order DHSS submitted its comments.

Recommendation 2.3.3 (p. 19)
Refine individual elements of the Budget Overview Presentations.
The department partially concurs. It should be noted that the department adjusts budget documents and presentations through a collaborative process with our Legislative (House and Senate) Finance Committees, and makes changes and edits based on their requests.

Response from Public Works: The recommendations suggested by **Public Works** would improve the readability of the documents. We suggest using the recommendations to inform the collaborative process described. The Legislative Budget and Audit Committee expressed a long-term interest on the part of the legislature in seeing such improvements.

Recommendation 2.3.5 (p. 22)
Illustrate interconnectivity at fiscal analysis stage.
The department partially concurs. It should be noted that in the process of preparing fiscal notes, DHSS looks across the department to determine how proposed legislation would affect different divisions and programs.

Response from Public Works: Objective 1 of the mandated scope of work for this review required recommendations for ways that DHSS budget documents can better show "interconnectivity of each individual division and the organizational structure utilized to connect individuals to services within each division and coordinate activities for those services through multiple divisions." This recommendation is in response to that requirement. It would require the department to apply a similar practice to fiscal note analysis for key parts of the budget in order better to inform decision-making.

Recommendation 2.3.6 (p.22)
Consider phasing in a zero-based budgeting process.
The department partially concurs. A fiscal analysis is needed to quantify the associated costs of agency resources needed to comply with the incremental change process, in addition to implementing the zero based budgeting process. This process could be considered on a statewide basis, but would take a significant amount of lead time to implement.

Response from Public Works: The scope of work for **Public Works** does not include calculating the cost of implementation. In this case, we believe that the department could comply using existing resources, in which case no additional expense would be incurred. Objective 1 required recommendations for ways DHSS budget documents can better facilitate the development of a well-informed budget. This recommendation is in response to that requirement.

Recommendation 3.1.A.2 (p. 28)
Implement the targeted strategies identified in the newly developed DHSS plan to recruit and retain field staff.
The department partially concurs. While the department concurs with the need to implement the strategies identified in the plan for recruitment and retention of field staff, the department asserts that there are still barriers that may make implementation of some strategies difficult to impossible. Because the State of Alaska is one employer with numerous departments, the department must follow statewide collective bargaining agreements, policies, and laws that may be barriers to making department-specific changes. However, the department concurs with the recommendation to implement strategies within these statewide parameters.

Response from Public Works: We do acknowledge that collective bargaining agreements and state policies and laws can create barriers. Regardless, implementing strategies within the department should be coordinated at the executive level so that these barriers can be addressed. We believe DHSS should implement strategies the department itself developed.

Recommendation 3.1.B.3 (p. 32)
Develop a formal succession plan to internally cultivate future leaders and certain skilled non-management positions.
The department partially concurs. The department agrees with the need to engage in increased succession planning. However, a succession plan including all of the elements in this recommendation will require changes will the state's collective bargaining agreements and that process is managed at a statewide level outside the authority of DHSS.

Response from Public Works: We acknowledge that collective bargaining agreements create challenges to succession planning, and such planning should be consistent with these agreements. These challenges should not prevent DHSS from undertaking such planning.

Recommendation 3.1.C.1 (p. 34)
Prioritize training needs based on risk to the department budget (including the direct and indirect costs of staff turnover) and to vulnerable populations.
The department partially concurs. The department is able to analyze department wide training needs based on risk to the budget and to vulnerable populations; however, division specific training should be developed and prioritized within each division. Division training should be reviewed at the department level to identify opportunities to consolidate training and best practices.

Response from Public Works: Public Works believes that some type of department-wide prioritization is imperative. We also have recommended the creation of a task force to study this issue.

Recommendation 3.1.D.1 (p.36)
Create a master trainer program in DPA modeled after the DJJ program and allow eligibility workers who have low error rates (comparable to experienced employees) to take on greater caseloads as early as possible.
The department partially concurs. DHSS division leadership recently visited another state to observe its training model. DPA will be pursuing additional recommendations by moving the training positions into the field. These trainers will be able to provide on-site training and eliminate the need for new staff to travel for classroom training. However, the training team will also create web based training and their duties may change to include completing case reviews along with development of training on-line.

Response from Public Works: We commend DHSS for considering training models that significantly reduce or eliminate the need for new hires to travel. These efforts do not conflict with our recommendation.

Recommendation 3.1.D.2 (p. 37)
Eliminate the additional four months of continued distance learning and reduced caseloads for DPA eligibility workers.
The department does not concur. Additional fiscal detail is needed for the reader to gain an understanding of proposed cost savings.

Response from Public Works: DHSS has not provided information to show that eliminating the additional four months of training would be detrimental. In the report, **Public Works** suggests using existing monitoring efforts to identify a subset of employees who may need continued training. The need to reduce the backlog in eligibility determination is discussed in detail in the report; this is one of several ways to achieve that needed goal, which, most importantly, will improve service while in the long-run allowing better drawdown of federal funds, thereby improving the bottom-line.

Recommendation 3.1.E.1 (p. 39)
Reduce the caseloads for new child welfare workers to meet the enhanced federal Title IV-E reimbursement rate requirements for workers in training, as well as during the first six months of employment.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. The recommendation does not include an analysis of workload impact on existing staff.

Response from Public Works: This recommendation is based on a concern about the alarming turnover rate among caseworkers; workload is one of the major contributors. Should DHSS conclude that it needs to hire additional caseworkers to implement this recommendation, the following recommendation, 3.1.E.2, suggests using the revenue from this effort to pay for them.

Recommendation 3.1.E.2 (p. 39)
Use the estimated additional revenue of $768,000 to hire additional caseworkers and supervisors in the appropriate ratio.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. It is unclear whether the addition of eight to ten caseworkers would offset the loss in productivity from new workers with a reduced caseload.

Response from Public Works: The recommendation identifies a revenue source to increase caseworkers in the department, which is a dire need. This increase may not meet the full needs of the department. However, levels of turnover such as that experienced amongst DHSS child welfare caseworkers itself diminishes their productivity, so that decreasing the workload should increase overall productivity.

Recommendation 3.2.C.1 (p.45)
Combine the DPA, HCS, and SDS facility licensing and certification functions into a single office or new division.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. The report needs to include a feasibility study identifying and quantifying existing administrative efficiencies. Since the proposed consolidation involves different programs, regulations, and standards, a one size fits all approach may increase inefficiencies and safety issues.

Response from Public Works: We believe that the efficiency gains from consolidating similar licensing and certification functions outweigh any increased difficulty in coordinating such efforts across different programs.

Recommendation 3.2.D.1 (p.46)
Expand cross-training opportunities so staff can conduct multi-purpose site visits.
The department partially concurs. A cost benefit analysis including the staff training costs associated with this recommendation is needed.

Response from Public Works: As discussed in our report, we believe that the efficiency gains from consolidating similar training and site-visit activities outweigh any increased difficulty in coordinating such efforts across different programs.

