AK DHSS Annual Medicaid Reform Report

FY2019

Alaska Statute 47.05.270 requires the Department of Health & Social Services to submit an Annual Report to the Legislature by November 15 of each year on the status of reforms enacted by that statute.

In compliance with Alaska Statute 47.05.270

Adam Crum
Commissioner
Department of Health & Social Services

FY 2019 Annual Medicaid Reform Report

I. EXECUTIVE SUMMARY

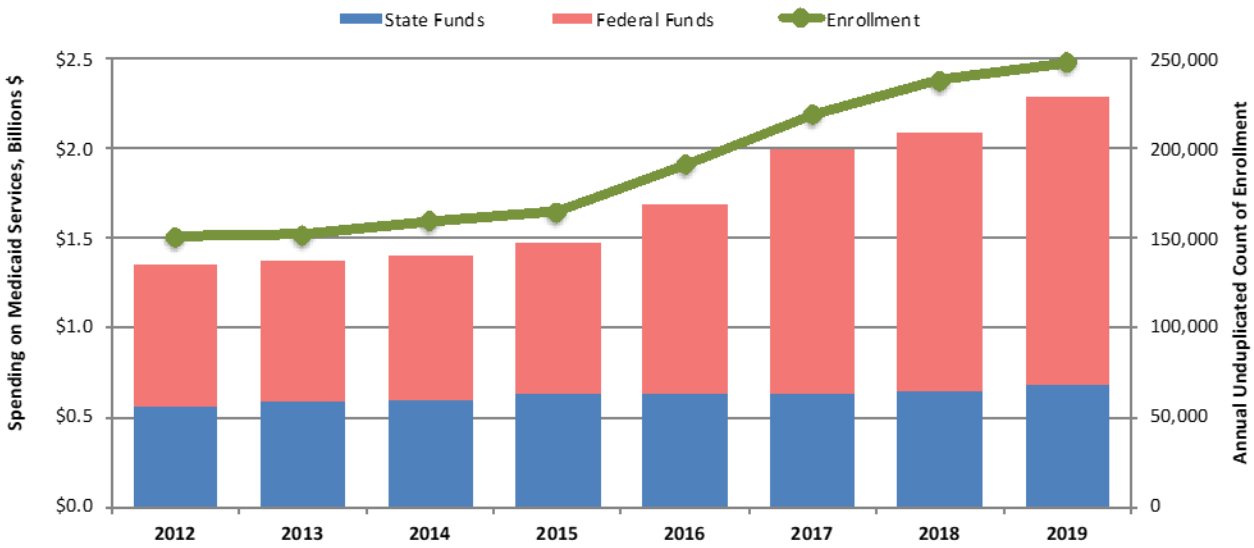
The Medical Assistance Reform Program was established under AS 47.05.270 by Senate Bill 74 (SB 74) in 2016. Under this statute, the Department of Health & Social Services (DHSS) is required to submit an annual report to the Legislature by November 15 of each year on the status and results of Medicaid reform activities.

This report identifies $166 million in State General Fund savings and cost avoidance that were achieved in FY 2019. Some of these savings are actual reductions in spending for a State service compared to prior year spending or are estimates of costs that would have been incurred had the described initiative not been implemented. Other savings are actual returns to the budget in the form of reimbursement from the federal government or providers. The following table presents a summary of the State General Fund savings and avoided costs identified throughout the report. These savings were all factored into the current year budget and into short-term (3-year) future spending projections.

