Recommendations for the Alaska Medical Care Advisory Committee

Telehealth/Remote Patient Monitoring

Issue:	Remote Patient Monitoring is an innovative telehealth technology that could improve care and clinical outcomes for Medicaid patients while enabling more efficient and cost-effective service delivery, but this service is not reimbursable under the Alaska Medicaid Program.
Summary of Issue and Background:	Remote Patient Monitoring (RPM) extends care to the patient in their home through electronic transmission of biometric data so a physician can monitor their condition daily. RPM has been used by certain providers in Alaska to monitor COVID-19 patients at home, and in a pilot project for certain Medicare patients. Patients with a diagnosis of heart failure are likely to benefit clinically from RPM due to the intensive need for clinical monitoring of their condition after hospitalization and to titrate medications in the outpatient setting. These patients have a high rate of hospitalization, with as many as 30% hospitalized each year, and rehospitalizations are common. They are sometimes discharged before they are clinically back to their baseline, requiring additional treatment and clinical monitoring. Research indicates that many heart failure patients do best when they are administered Guideline Directed Medical Therapy (GDMT), which is a medication regimen of as many as four different drugs. GDMT medications must be carefully titrated based on the patient's symptoms and vital signs to achieve the maximum-tolerated dosages to improve symptoms and reduce the need for hospitalization.[1] Because these patients must be closely monitored to optimize their medication, a periodic office visit is not sufficient to monitor the patient's condition regularly enough to keep them safe. Heart disease, including heart failure, is the second leading cause of death in Alaska and contributes significantly to the need for inpatient and outpatient hospital treatment. In 2016 the Alaska Medicaid program paid more than $300 million for services for the 9,527 Medicaid beneficiaries diagnosed with heart disease (either alone or co-occurring with other conditions), or an average of more than $34,000 per patient.[2]
Recommendation for action for DOH	Implement a pilot project for Medicaid patients diagnosed with heart failure who are not optimized on a medication regimen to demonstrate the effectiveness of RPM for improving clinical outcomes for Medicaid patients and reducing Medicaid costs.

[1] https://heart.bmj.com/content/107/5/366

[2] https://dhss.alaska.gov/dph/Chronic/Documents/Cardiovascular/pubs/2019HDSP_BurdenReport.pdf ; Note this data applies more generally to Medicaid patients with heart disease, of which heart failure is a part, but this was the only related publicly available data we could find.

Lack of Complex Post-Acute Care Options

Issue:	Alaskans stranded in acute settings waiting for a safe discharge (lack of complex post-acute care capabilities in Alaska).
Summary of Issue and Background:	Alaska's post-acute care continuum has multiple gaps in care options available, disproportionately impacting Alaskans experiencing disabilities. Several key patient populations impacted include (not limited to) Alaskans with: • Complex wounds • Chronic tracheostomies with deep suctioning needs • Ventilator-dependent airway management needs • Complex neurological debilities • Long-term antibiotic needs • Dementia needs • Dialysis needs For some of these Alaskans experiencing disabilities, they can face months, and sometimes years, stranded in an acute setting. They are separated from their families and communities and limited in their ability to lead full lives despite their disabilities. These Alaskans experiencing disabilities lack the regulatory supports Alaskans benefit from in a lower level of care setting that cultivates a home-like surrounding. Some Alaskans end up making the difficult choice to leave Alaska to seek more appropriate care in a lower-level setting in the lower 48, giving up their family support network, friends and community to be able to move out of the higher acuity setting. In other parts of the country with more robust post-acute care offerings, these Alaskans can often be cared for at a lower level of care (post-acute SNF, ALF, and often with home services in the community). In Alaska, it is common to have acute care facilities with anywhere from 20-40% of acute beds utilized by Alaskans waiting for a safe discharge option that may never come. These acute care providers receive little, if any, reimbursement to provide care while awaiting a safe discharge option that doesn't exist in Alaska. The uncompensated care represents tens of millions of dollars each year [3]. As Alaska's healthcare capacity is utilized by Alaskans that no longer have an acute need and are waiting for a safe discharge, Alaskans form long lines in emergency departments waiting sometimes for days for placement in an acute bed. Critical surgeries and procedures are not performed, and care needs go unmet. In discussion with post-acute care leaders, there are a multitude of challenges and barriers to increasing complexity of post-acute care options provided. Foremost is the lack of innovation in payment models. Additionally, the burden created by the CMS rule of 5 as implemented in Alaska creates a disincentive to innovatively look at increasing the complexity of patients served, along with other regulatory challenges. Coming together as a healthcare community to better understand these continuum gaps would afford an opportunity to honor the dignity of Alaskans experiencing disabilities and their needs and rights to be cared for in less institutionalized settings

[3] AK DHSS Annual Medicaid Reform Report 2021, Page 40-41

	closer to family, friends and community. Additionally, helping to support Alaskans receiving the right care in the right setting, increases healthcare capacity and access in Alaska.
Recommendation for action for DOH	Form a group to partner with key stakeholders to understand the Alaskans stranded in acute settings waiting for safe discharge options, that often do not exist. Study the impacted Alaskans' needs, the options available in the community, and formulate recommendations for how to support potential solutions to increase post-acute capacity in Alaska. • Consider innovative payment models to incentivize increasing access to higher acuity post-acute care options in Alaska. For example, Medi-Cal has a special rate / model to support higher complexity post-acute patients. • Consider disproportionately burdensome regulatory challenges for Alaska post-acute care providers and potential advocacy options to improve access to care.