Recommendation 3.2.F.1 (p. 49)
Create an Office of Tribal Relationships in the Office of the Commissioner at DHSS.
DHSS partially concurs with the creation of an Office of Tribal Relationships in the Office of the Commissioner. This could improve cross communication with the existing tribal liaisons in each division, tribal entities, and lead to better coordination and planning across all divisions. A fiscal analysis does not appear to be provided quantifying potential cost savings.

Response from Public Works: This recommendation is cost-neutral if an existing position within a division is moved into this position.

Recommendation 3.2.G.1 (p. 51)
Continue to evaluate opportunities to update the Fairbanks Youth Facility kitchen for full-time meal service.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. The finding fails to include availability of PCNs in other locations. An analysis of available PCNs will be required due to cost containment measures implemented. If no PCNs are available the associated fiscal analysis will need to be updated as it did not include the costs associated with new PCNs.

Response from Public Works: The DHSS assertions are correct. The savings identified in this recommendation are contingent upon PCNs becoming available in other locations and this is noted in the report. For this reason, Recommendation 3.2.G.1 calls for DHSS to continue to evaluate opportunities to offset the cost of a new kitchen rather than to implement this recommendation immediately.

Recommendation 3.2.G.2 (p. 51)
Pursue federal and private grant funding to help offset the cost of needed kitchen remodeling and equipment purchases.
Please see response to Recommendation 3.2.G.1.

Response from Public Works: Same response as 3.2.G.1.

Recommendation 3.2.G.3 (p. 51)
Review opportunities to increase DJJ Workforce Investment Act funding as vocational training opportunities – including a culinary arts program – are expanded.
Please see response to Recommendation 3.2.G.1.

Response from Public Works: Same response as 3.2.G.1.

Recommendation 3.2.H.1 (p. 52)
Implement juvenile prosecution and sentencing strategies that will reduce recidivism, lower costs, and improve outcomes for youth, including the following advocated by the Alaska Juvenile Justice Advisory Committee.
The department partially concurs. Under Alaska's juvenile justice statutes, juveniles who are adjudicated as delinquent are not sentenced as is the rule in the adult justice system. These cases face a disposition which may or may not involve a period of custody that is determined by law and a positive response to DJJ intervention. Changes in juvenile justice statutes, especially in regard to the transfer of sixteen and seventeen year old juveniles to the adult system when charged with specific serious offenses, cannot be unilaterally implemented by the department, and would require collaboration with other agencies.

Response from Public Works: Public Works agrees with this assertion and this is acknowledged in the report. We urge DHSS to collaborate with the other relevant agencies to achieve the improvement recommended.

Recommendation 3.2.I.1 (p.55)
Maintain sufficient staffing by hiring caseworkers and providing all workers with manageable caseloads.
The department partially concurs with the recommendation. While DHSS has made recent improvements by adding new positions, the OCS workload for frontline caseworkers still does not meet the CWLA recommendations. OCS is evaluating what can be extrapolated for current use from the caseload studies as well as looking nationally for what other states are finding most effective to assist the division in designing a methodology and/or strategy to more continually and accurately measure workload in comparison to recommended national standards.

Response from Public Works: We commend DHSS for considering any models that will allow OCS fully to staff its caseload.

Recommendation 3.2.I.4 (p. 56)
Develop a template or checklist for OCS workers and/or eligibility technicians to assist in correctly documenting the components of Title IV-E eligibility within the appropriate timeframes.
The department partially concurs. Eligibility information for children in OCS care is documented in the division's SACWIS system, ORCA. The eligibility technician fills information into an ORCA-based template to determine eligibility. The completion date is also tracked in ORCA. Further, a technician's ability to document the eligibility determination within appropriate timeframes is dependent on many factors, including court scheduling, court orders, and availability of parental income and resources.

Response from Public Works: The recommendation is a suggestion to improve the accuracy of the documentation process for Title IV-E eligibility so that OCS is in compliance with federal regulations. At the time of the review, existing documentation did not appear to be adequate to assist inexperienced caseworkers.

Recommendation 3.2.I.5 (p. 56)
Prioritize technology purchases and implementation to assist OCS workers.
The department partially concurs. While there is a need for this, there is a significant cost as well.

Response from Public Works: We recognize that these items carry costs. However, everyone, including the department, believes that technology support for OCS caseworkers should be a priority for DHSS as funds are available.

Recommendation 3.2.J.1 (p. 58)
Prioritize and accelerate plans to shift OCS intake from a regional intake system to a centralized intake system comprised of a distinct unit of trained CPS workers who receive reports of child abuse and neglect 24 hours a day, 7 days a week.
DHSS partially concurs. The department agrees with prioritization, but notes that acceleration of these plans needs to occur at the speed that communities can accept/tolerate.

Response from Public Works: Public Works understands the need to ensure community acceptance of the physical change in the location of the intake caseworkers to Anchorage. However, consistency across regions can be improved immediately by having all intake workers report to a single manager and creating a virtual hot-line number that can be answered in each region; existing intake telephone numbers can remain in place until the transition is complete.

Recommendation 3.2.K.1 (p. 59)
Designate an existing Deputy Commissioner to oversee the programs within DHSS that operate institutions to create standardized administrative functions and realize efficiencies that can be achieved by consolidating many of the support functions.
The department does not concur. The findings fail to include a cost benefit analysis to support potential savings associated with consolidation of these facilities under a designated Deputy Commissioner. Since the proposed consolidation will involve facilities governed by different accreditation agencies and managed by agency staff who are also managing other similar programs, additional analysis on existing resources is needed. There are also concerns that the unique needs of each institution would negate some or all of the financial benefit of consolidation.

Response from Public Works: Recommendations 3.2.K.1-3.2.K.4 suggest how to address the inefficiencies identified during the review. The department's responses to all four of these recommendations are essentially the same. The potential savings will be realized in better

coordinating administrative functions (i.e., sharing maintenance staff or obtaining better pricing on major purchases). The department already faces challenges posed by the differing requirements from accreditation agencies; under the recommendation, those accreditation efforts will be better coordinated.

Recommendation 3.2.K.2 (p. 59)
Redirect the oversight and management of API to a Deputy Commissioner designated to oversee institutions.
The department does not concur. The benefits of merging would likely be outweighed by the disruptions this would cause. Both API and DJJ facilities are part of an integrated system of care within their divisions. Removing the facilities from that organizational structure will lead to more silos and conflicts between the most restrictive and least restrictive settings. All three types of facilities have different accrediting bodies with different standards and expectations, so expertise in many areas would be required. The statutory responsibilities of the Alaska Psychiatric Hospital for Title 47 commitments make this recommendation undesirable from both a management and a client safety perspective. Additionally, the Designated Evaluation and Treatment program is closely linked to API as it "stretches" their capacity at the regional level. They are most effective when managed together.

Response from Public Works: **Public Works** does not suggest separating out the facilities from the other programs within DJJ. Rather, we suggest that DJJ as a division, API as an institution, and Pioneer Homes as a division should report to the same Deputy Commissioner. We believe that the management of API, BH Medicaid benefits, and BH grants within one division does not allow for a focus on the operation of an institution. Under the recommendation, those accreditation efforts will be better coordinated.