FY 2019 General Fund Savings and Cost Avoidance Resulting from Medicaid Reforms and Cost Containment Initiatives	
SB 74 Medicaid Reform GF Savings/Cost Avoidance — DHSS	
Federal Tribal Reimbursement Policy	$ 72,647,136
Alaska Medicaid Coordinated Care Initiative (Primary Care Case Management)	$ 1,605,000
Subtotal	**$ 74,252,136**
SB 74 Medicaid Reform GF Cost Avoidance — DOC	
Medicaid enrollment for prisoners; out-of-facility hospital services	$ 2,241,160
GF Savings/Cost Avoidance from Other Medicaid Reforms — DHSS	
Pharmacy Preferred Drug List	$ 5,700,000
Pharmacy Prospective Drug Utilization Reviews	$ 12,000,000
Pharmacy Payment Reform: NADAC Implementation	$ 12,250,000
Opioid Utilization Decrease	$ 335,000
Tribal Health System Partnerships	$ 25,300,000
Subtotal	**$ 55,585,000**
GF Savings/Cost Avoidance from On-Going Care Improvement/Cost Containment Initiatives — DHSS	
Home & Community Based Services Utilization Control & Process Improvement	$ 6,466,225
Surveillance & Utilization Review Subsystem (SURS) Overpayment Collections	$ 275,882
Medicaid Program Integrity Overpayment Collected from Providers	$ 8,766,106
Medicaid Program Integrity Cost Avoidance	$ 1,402,000
Third-Party Liability Contract and HMS Audit Recovery	$ 8,896,765
Care Management Program	$ 785,400
Case Management	$ 633,842
Utilization Management Services	$ 6,706,095
Subtotal	**$ 33,932,315**
TOTAL	**$166,010,611**

For context, it is helpful to understand how enrollment and spending have changed in recent years. The following graph from the recent update to the Medicaid long-term forecast published in September[1] illustrates how enrollment has grown over the past four years due to Alaska's economic recession and to Medicaid expansion. Total spending has grown at the same time, but with the help of the reforms enacted by the Legislature, DHSS has been able to hold State General Fund spending flat.

Medicaid Enrollment & Spending in Alaska
2012 – 2019 Date of Service Actuals

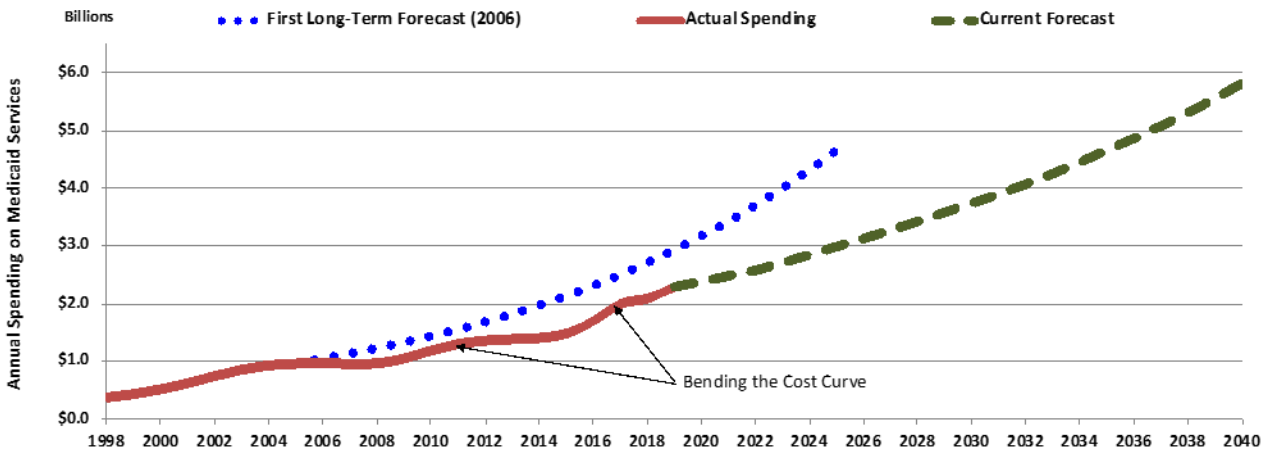


[1] Evergreen Economics. (November, 2019). Long Term Forecast of Medicaid Enrollment & Spending in Alaska ("MESA"): FY 2020 – FY 2040.