Behavioral Health Recommendation

Issue:	Alaskans unable to access a full continuum of behavioral health services. (Medicaid gaps in service reimbursement limit behavioral health continuum).
Summary of Issue and Background:	Behavioral health services are a critical part of the health continuum, as well as the overall economy in Alaska. Needs for services have risen during COVID-19. A behavioral health continuum must include a full range of services, available in both urban and rural settings, for a diversity of ages and needs, paid at rates that correspond with cost of doing business to ensure sustainability of services and access. Absence of a full behavioral health continuum include such consequences as decreased quality of life, homelessness, unnecessary institutionalization, criminalization of mental illness, suicide, substance use and related consequences, increased morbidity and mortality rates, and other poor health outcomes. The State of Alaska has not adequately funded a continuum of services in community-based settings, resulting in a fragmented and stressed system and overuse of acute and emergency care. There are known gaps in Medicaid coverage for behavioral health services, which limits Alaskan's access to these services. The lack of coordinated care, data management, and investment in system restoration limits Alaskan's access to these services. The results of limited or delayed access can be devastating to families and individuals.
Recommendation for action for DOH	1) **Form a behavioral health workgroup.** Form a working group under the direction of MCAC focused on behavioral health. This group would represent a diversity of behavioral health service providers in Alaska including urban, rural, tribal, non-tribal, mental health and substance use disorder, outpatient and facility-based, as well as both children and adult services. This group would be staffed by DHSS leadership including Medicaid leaders and develop and prioritize specific recommendations for Alaska's behavioral health Medicaid program. Through input from service providers and community members, this workgroup could (though not limited to) 1) identify necessary behavioral services that are not currently adequately supported by Medicaid (and are currently funded by service providers, philanthropy, and/or grants) 2) prioritize changes to Medicaid that begin to address recommendations around adding necessary services and/or recommended changes to existing services. 2) **Review contract with ASO (Optum) and create a shared plan for 35% reduction in administrative burden.** Excessive administrative burden is a costly loss to the behavioral health system, exacerbating workforce shortage issues, and reducing service provider time spent in active service delivery. Recommendation is to demonstrate through a shared plan how the contractual obligations for a 35% reduction in administrative burden will be accomplished.

Podiatry Recommendation

Issue:	The current Medicaid system does not include podiatric physicians in treatment of adult enrollees. Podiatric physicians offer not only limb and life sustaining specialty care for foot and ankle trauma and disease, but also provide that treatment in the most cost-effective manner. The addition of podiatric physicians into the adult Medicaid system will benefit Alaska including its finances, the Medicaid program, referring physicians who have expressed their desire for podiatrist participation and availability. More importantly podiatry participation in Medicaid will be of most benefit to the individual enrollees who currently do not have access to this especially important care
Summary of Issue and Background:	Podiatric physicians are an integral and an integrated part of the medical community in Alaska. Podiatrists are one of the three doctor level medical providers licensed by the State Medical Board. Podiatrists are active medical staff at hospitals and ambulatory surgery centers. Podiatrists have surgical privileges at hospitals and ambulatory surgical centers. Podiatrists are fully licensed with the DEA including the prescribing of controlled substances. Podiatrists participate in Medicare, Tricare, VA, Workers' comp, all private insurers (BCBS, Aetna, UHC, etc.) as well as Medicaid for enrollees below the age of twenty-one. Alaska is one of only 4 states that does not allow podiatry participation for adult Medicaid enrollees. (Alaska, Alabama, Kansas, Wyoming) Access to podiatry in the Medicaid population has demonstrated cost savings to the system in multiple states. Alaskan physicians from a full spectrum of specialties have expressed their desire that their adult Medicaid recipients have access to podiatry for outpatient and inpatient care. For further background detail please refer to the educational summary document.
Recommendation for action for DOH	Proposal to accomplish needed change in Alaska and allow adult Medicaid recipients unfettered access to podiatric specialty care: 1: Adopt language within the Alaska Medicaid regulations that place podiatry within the same category of fully covered provider as physician and osteopath consistent with state medical board licensing of providers – i.e., practice "medicine, podiatry, or osteopathy. See example below; 7 AAC 110.400. Physician services provider enrollment requirements (a) To be eligible for payment under 7 AAC 105 - 7 AAC 160 for providing physician services, the provider must (1) be enrolled as a physician in accordance with 7 AAC 105.210; and (2) have an active license to practice medicine, *podiatry* or osteopathy issued by the jurisdiction in which the physician provides services; if services are provided in this state the individual must hold an active license under AS 08.64. 2: Remove from the Medicaid statutes any language that would restrict Medicaid enrollee access to podiatrists based on age, condition, or place of service etc. – i.e., "7 AAC 110.505 - Podiatry services"