Recommendation 3.2.K.3 (p. 59)
Move all of the institutional administrative functions currently managed by DJJ and Pioneer Homes under the designated Deputy Commissioner.
The department does not concur. The findings fail to include a cost benefit analysis to support potential savings associated with consolidation of these facilities under a designated Deputy Commissioner. Since the proposed consolidation will involve facilities governed by different accreditation agencies and managed by agency staff who are also managing other similar programs, additional analysis on existing resources is needed. It should also be noted that at its core, AKPH differs from DJJ and API because individuals in AKPH choose to be residents. These individuals are also paying what they can for their care.

Response from Public Works: This recommendation provides a suggestion for how to address the inefficiencies identified during the review. A single Deputy Commissioner will be better able to identify similarities and differences between the institutions and coordinate the achievement of efficiencies. We do not believe that the differences in institutions noted by DHSS affect the administrative issues, such as procuring supplies, at issue here. The

department already faces challenges posed by the differing requirements from accreditation agencies; under the recommendation, those accreditation efforts will be better coordinated.

Recommendation 3.2.K.4 (p. 59)
Establish an administrative office under the Deputy Commissioner that would provide all administrative support functions such as purchasing, human resources, billing, and other services to operate facilities for all 13 institutions.
The department does not concur. The findings fail to include a cost benefit analysis to support potential savings associated with consolidation of these facilities under a designated Deputy Commissioner. Since the proposed consolidation will involve facilities governed by different accreditation agencies and managed by agency staff who are also managing other similar programs, additional analysis on existing resources is needed.

Response from Public Works: See response to Recommendation 3.2.K.1.

Recommendation 3.3.B.1 (p.73)
Combine all program integrity and compliance units across the department, including provider enrollment and the surveillance and utilization review subsystem (SURS).
The department does not concur. Additional information pertaining to how the cost savings were determined is needed. The department has had considerable success at pursuing program integrity efforts from within the operating divisions with the support of some centralized functions. Past efforts to consolidate have failed to achieve the specific program knowledge and experience necessary to operate effectively.

Response from Public Works: Our review found that the department's existing efforts are not uniformly successful or optimized. The cost-saving figures presented in our recommendation are targets, which should be easily met.

Recommendation 3.3.C.1 (p. 75)
Elevate the Medicaid CQI function within DHSS.
The department partially concurs. While sharing CQI knowledge is desirable, Federal Medicaid rules have very specific requirements for CQI for home and community-based waivers, targeted specifically to those services. CQI in other services may not mirror those requirements. Consequently, there may not be a great deal of efficiency gained by consolidating functions where there are different program requirements.

Response from Public Works: Public Works believes that there are benefits to looking at quality across the Medicaid program as a whole. The department should develop a comprehensive and coordinated CQI (Continuous Quality Improvement) process to the extent possible.

Recommendation 4.1 (p.83)

The efforts of the Alaska Council on Emergency Medical Services should be refocused from professional advocacy to providing more formalized policy and budget advice to the DHSS commissioner and governor.

The department partially concurs. While the current mission of the Alaska Council on Emergency Medical Services is different from the original statutory purpose, the council should first be evaluated as suggested in Recommendation 4.4 before being refocused.

Response from Public Works: **Public Works** agrees that all advisory bodies should be evaluated against the criteria enumerated in our report. Recommendation 4.1 is intended to provide a third-party observation for departmental consideration as part of the evaluation recommended in 4.4.

Recommendation 4.2 (p. 83)

The travel budget for the Alaska Pioneer Homes Advisory Board should be eliminated.

The department does not concur. The recommendation undervalues the Pioneer Home Advisory Board by not acknowledging that public/stakeholder feedback given to the board and its members are both (1) relevant and (2) related to health & safety within the homes. While highlighting the travel budget of the board, the reviewers have overlooked its impact.

Response from Public Works: The board's statutory purpose duplicates the work of professional staff within FMS.

Recommendation 6.2.1 (p. 91)

The State of Alaska should consider managed competition or privatization for the Alaska Pioneer Homes, the costs of which are discussed more fully in Sections 8.1.G and 8.1.I of this report.

The department partially concurs. A cost benefit analysis including a facility that offers level three care is missing and is needed to evaluate the findings and resulting recommendation.

Response from Public Works: Sufficient concerns were raised during the review to warrant exploring the issue of privatization. As stated in the first sentence under "Findings" in Section 6.2, **Public Works** has not conducted the analysis to determine whether the state should move forward with privatization, as this type of analysis is beyond the scope of this performance review; rather, we recommend that this issue be explored. A review of privatization would certainly include a cost-benefit analysis.

Recommendation 6.3.1 (p. 93)

Elevate prevention issues within DHSS.

The department partially concurs. OCS would support a prevention focus, but questions the availability of funding to support this change. From a department perspective, elevating could include identification of discrete prevention efforts, planning and collaborating across divisions on these efforts, and generally working to reduce "silos" related to prevention work.

Response from Public Works: Public Works agrees with the last sentence here. We believe that such an effort could be done with no additional funds.

Recommendation 6.3.2 (p. 93)
Move forward with the transfer of the ILP program to DEED.
The department does not concur. DHSS is evaluating how to strengthen the program and determine the best placement within the department.

Response from Public Works: At the time of this review, moving ILP to DEED was determined to be in the best interest of DHSS, as noted in the report.

Recommendation 7.1.2 (p. 104)
Revise the ITG process to limit the number of projects that must be vetted by the ITG Committee.
The department partially concurs with the recommendation. IT Planning is working with the IT-PMO to develop "fast track" options for small projects or projects that do not significantly impact infrastructure. It is very difficult to develop "fast track" options since the governance processes are critical for maintaining knowledge at an enterprise or department-wide level of how IT resources are being impacted.

Response from Public Works: We understand that there may be challenges to implementing the recommendation. We commend DHSS for developing a process to address this issue.

Recommendation 7.2.2 (p. 107)
As new video conferencing capabilities come on line, the Commissioner should establish a target reduction in travel of 10 percent for the first year and 20 percent in the second year.
The department partially concurs. The report fails to provide a cost benefit analysis with information about the cost of expanding video conferencing and appears to be making an assumption that it will be less expensive than travel and replaces some travel needs. As VC capabilities are expanded, we will analyze travel savings and reduce costs appropriately.

Response from Public Works: VC (video conferencing) comes at a cost, but out-of-pocket costs can be reduced by capturing a reduction in travel expenses. In addition, there are efficiency gains by reducing time associated with travel. A cost-benefit analysis will need to be conducted on a case-by-case basis for each VC implementation project contemplated.

Recommendation 7.3.1 (p. 108)
Implement mandatory project management training and mentoring for IT and division staff, including Division Business Alignment Liaisons and project managers, who are tasked with responsibilities concerning development, integration, and implementation of technology systems.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. The report fails to provide a cost benefit analysis associated with the training, including the cost to divisions for staff to participate. There is the cost of

establishing training that relates to how DHSS applies project management and the tools that it employs. There is also the cost for the divisions to allow their staff to take time away from their regular duties in order to attend the course. Additionally, while project management is generic and the application training can use other materials that are available online or at a reduced cost it would still need to be customized for application to the DHSS roles and activities that project staff would be performing.