The reforms instituted by the Legislature through SB 74 and other cost saving efforts by DHSS have also helped to hold Medicaid spending *per enrollee* flat. The graph below, also from the long-term forecast, depicts how the per-enrollee cost curve has turned down and has held steady, well below the original forecast. It also shows how turning the cost curve can contribute to much slower growth rates and increased savings well into the future.

[1] Evergreen Economics. (November, 2019). Long Term Forecast of Medicaid Enrollment & Spending in Alaska ("MESA"): FY 2020 – FY2040.
http://dhss.alaska.gov/fms/Documents/AK%20LongTermMedicaidFcast_MESA%20FY2019%20to%20FY2039.pdf

Total Medicaid Spending per Enrollee (all fund sources)
1998 – 2019 Actuals and 2020 – 2040 Projected



[1] Evergreen Economics. (November, 2019). Long Term Forecast of Medicaid Enrollment & Spending in Alaska ("MESA"): FY 2020 – FY 2040.

The following is a brief summary of FY 2019 Medicaid reform activities and accomplishments. More details for each are provided later in the report.

Explanation of Benefits: Electronic explanations of medical benefits (EOMBs) were available to adult Medicaid recipients via computer and smart phone from October 2018 to August 2019. During this time approximately 3,500 adult recipients accessed the portal to review claims. Based on the low participation rates and significant contract expense, electronic distribution of EOMBs were paused until a more cost effective delivery mechanism can be identified.

Telehealth: Medicaid expenditures for services delivered via telehealth increased 55 percent since FY 2016. The top diagnoses/conditions treated via telehealth in FY 2019 were behavioral health, followed by injuries and poisoning and ear infections.

Fraud, Waste & Abuse: During FY 2019 Medicaid Program Integrity (MPI) recovered $8.7 million in overpayments paid to providers and 10 payment suspensions were initiated based on credible allegation of fraud determinations. MPI also partnered with the Healthcare Fraud Prevention Partnership (HFFP), a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations in order to exchange data, leverage the various tools used by partners and exchange information to more effectively detect and prevent healthcare fraud. Overall Medicaid Program Integrity saved the Medicaid program $10 million for a total return on investment of $11.27 per dollar spent.

Home & Community-Based Services (Long-Term Services and Supports Reforms): Home and Community-Based Services (HCBS) help people to remain in their home or community when their level of need would otherwise be provided in an institution. HCBS services include 1915(c) waiver services, 1915(k) State Plan Community First Choices (CFC), and personal care services. DHSS continued efforts to improve utilization controls and address fraud and abuse in the provision of waiver and personal care services. As a result of these actions, there was a reduction of 4.2 percent in total spending for waiver

services and a 14 percent reduction in total spending for personal care services. The overall savings to the State General Fund spending was $10 million.

Pharmacy Initiatives: Over the past two years, negotiated pricing and utilization management within the pharmacy program contributed to an overall decrease of 0.5 percent in final net program cost per prescription, despite a 0.9 percent overall increase in pharmacy reimbursement per prescription due to increasing drug acquisition costs. The opioid crisis continues to place a strain on state resources; however, the Alaska Medicaid Drug Utilization Review (DUR) program has been active in addressing the epidemic in a variety of ways including utilizing quantity limits, implementing a Medication Assisted Therapy Standards of Care program to promote evidence-based prescribing practices, and continuing to employ safety edits that alert pharmacists when patients have filled three or more naloxone prescriptions annually.

Enhanced Care Management: Current programs are expanding and additional initiatives under SB 74 are under development to continue to enhance care coordination and case management. There was a total of $3 million in State General Fund/cost avoidance savings due to current care management programs including case management with Comagine Health, DHSS's Care Management Program (CMP) and Alaska Medicaid Coordinated Care Initiative (AMCCI) also known as the "super-utilizer" initiative.