Response from Public Works: Costs due to the training itself, if any, as well as travel and the time required for training by being away from productive work, are inherent in all training programs. Training and other professional development opportunities nonetheless provide important long-term benefits to employees and their employer.

Recommendation 7.4.B.1 (p. 113)
Develop a plan to address the significant shortcomings and productivity issues identified by operational staff using DSM.
The department partially concurs with this recommendation. Since this review has been initiated DHSS has implemented a feedback mechanism to ensure that productivity issues are resolved in a timely manner.

Response from Public Works: We have acknowledged in the report that DHSS is making progress on resolving these issues.

Recommendation 7.4.B.2 (p. 113)
Expedite the execution of this plan.
The department partially concurs with this recommendation. Please reference response to recommendation 7.4.B.1

Response from Public Works: We have acknowledged in the report that DHSS is making progress on resolving these issues.

Recommendation 7.4.B.3 (p. 113)
Communicate progress on the plan and how problems are being addressed to all DHSS staff at regular intervals.
The department partially concurs. DHSS has developed a remediation plan for DSM that includes:

- *Working with the DSM vendor to remediate DSM specific problems*
- *Certifying the State's email system for internal secure messaging*
- *Procuring an online secure file transfer system*
  While this is communicated via department-wide forums, it is recognized that this may not be adequately communicated to all staff and the department will consider additional notification methods.

Response from Public Works: We acknowledged in the report that DHSS is making progress on resolving these issues.

Recommendation 7.5.2 (p. 114)
Prioritize migration to electronic health records (EHRs) for all divisions – particularly SOPHN – to reduce medical errors, maximize operational efficiency, and minimize redundant training.
The department partially concurs with this finding. DHSS agrees that the use and availability of technology for the Section of Public Health Nursing should be expanded, particularly migration to electronic health records. However, a cost benefit analysis will need to be completed to determine whether the department has the resources for a complete implementation across all divisions.

Response from Public Works: We recognize that EHR carries costs. However, EHR should be a priority for DHSS as funds are available. This suggestion mirrors an earlier response on information technology for OCS workers.

Recommendation 8.1.A.1 (p. 128)
Conduct a comprehensive review of the fee structure for all licensing and certification functions, with the goal of establishing fees equal to costs, accompanied by indexing to provide automatic adjustments of fees as costs change.
The department partially concurs. DHSS has concerns that fees could become a barrier to being able to provide services or develop new agencies, especially given the shortage of service providers in rural Alaska.

Response from Public Works: Policy considerations such as this would be factored into the comprehensive review of the fee structure recommended in Recommendation 8.1.A.1.

Recommendation 8.1.A.2 (p. 129)
Implement nominal annual child care licensing fees, as shown in Table 8-3, resulting in total biennial revenue of $14,975.
The department partially concurs, but has concerns that the impact could be detrimental to recruitment and retention of licensed child care facilities that are already struggling. The resources needed to implement these fees (relative to the amount of revenue gained) should also be considered.

Response from Public Works: Policy considerations such as this would be factored into the comprehensive review of the fee structure recommended in Recommendation 8.1.A.1.

Recommendation 8.1.A.3 (p. 129)
Establish a minimum license fee for smaller residential care facilities.
The department partially concurs, with the concern that fees may negatively impact providers. Additional fiscal analysis is needed to determine whether this recommendation would be cost effective to implement.

Response from Public Works: Policy considerations such as this would be factored into the comprehensive review of the fee structure recommended in Recommendation 8.1.A.1.

Recommendation 8.1.A.4 (p. 129)
Establish an application fee for all licensing services provided by DHSS.
The department partially concurs, with the concern that fees may negatively impact providers. DSDS points out that there are currently provider shortages for long term care services even in the Anchorage area, with severe shortages in rural Alaska. Additional costs to providers may become a barrier to providing services or developing new agencies.

Response from Public Works: Policy considerations such as this would be factored into the comprehensive review of the fee structure recommended in Recommendation 8.1.A.1.

Recommendation 8.1.B.1 (p. 131)
Reestablish a fee system to help cover the state's cost for laboratory testing.
The department partially concurs with the recommendation. The fees need to be evaluated with the market pricing factors and potential negative impact on public health. An in-depth cost/benefit analysis must also be completed before any decisions are made regarding reestablishing fee-for-service. The Division of Public Health is currently evaluating strategies to determine the feasibility of implementing a clinical billing system and maximizing collections. The fiscal impact on other state agencies using the lab should also be analyzed.

Response from Public Works: Cost/benefit analysis by DHSS would be an important part of a comprehensive review of the fee structure.

Recommendation 8.1.B.4 (p. 131)
Maintain Services for state agencies currently receiving laboratory work from ASPHL when instituting a fee-for-service system.
DHSS partially concurs that fees should be assessed to other state agencies when doing so can reduce the overall use of general funds. The determination on whether or not to assess fees should be based on the possible negative impact to the Lab's public health purpose and not the fund source. However, the Lab should consider waiving fees if it does not reduce the overall use of general funds. If the other state agency has non-general funds available, those funds should be used to pay for state lab testing.

Response from Public Works: **Public Works** is in agreement with DHSS on the determination of fees assessed to state agencies.

Recommendation 8.1.C.2 (p. 134)
Explore whether the contract for third party billing in the Division of Health Care Services (HCS) could be expanded to include billing for API, DPH, and Pioneer Homes.
The department partially concurs, but would need to verify that outsourcing billing services for Alaska Pioneer Homes under HCS would not be a conflict of interest, as HCS is responsible for oversight of Alaska Pioneer Homes.

Response from Public Works: If outsourcing billing services for Alaska Pioneer Homes under HCS were proven to result in a conflict of interest, **Public Works** has provided other recommendations for third-party billing in Recommendation 8.1.C.1.

Recommendation 8.1.D.1 (p. 135)
Expedite the implementation of electronic document imaging throughout DPA and eliminate the courier budget.
The department partially concurs. The division is unable to commit to an expedited implementation of the electronic document imaging system at this time. However, it is in the plan moving forward with ARIES Release 2.

Response from Public Works: **Public Works** understands that the implementation of electronic document imaging is tied to ARIES Release 2; it should be expedited as soon as this component of ARIES is available.

Recommendation 8.1.F.1 (p. 136)
Ensure that DJJ draws down all eligible federal funding from the National School Lunch Program (NSLP), School Breakfast Program (SBP), Special Milk Program, and After School Snack Program by supplementing meals provided by the Department of Corrections with other foods that will meet minimum USDA nutritional standards.
The department partially concurs. While DJJ agrees with the recommendation conceptually, it is difficult to implement. Of the eight facilities within DJJ, five of them participate in the NSLP. Three of those facilities purchase meals from local providers, one contracts with Department of Corrections (DOC), and our largest facility in Anchorage has its own kitchen. The three facilities that do not participate in the NSLP all have contracts with a DOC institution. DOC has made it clear to DJJ that they will provide food, but will not alter the preparation of that food. For DOC to prepare meals for DJJ that meet all of the nutritional standards for NSLP reimbursement would create a significant cost increase to DJJ (i.e. it would not be cost effective to participate in NSLP if the main purpose is to qualify for federal reimbursement.) DJJ would be willing to begin another dialogue with DOC, but from community to community, meal provider options are very limited and it is beneficial to have a relationship with DOC that allows DJJ to purchase meals even if they don't always meet the requirements of NSLP.

Response from Public Works: **Public Works** agrees that each of the DJJ facilities faces unique cost/availability challenges. This is why we did not recommend discontinuing the partnership with DOC for meal service, but rather recommended that DJJ consider ways to supplement the DOC meals with other/additional foods that will meet the minimum USDA nutritional standards.

Recommendation 8.1.F.2 (p. 136)
Provide information to youth and their families regarding continued eligibility for free or reduced cost meals in schools as youth are released from DJJ facilities.
The department partially concurs. Providing information to families about free and reduced meals in schools is not something DJJ is opposed to. However, this is a popular program that students and families are exposed to at an early age. The free and reduced applications are part of the school enrollment package. In addition, while it is true that all DJJ facility residents are eligible for the free and reduced meal program, that is not necessarily true when youth are released back into the community, as this program is based on financial need and not all of the youth released remain eligible once they leave a DJJ facility. This is an issue that the division is

willing to discuss with the school located in DJJ facilities to ensure that each family has access to that information.

Response from Public Works: Public Works agrees with the comments from DHSS and the suggested plan to discuss the issue with the school located in DJJ facilities.

Recommendation 8.1.G.1 (p. 138)
Increase revenue and reduce general fund expenditures by developing a fee schedule for Pioneer Homes.
The department partially concurs, as Alaska Pioneer Homes is open to expanding revenue collection efforts. However, this analysis does not acknowledge that 50% of the Alaska Pioneer Homes' current resident populations are unable to pay the current monthly rate. Increasing monthly rates charged to a population who is unable to pay the lower rates would reduce the estimated net gains on page 125. Also, imposition of an application fee/deposit for the Pioneer Home wait list may advantage higher income Alaskans trying to access a limited state resource.

Response from Public Works: Public Works acknowledges on page 137 of the report that half of the residents are private pay; we understand that 50 percent of residents cannot pay the full monthly rate. On page 138, we again acknowledge that approximately half of the residents are considered low-income. This information is factored into our analysis.

Recommendation 8.1.G.2 (p. 138)
Require a denial letter from Medicaid before a resident may move into a Pioneer Home.
The department does not concur. Alaska Pioneer Homes questions the enforceability of this recommendation. A requirement that an applicant apply to Medicaid and be approved or rejected before being admitted into the homes: (1) would delay necessary care to Alaskan elders; and 2) goes beyond the current statutory authority of the division.

Response from Public Works: Alaska Administrative Code already requires that applicants apply for Medicaid, but this is not enforced by Pioneer Homes. A denial letter is definitive proof of application.

Recommendation 8.1.G.3 (p. 139)
Centralize billing functions within DHSS to consistently and aggressively pursue payment from private sources.
The department partially concurs. Alaska Pioneer Homes adheres to the requirements for insurance companies who provide residents with long-term care insurance. Also, requiring potential residents to completely liquidate their non-cash assets so that they can pay Alaska Pioneer Homes goes beyond the current statutory authority of the division.

Response from Public Works: Public Works encourages DHSS to do everything within its statutory authority aggressively to pursue payment and to work with legislators if current statutory authority is not sufficient.

Recommendation 8.1.G.4 (p. 139)

Increase rates for Pioneer Homes to private market rates.

The department does not concur. Calculating a rate increase based solely on 50% of the current residents does not give a complete picture of the payer mix and revenue collection possibilities within Alaska Pioneer Homes. Further, it is not clear what the market rate for the Pioneer Homes would be, since there is no like facility.

Response from Public Works: We have reviewed DHSS' response and nothing contained in the response provided sufficient information to persuade us to revise or remove our finding or recommendation.

Recommendation 8.1.G.5 (p. 140)

Eliminate the travel budget for the Pioneer Homes Board and remove the facility inspection requirement from statute.

The department does not concur. The travel budget allocated to the Pioneer Homes Advisory Board allows for board members to interact with residents. This face-to-face connection encourages residents to share their concerns in a manner that they do not usually share with Pioneer Homes' staff. Alaska Pioneer Homes' management relies on the Pioneer Home Advisory Board to connect with residents and to report on the sense/feeling of home that is expected within every Eden Alternative Model assisted living home. This sense/feeling of home is distinct from the physical inspection of the facilities which is done by the Facilities section of Finance and Management Services.

Response from Public Works: As noted twice previously, above, the board's statutory purpose duplicates the work of professional staff within FMS.

Recommendation 8.1.G.6 (p. 140)

Reduce the amount of information materials produced and distributed, and limit printing to black and white forms.

The department partially concurs. Alaska Pioneer Homes seeks to inform families and potential residents in a format that best promotes reading comprehension while inviting readers into the Alaska Pioneer Homes' community. Changing the format to black and white reduces the impact of photos used within promotional materials reducing the connection to the reader.

Response from Public Works: Recruitment is not an issue with such a long waiting list.

Recommendation 8.1.H.1 (p. 141)

Negotiate rates for the lease of space at the Pioneer Homes and any other state-owned facility.

The department partially concurs. While this recommendation may increase revenue for the State of Alaska, the revenue gained from lease negotiations would not come to DHSS and the department has no control over the rate negotiation process of state-owned facilities.

Response from Public Works: We have reviewed DHSS' response and nothing contained in the response provided sufficient information to persuade us to revise or remove our finding or recommendation.

Recommendation 8.1.I.1 (p. 144)
Review staffing levels and identify ways to reduce staffing ratios to be more in line with other state-operated assisted living facilities, with due consideration given to variations in care models
The department partially concurs with the recommendation. DHSS cannot guarantee that a staffing level review will result in a finding to reduce staff levels. The Centers for Medicaid and Medicare Services (CMS) increase the service level ratings for facilities, which have higher than average staffing levels. Alaska Pioneer Homes agrees with CMS that higher staffing levels benefit residents by positively impacting the care that they receive. When Alaska Pioneer Home staff followed the CMS rating calculation guidelines for nursing facilities the division had a calculated 5-star rating, the highest rating available, with the current staffing levels. The instructions to calculate a service level rating can be found at the following link: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf..

Further, the state-operated assisted living facilities in Wyoming and Arizona do not care for the same resident mix as the Alaska Pioneer Homes. Comparing the three state-operated assisted living facilities when they do not provide the same level of care is a potential risk to the residents within the Alaska Pioneer Homes whose care would be hindered by the reduction of staff. Residents receiving Level II and Level III care would be at the most risk as the other state-operated facilities provide care to residents similar to the Alaska Pioneer Homes' Level I.