Redesigning the Payment Process: Payment reform continues for pharmacy and also further development of the demonstration projects authorized under behavioral health system reforms (including the Section 1115 Demonstration waiver) and the Coordinated Care Project.

Quality & Cost Effectiveness Targets: DHSS is able to report second-year Medicaid program performance on the measures and targets established by the Quality & Cost Effectiveness Targets Stakeholder Workgroup. Results of the second-year performance baseline for services, delivered during state FY 2018, demonstrate that the program met or exceeded annual performance targets for five measures, partially met targets for three measures, is monitoring numbers for one measure, and failed to meet targets for the remaining eight measures.

Travel Costs: Total travel expenditures increased 28 percent from FY 2018 to FY 2019, the overall increase aligning with enrollment growth in the Medicaid Program. However, only 4 percent of the increase is attributed to General Fund spending. The Medicaid program continued to contain costs through a variety of initiatives such as continued efforts to increase Tribal claiming, employee training to support contracting for non-emergency travel, and project planning to develop a tracking database.

Disease Prevention & Wellness: DHSS continues to move towards updating Medicaid coverage policies to ensure efficient delivery and availability as well as ensure wellness and preventive services are evidence-based. DHSS participated in the Medicaid Innovation Accelerator Program (IAP) for State Medicaid Housing Agency Partnerships. Alaska's top accomplishments under the IAP included developing a cross-agency team that completed a review of current services and housing resources and is aimed at implementing the formal Alaska State Plan for Permanent Supportive Housing.

Behavioral Health System Reform: DHSS applied for a Section 1115 Demonstration waiver with the Centers for Medicare and Medicaid Services (CMS) to establish a network of behavioral health services at the community and regional level to reduce the need for crisis-driven and urban-based emergency, acute, and residential care in Alaska. In November 2018, DHSS received approval from CMS for the Substance Use Disorder (SUD) component of the 1115 waiver. The Behavioral Health portion of the 1115 waiver was approved in September 2019. The Substance Use Disorder (SUD) portion of the waiver is currently being implemented and the Behavioral Health portion will be implemented in FY 2020. In

October 2019, DHSS entered into a contract with an Administrative Services Organization (ASO) to administer the waiver benefits, services, and claims processing.

Emergency Care Improvement: Real-time electronic exchange of patient information among hospital Emergency Departments (ED) is now live in 14 hospitals. Uniform statewide guidelines for prescribing narcotics in an ED have been in place for three years and are helping to combat the opioid epidemic.

Coordinated Care Demonstration Project: Negotiations with Coordinated Care Demonstration Project offerors began in FY 2018, and two Notices of Intent to Award were released. A contract was awarded to Providence Family Medicine Center to demonstrate a patient-centered medical home model in the Anchorage area, and that project went live September 1, 2018.

Health Information Infrastructure Plan: DHSS is using the Health Information Infrastructure Plan to support care coordination and quality improvement efforts through information technology. These plans include a Health Information Exchange (HIE) platform modernization and enhancement, a document management system for DHSS, electronic health record adoption, and testing and quality assurance services.

Tribal Medicaid Reimbursement Policy: DHSS's Tribal Health Unit tracked 1,713 Coordinated Care Agreements (CCAs) between Tribal and non-Tribal providers and saw a total of 31,952 referral requests in FY 2019. DHSS was able to save $72 million in State General Funds in FY 2019 and a total of $152 million in State General Funds from February 2016 through the end of FY 2019.

State GF Savings from Implementation of the Tribal Medicaid Reimbursement Policy

State Fiscal Year	State GF Savings: Transportation	State GF Savings: Other Services	Total GF Savings
2017	$ 10,589,538	$ 24,192,302	**$ 34,781,839**
2018	$ 28,863,462	$ 15,901,959	**$ 44,765,420**
2019	$ 45,724,251	$ 26,922,884	**$ 72,647,136**
TOTALS	**$ 85,177,251**	**$ 67,017,145**	**$ 152,194,395**

II. Responses to AS 47.05.270(d) Reporting Requirements

A. Status & Realized Cost Savings Related to Reforms

This part of the report (II.A) responds to the reporting requirements specified in AS 47.05.270(d)(1), related to realized cost savings from reforms required under AS 47.05.270. Information on project status is provided, in addition to realized cost savings and cost avoidance for those projects for which cost data is available.