Response from Public Works: DHSS' concern for quality of care is valid, and is addressed in our report. Nonetheless, the department must consider ways to reduce General Fund expenditures for the Alaska Pioneer Homes; reviewing staffing ratios is one such opportunity to find cost savings. Nothing contained in the DHSS response provided sufficient information to persuade us to revise or remove our finding or recommendation.

Recommendation 8.1.I.2 (p. 144)
Evaluate the reasons for higher monthly costs per resident, including administrative overhead, maintenance staffing, travel, and other expenses.
The department does not concur, but would be willing to reconsider this position upon further information from the reviewers. Supporting calculations and fiscal analysis is necessary. Assuming that Alaska Pioneer Homes is spending $1,000 more per month on each resident than is necessary without enumerating where that assumption came from leaves the division without guidance on how to find this proposed savings. As this is the largest portion of the report's year one net savings in UGF, additional details are needed to support the reported savings.

Additionally, DHSS has the following clarification: Alaska does not have a codified state minimum staffing level for the Alaska Pioneer Homes to reduce their personnel. An article entitled "Effects of State Minimum Staffing Standards on Nursing Home Staffing and Quality of

Care" investigates the use of staffing standards to raise the level of care, not to reduce it. The article can be found online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2669632/. Also, the state-operated assisted living facilities in Wyoming and Arizona do not care for the same resident mix as the Alaska Pioneer Homes. Comparing the three state-operated assisted living facilities when they do not provide the same level of care is a potential risk to the residents within the Alaska Pioneer Homes whose care would be hindered by the reduction of staff.

Response from Public Works: Regardless of the unique characteristics of the Alaska Pioneer Homes, which we acknowledge in our report, DHSS must consider how to reduce General Fund expenditures for the Alaska Pioneer Homes. In the report, we have provided a number of suggestions for where there may be opportunities for achieving cost savings and increasing revenue. Our report provides context for the discussion on minimum staffing standards.

Additional Comments, Clarifications, and Technical Corrections:

DHSS Efforts and Challenges (p. 1)
Additional Comment: *The lack of network and communication connectivity which impacts department employees working in rural Alaska also presents safety concerns. Several department divisions have employees who travel often to rural Alaska and face the difficulties associated with that work. Staff from the Division of Juvenile Justice carry caseloads or have other job responsibilities that require rural travel and must make use of the available travel possibilities whether it is small aircraft, snowmachine, and/or boat. Due to Alaska's unpredictable weather, especially in winter, they have to be prepared for the possibility of being "weathered in" and spending a night or two on the floor of some public building. The possibility of travelling with a juvenile in secure custody also complicates the picture.*

Response from Public Works: Public Works agrees that these are significant and unique concerns in Alaska and we considered these conditions when developing our findings and recommendations.

1.5 Departmental Challenges (p. 10-11)
Additional Comment: *Discussion pertaining to flexibility fails to include the existence of collective bargaining agreements that are also outside the control of the agency*

Response from Public Works: We acknowledge on page 11 that collective bargaining agreements can affect the ability to develop flexible work arrangements. Regardless, negotiations regarding flexibility within the department should be coordinated at the executive level.

Additional Comment: *Discussion pertaining to flexibility fails to include risk assessments and potential cost of security violations the agency would need to consider in advocating for telecommunicating*

Response from Public Works: Security risks should be considered, but should not preclude efforts to increase opportunities for telecommuting.

2.3 Enhancing the Existing Documents (p. 17)
Additional Comment (p.17): *The decision to use incremental budgeting versus zero-based is outside the department.*

Response from Public Works: Phasing in a zero-based budgeting process would achieve an interconnected, enterprise-level budget. This effort would not replace the current budget process required for all departments, but would enhance that process.

A.3 Workforce Demographics (p. 27-28)
Additional Correction: *The Division of Juvenile Justice (DJJ) is not leading an inter-departmental work group as stated.*

Response from Public Works: Our information for this statement came from the DHSS 2014 Budget Overview, page 260.

B. Succession Planning (p. 29)
Additional Comments: *Succession planning typically focuses on senior or key positions in an organization. Its focus implies some degree of selection or choice in replacing key personnel and is reliant on the willingness of staff to move into more responsible positions. Encouraging movement into leadership position is often thwarted by impacts of shifting between bargaining units, loss of overtime eligibility, etc. Succession planning, especially in a unionized workforce is difficult to do, as it may confer a guarantee of a position.*

Response from Public Works: We acknowledge on page 33 that succession planning efforts should be consistent with collective bargaining agreements. Succession planning should never be used to usurp good hiring practices and should never imply a guaranteed position.

Additional Clarification Table 3-1: *Clarification is needed as to whether the percent of positions vacant is based on both permanent and non-permanent positions.*

Response from Public Works: The paragraph above Table 3.1 indicates that percentages are "of all authorized positions, including permanent, temporary and internships".

D. Division of Public Assistance Training (p. 35)
Additional Comments: 2nd paragraph- *A comprehensively, well-trained workforce generates fewer errors and creates fewer risks to performance expectations.*

Response from Public Works: We agree that training should be targeted based on an analysis of errors.

Additional Correction: 4th paragraph-*The aggression replacement program needs to be replaced as Aggression Replacement Training® (ART®).*

Response from Public Works: Public Works has referred to this as a generic program, not a specific, trademarked program.

3.2 Specific Efficiency Issues (p. 39-40)

Performance Evaluations

Additional Comments: *This discussion of performance evaluations does not consider the distinction between merit steps and pay increments. The statement that a performance evaluation must be completed before a merit raise is given is partially accurate. An evaluation must be completed prior to a pay increment being given, but a merit step is granted automatically, unless an unacceptable or low acceptable evaluation was completed prior to the merit step being granted. The number of evaluations that were considered past due are for pay increments only. We believe the data from Table 3-4 is based on the pay increment due report that was provided to Legislative Audit. This report shows overdue pay increment evaluations and upcoming pay increment evaluations that are due. It is used as a tool to inform supervisors of upcoming due dates and which pay increment evaluations are past due. There are thousands of performance evaluations completed in the department each year. We believe that the conclusion in the percent late column is inaccurate because it is not comparing late evaluations as a percentage of total evaluations processed. It is comparing upcoming pay increment evaluations with late evaluations, which does not create an accurate way to determine a percentage of late performance evaluations. This is not to say that late pay increment evaluations are not a problem, but the conclusion of percent late, is not accurate. Based on this incorrect analysis, the findings and recommendation may not be accurate.*

Additional Comments Findings and Table 3-4: *The analysis appears incomplete and inaccurate in that it fails to compare late evaluations as a percentage of total evaluations processed. The discussion also fails to consider the distinction between merit steps and pay increments. An evaluation must be completed prior to a pay increment but a merit step is granted automatically, unless an evaluation with the rating of unacceptable or low acceptable was completed prior to the merit step being granted. The department completes thousands of performance evaluations each year and they are not all specific to pay increments.*

Response from Public Works: The data provided to **Public Works** by DHSS and shown in Table 3-4 did not include the number of performance evaluations processed. If we had that data, we would also need to know how many of those already processed were completed on time and how many were completed after the due date. We believe the comparison in the report is valid – we are showing that as of April 1, 2015, 386 evaluations have due dates for completion by the end of FY 2015, of which 57 percent were already late. We edited the text and the table for further clarification prior to the final version of our report to which DHSS is responding, but the department repeated this comment from an earlier draft.

Site Visits (p. 46)

Additional Comments: *The functions of licensing and certification vary and have different standards and rules. SDS benefits from the current structure as it gives the division the ability to work closely and quickly with its own investigative and quality assurance resources to minimize compliance issues and report fraud. There are opportunities now to cross train to reduce travel expenditures without removing certification from SDS*.

Response from Public Works: We have reviewed DHSS' response and nothing contained in the response provided sufficient information to persuade us to revise or remove our finding or recommendation.

Mini Grants (p. 47)

Additional Comments: *The use of the "mini-grant" model of services delivery could be useful to expand service delivery in rural and remote areas of the state; however, consideration must be made for the cost of this service delivery model so that funds are not diverted from direct services to pay additional fees for administration.*

Response from Public Works: The concern expressed by DHSS for administrative costs diverting funds from direct services could be addressed by incorporating terms into grant agreements that limit total project administration costs to no more than the administrative costs that would have been charged by multiple smaller grant recipients. We urge DHSS to consider doing so. This approach can cultivate the increase and improvement of smaller providers and can bring direct services to parts of the state that would have none otherwise.

Federal Reimbursement for Foster Care (p. 52-55, p. 148)

Additional Comments (p.52): *The national downward trend in penetration rates since 2002 may be attributed to changes in the federal title IVE regulations and policies, in addition to still relying on the former Aid for Dependent Families (AFDC) income and resource criteria in place in the previous state plan of 1996.*

Response from Public Works: Public Works understands that eligibility is based on former AFDC income criteria, and we have noted that growing parental income is a concern in the declining rates.

Additional Comments (p. 53): *While best practices and safety are of first consideration, there are fiscal ramifications of removing emergency licenses because currently if the relative caretaker has been issued an emergency license and is in the process of becoming licensed for a child that is potentially IVE eligible, the state can claim the associated administrative costs through the IVE administrative penetration rate for 272 days (approximately 3 quarters). Currently the maintenance portion of the Title IVE foster care claim only makes up approximately 20% of the IVE quarterly claim. Since the IVE administrative penetration rate is heavily relied upon for direct and indirect reimbursement by the largest cost centers, including*

the front line social worker component and management, any reduction to the numerator may adversely impact federal participation.

Response from Public Works: The first paragraph on page 54 of the report contains a statement that OCS is developing a process to replace emergency licenses, which is information that was provided by DHSS. We believe that there will be a positive fiscal impact as a result of implementing this recommendation.

Additional Comments (p. 54): *Child Trends is an association and calculates the IV-E maintenance penetration rate, while the state relies on an administrative IV-E penetration rate defined in the US DHHS ACF Child Welfare Manual (8.1.C #8) and in the department's federally approved public assistance cost allocation plan. The administrative IV-E penetration rate is always higher by several percentage points because it currently includes clients who are IV-E eligible for administrative costs but for whom the state has opted to accept a higher rate of social security benefits instead of IV-E maintenance and for IV-E eligible clients placed with relatives in the process of becoming fully licensed. Increasing the number of fully licensed relative placements will benefit both the IV-E maintenance and IV-E administrative penetration rates. However, the IV-E administrative rate will always be higher due to the IV-E eligible clients for whom the state does not claim IV-E maintenance. Additionally, other sources do exist that provide Title IV-E comparative data, such as Casey Family Program.*

Response from Public Works: Child Trends provides a source of comparative data across all 50 states. While we note in our report that the methodology used by Child Trends is different from that used by DHSS, DHSS has not indicated that the Child Trends data is inaccurate.

Additional Comments (p. 54): *The maintenance penetration rate and administrative penetration rates shown do not match actual statistics. Also, the explanation of the difference between the two rates is inaccurate. Actual numbers are as shown in the following table:*

	Average Maintenance Penetration Rate	Average Administration Penetration Rate
FFY 2008	28.50%	47.75%
FFY 2012	38.50%	50.28%

OCS provides definitions as shown below:
Maintenance penetration rate: *The percentage of Title IV-E children placed in a fully licensed home and eligible for IV-E maintenance (i.e. room/board) reimbursement at 50%.*

Administrative penetration rate: *The children in the maintenance penetration rate* ***PLUS*** *children placed with a relative in a licensed home that does not meet Title IVE requirements (not to exceed 272 days).*

Response from Public Works: The maintenance figures provided in the table in the DHSS comment are the same as the numbers we used in the report. We do not refer to 2008 or 2012 administrative figures, we used 2015. Our definitions of the rates are the same as DHSS. Footnote 49 reflects the concern identified by DHSS.

Correction Needed - Footnote #49 (p.148): *The first sentence is inaccurate. There is no Title IV-E reimbursement for either maintenance or administrative expenditures associated with unlicensed foster homes. This sentence should read: "…but are placed in a licensed home that does not meet title IVE requirements, the state is only reimbursed for 50 percent of the administrative component of the Title IV-E rate".* This is different from "unlicensed", as DHSS does not pay unlicensed homes.

Response from Public Works: The final version of our report, to which DHSS is responding, included a modification to Footnote #49 that we believe addresses this concern by DHSS. The department has repeated this comment from an earlier draft.

Medicaid Administration and Structure (p. 63-69)

Additional Comment: Chart 3-1: *It would be helpful to add Arizona as it will add consistency and a comparison when talking about the cost per resident of the Pioneer Homes on page 146.*

Response from Public Works: Chart 3-1 relates to Medicaid spending. We do not see how that is related to the Pioneer Homes.

Additional Comment (p. 63) *It would be helpful to add the cost of Medicare to provide those services also to show that Medicare also pays more in Alaska for those services.*

Response from Public Works: Chart 3-3 shows the relationship between Medicaid and Medicare payments.

Additional Comment (p. 63) *DHSS continues to be concerned that a "managed care" solution is recommended in a state where we do not have a sufficient number of people to make this work. The basic model is to spread the high costs of a small portion of covered lives over the less expensive majority. Therein lays the opportunity of covering the medical needs at a lower cost. From the perspective of behavioral health this is particularly risky with our Medicaid population.*

Response from Public Works: Many states have implemented managed care in rural areas. While this may not be appropriate in Alaska given its unique geography, Recommendation 3.3.A.2 suggests creating a pilot project in the Anchorage area.

Objective 4: Boards and Commissions (p. 82)
Additional Comment Table 4-2: *This table contains a conclusion that the Alaska Pioneer Home Advisory Board meets only one criteria utilized by the reviewer for their analysis. The reviewer appears to undervalue the Pioneer Home Advisory Board by not acknowledging that public/stakeholder feedback given to the board and its members are both (1) relevant and (2) related to health & safety within the homes. While highlighting the travel budget of the board, the report fails to include its impact.*

Response from Public Works: The board's statutory purpose duplicates the work of professional staff within FMS.