1) Referrals to Community and Social Support Services

AS 47.05.270(a)(1): Referrals to community and social support services, including career and education training services available through DHSS of Labor and Workforce Development under AS 23.15, the University of Alaska, or other sources.

The Division of Public Assistance (DPA) currently provides case management services and access to support that promote employment and self-sufficiency for families in the Alaska Temporary Assistance Program (ATAP). ATAP recipients complete a Family Self-Sufficiency Plan that includes specific goals, tasks, and deadlines. Tasks and supports may include, but are not limited to: identifying child care, help with job searches, short-term training leading to employment, and removal of medical or psychological barriers. The division leverages community services at no or low cost to the recipient to ensure basic needs are met and supports are in place for upward mobility.

Similar services have been developed for Anchorage residents receiving Supplemental Nutrition Assistance Program (SNAP) benefits. DPA has entered into agreements with four non-profit agencies in the Anchorage area. Ongoing discussions are underway with a Career and Technical College that offers a pathway for statewide expansion through the University system. In addition, DPA will continue to meet and develop an agreement with a large regional Tribal Entity identified as a major provider and coordinator of vocational training services for Alaska Natives in its geographic region. This partnership would potentially offer a model for statewide expansion with other Tribal entities through its proposed innovative use of 477 program funds. These agencies assist SNAP recipients with job search and retention, English as a second language instruction, supportive services, and vocational training. The agreements are funded through the SNAP Employment & Training Program. Related expenses are met at no cost to the state. Each agency agrees to provide the services to SNAP recipients and receives a reimbursement of 50 percent from the Food & Nutrition Service of the U.S. Department of Agriculture. During state FY 2019, 2,528 participants were provided services with an increase estimated in state FY 2020.

DPA will continue exploring an agreement with Department of Labor & Workforce Development (DOLWD) to participate as a provider through their State Training and Employment Program (STEP), which is funded by a set-aside from the Unemployment Insurance Trust Fund. The purpose of STEP is to make Alaska job training and employment assistance easily available to employers, employees, and future workers. DPA's Employment & Training program will provide 50 percent federal pass-through reimbursement to DOLWD for the allowable costs incurred by the STEP program in providing job training services to individuals.

2) Explanation of Benefits

AS 47.05.270(a)(2): Electronic distribution of an explanation of medical assistance benefits to recipients for health care services received under the program.

Electronic explanations of medical benefits (EOMBs) were available to adult Medicaid recipients between October 2018 and August 2019. During these dates approximately 3,500 adult recipients accessed the EOMB portal to review claims paid on their behalf. The utilization rate for EOMB functionality in the adult population was less than six percent of the 85,000 adult members eligible to utilize this service. However, EOMBs were produced for all adult members each month at a significant contract expense ($1.30 per member, per month).

Of the 3,500 members that reviewed EOMBs, there were a small number of issues reported to the division regarding potentially improper payments for services rendered. The division continues to evaluate each report of improper payment and at this time less than 50 percent of issues reported appear to have merit. Provider training, policy clarifications, and member education have been the primary outcome for the reported issues. As investigations into these reports progress, routine collaboration with Medicaid Program Integrity and the Medicaid Fraud Control Unit will occur.

Based on the low participation rates and contract expenses that far exceeded the overpayments identified, electronic distribution of EOMBs was paused until a more cost-efficient delivery mechanism is completed. The division expects to resume electronic distribution of EOMBs in Fall 2020, and this functionality will be available for both adults and children. Additionally, when the new EOMB solution comes online, 24 months of claims payment information will be loaded to ensure there is no gap between the dates of service found in the previous portal, and the data available in the new solution.