Demands on the ITG Committee (p. 103)

Additional Clarification: *The State HIT Coordinator and the IT Planning Office Director are one and not two positions, as stated in the report. The title State Health Information Technology Coordinator was developed by a federal agency, Office of the National Coordinator, as a result of ARRA.*

Response from Public Works: The report states, "One person serves three roles in the ITG process: as the IT Planning Office Director, member of the PPMR team, and as the State HIT Coordinator." We do not state that there are two positions.

Video Conferencing Technology (p. 104-107)
Additional Comments: *DHSS has the additional requirements of complying with HIPAA. Organizations that would otherwise not be required to comply with HIPAA must comply in Alaska because they are part of a single covered entity (HSS). Comparing HSS with organizations that may or may not be exempt from HIPAA is comparing apples to oranges. HIPAA compliant solutions are available, but they tend to be more expensive than free solutions such as Skype.*

Response from Public Works: The discussion in the report provides suggestions for how video conferencing can be used, not as an endorsement of any specific solution. The appropriateness of specific video conferencing software, including Skype, would need to be analyzed by the department. In any event, video conferencing should be explored and utilized wherever appropriate, to achieve greater efficiency and savings.

Additional Comment (p. 111): *The finding seems to be inaccurate, for removable storage risk. DHSS has excellent tools and processes in place to encrypt our removable storage and limit social media to the minimum necessary, and exceptions are carefully reviewed through a waiver request, and only approved when the justification and agreements are signed. Centralized, recurring and required training in IT policies and secure computing practices are absolutely necessary to minimize misinformation and misunderstanding of department's policies and procedures. The challenge is in being resourced so we can provide targeted, role-based training.*

Response from Public Works: Our finding and recommendation is more about educating users on why there are restrictions, not that the DHSS IT division is failing to do something it should be doing. One of our findings is that users continue to ask for waivers, which may be less of a resource challenge and more about educating users and their managers.

Objective 8: Evaluate Budget Reductions (p. 119)
Additional Comment: *The value of such retroactive assessment and judgment, when the proposed budget actions have long come and gone, is questionable. The reviewer both criticized DHSS for not submitting data timely and not identifying the requested 10% UGF reduction, and at the same time judging our smaller 3.7% UGF reduction as likely to impact our ability to serve vulnerable Alaskans. This may point out the obvious – that DHSS did not have 10% of excess UGF that we could eliminate without repercussion to our clients and achievement of our mission. Staff reductions stress those employees remaining onboard through increased workload, and cutting needed benefits hurts our priority populations. A number of the UGF reductions in turn caused a multifold reduction in DHSS's ability to draw down federal revenues.*

Response from Public Works: This assessment was a requirement of the performance review and mandated by the legislature. **Public Works** was required to assess the proposed budget actions in terms of whether they met legislative requirement for timeliness and scale, as well as whether they were supported by our review. Our review found that the department chose to suggest small cuts broadly instead of proposing more strategic cuts that may have enabled it to meet the 10 percent reduction required under statute.

Table 8-2 (p. 122-124): Titled Additional Reductions and Revenue Enhancement Measures Identified During the Performance Review
Additional Comment: *The report needs to provide additional information as to how it determined the reported cost savings. Some of the numbers do not appear realistic, such as those for the division of Alaska Pioneer Homes and will require additional analysis by the department prior to being able to provide comments.*

Response from Public Works: Table 8-2 is a table summarizing the results of the review. We do not recapitulate our analysis in this section of the report. For information on how the cost savings were determined, please see the body of the report.

In summary, we reaffirm the findings and recommendations presented in this report.

Eric B. Schnurer,
President

ATTACHMENT D: GLOSSARY OF ABBREVIATIONS

GLOSSARY OF ABBREVIATIONS

ACA	Affordable Care Act
ACE	Adverse Childhood Experience
ACO	Accountable Care Organization
AECCC	Alaska Early Childhood Coordinating Council
AFF	Alignment Framework Form
AJJAC	Alaska Juvenile Justice Advisory Committee
AKSAS	Alaska State Accounting System
ALI	Alaskans Living Independently
APH	Alaska Pioneer Homes
API	Alaska Psychiatric Institute
APS	Adult Protective Services
ASPHL	Alaska State Public Health Laboratories
ATAC	Alaska Telehealth Advisory Council
CAP	Corrective Action Plan
CCPO	Child Care Program Office
CMS	Centers for Medicare and Medicaid Services
CPI	Consumer Price Index
CQI	Continuous Quality Improvement
CWLA	Child Welfare League of America
DBH	Division of Behavioral Health
DEED	Department of Education and Early Development
DHSS	Alaska Department of Health and Social Services
DJJ	Division of Juvenile Justice
DOA	Alaska Department of Administration
DOC	Alaska Department of Corrections
DOT&PF	Alaska Department of Transportation and Public Facilities
DPA	Division of Public Assistance
DPH	Division of Public Health
DSM	Direct Service Messaging
EFS	Electronic Financial Services
EHR	Electronic Health Record
EIS	Eligibility Information System
ePHI	Electronic Protected Health Information
ETS	Division of Enterprise Technology Services
FFP	Federal Financial Participation

FFS	Fee-For-Service
FMS	Finance and Management Services
FPL	Federal Poverty Level
FTE	Full-time Equivalent
GASB	Government Accounting Standards Board
GEMS	Grants Electronic Management System
GFOA	Government Finance Officers Association
HCS	Division of Health Care Services
NCSD	National Coalition of STD Directors
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
ILP	Infant Learning Program
IT	Information Technology
ITG	Information Technology Governance
ITS	Information Technology Services
JPO	Juvenile Probation Officer
LBAC	Alaska Legislative Budget and Audit Committee
MMIS	Medicaid Management Information System
MyIR	My Immunization Record
NACCHO	National Association of County and City Health Officials
NACSLB	National Advisory Council on State and Local Budgeting
NAPT	Native American Pass Through
NCQA	National Committee for Quality Assurance
NSLP	National School Lunch Program
OCR	Office of Civil Rights, U.S. Department of Health and Human Services
OCS	Office of Children's Services
OIT	Office of Information Technology
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OSPHL	Oregon State Public Health Laboratory
PIP	Performance Improvement Plan
PMI	Project Management Institute
PMO	Project Management Office
PPMR	Project and Portfolio Management Review
PCI DSS	Payment Card Industry Data Security Standard
PSR	Protective Service Report
QARC	Quality Assessment Review Committee
RA	Resolution Agreement

RAS	Roadmap Alignment Score
RBA	Results-Based Alignment
RPMS	Resource and Patient Management System
RurAL CAP	Rural Alaska Community Action Program
RWJF	Robert Wood Johnson Foundation
SBP	School Breakfast Program
SDS	Division of Senior and Disabilities Services
SOPHN	Section of Public Health Nursing
HIT	Health Information Technology
SURS	Surveillance and Utilization Review Subsystem
VC	Video Conferencing
WIA	Workforce Investment Act