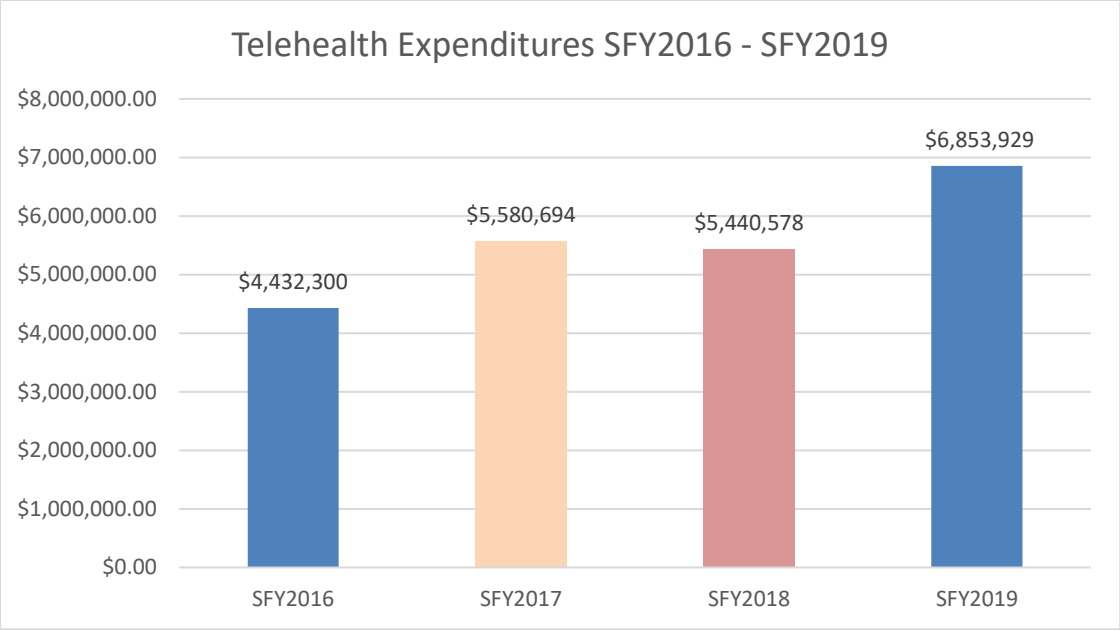
3) Telehealth

AS 47.05.270(a)(3): expanding the use of telehealth for primary care, behavioral health, and urgent care.

Telehealth is a mode of delivering a Medicaid-covered service. Medicaid pays enrolled providers for medical services delivered through telehealth methods if the service is:

1) Covered under traditional, non-telehealth modes;
2) Provided by a Medicaid-enrolled treating, consulting, presenting, or referring provider;
3) Can be provided via telehealth.

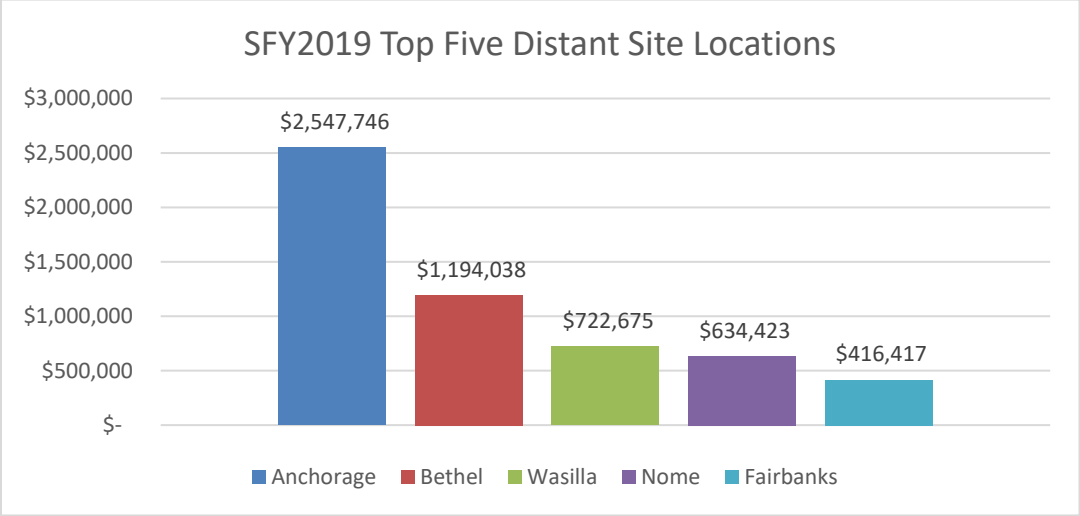
In FY 2019 the Medicaid program paid $6.8 million in claims for services delivered via telehealth methods, an increase of 55 percent over the amount paid for services delivered via telehealth in FY 2016.



A service delivered via telehealth is reimbursed at the same rate as the same service delivered in a face-to-face setting. Alaska Medicaid currently restricts telehealth coverage to services provided through one of these three modes:

- **Interactive method:** Provider and patient interact in "real time" using video/camera and/or dedicated audio conference equipment.
- **Store-and-forward method:** The provider sends digital images, sounds, or previously recorded video to a distant site provider at a different location. The distant site provider reviews the information and reports back his or her analysis.
- **Self-monitoring method:** The patient is monitored in his or her home via a telehealth application, with the provider indirectly involved from another location.

In FY 2019 the top five distant site locations (locations of the health care provider delivering the service via telehealth) were Anchorage, Bethel, Wasilla, Nome, and Fairbanks.



The following table lists the top disease categories and diagnoses for telehealth-delivered service claims billed in FY 2019.

Top Disease Categories	# of Medicaid Claims	Top Diagnoses in Each Category
Mental, Behavioral, and Neurodevelopmental Disorders	11,893	• Opioid dependence • Attention-deficit hyperactivity disorder • Alcohol dependence • Post-traumatic stress disorder • Major depressive disorder
Injury, Poisoning, and Certain other Consequences of External Causes	3,402	• Fractures of the arm, hand or finger • Fractures of the leg or foot • Fractures of the collarbone
Diseases of the Ear and Mastoid Process	2,560	• Otitis media (inflammatory disease of the middle ear) • Otorrhea (ear drainage) • Otalgia (ear pain)
Factors Influencing Health Status and Contact with Health Services	1,014	• Malignant neoplasm (cancerous tumor) • Disease of nervous system/sense organs • Orthopedic aftercare • Screenings • Surgical aftercare

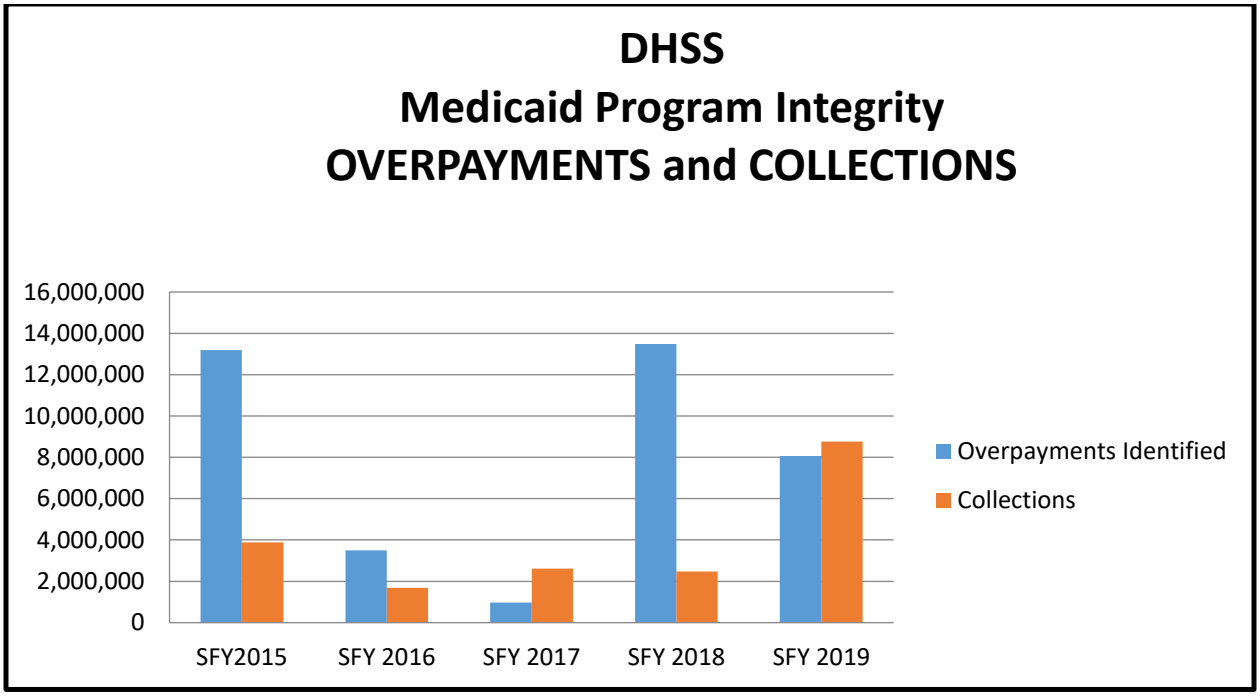
Estimated savings from transportation costs avoided due to services delivered in a recipient's home community via telehealth have not been quantified. DHSS is currently working on updates to Medicaid telehealth regulations to ensure reimbursement policies support increased access to care in underserved communities in the most cost-effective manner. Please see Part II.B.7 of this report starting on page 29 for additional information about DHSS's efforts to improve Medicaid telehealth policy.

4) Fraud Prevention, Detection, and Enforcement

AS 47.05.270(a)(4): Enhancing fraud prevention, detection, and enforcement.

The Medicaid Program Integrity section within the Division of Finance and Management Services oversees the audit contract required under AS 47.05.200. In addition to managing the audit contract, which requires a minimum of 50 audits annually, the Medicaid Program Integrity section conducts reviews of Medicaid provider claims submission and documentation to ensure Alaska's Medicaid program is paying for quality services in accordance with the regulations and policies adopted by DHSS.

During FY 2019, Medicaid Program Integrity clarified regulations addressing provider recordkeeping and self-audits as required by AS 47.05.235 and AS 47.05.270. Medicaid Program Integrity recovered over $8.7 million in overpayments paid to providers, and 10 payment suspensions were initiated after credible allegation of fraud determinations were made by Program Integrity working in conjunction with Department of Law, Medicaid Fraud Control Unit. As a result of the self-audit requirement from Medicaid reform, Medicaid Program Integrity is experiencing an increase in the number of provider self-disclosed overpayments.



During 2019 Medicaid Program Integrity became a partner with the Healthcare Fraud Prevention Partnership (HFFP) which is a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations. The purpose is to improve the detection and prevention of healthcare fraud by:

- Exchanging data and information between the public and private sectors.
- Leveraging various analytic tools against data sets provided by HFPP partners.
- Providing a forum for public and private leaders and subject matter experts to share successful anti-fraud practices and effective methodologies for detecting and preventing healthcare fraud.

Medicaid Program Integrity coordinated the Payment Error Rate Measurement (PERM) program for federal FY 2017. The FY 2017 review identified concerns with fee-for-service data processing review criteria and as a result, CMS did not release FY 2017 state-specific error rates for the Medicaid program. CMS did issue a Final Errors for Recovery report for the Medical Review portion identifying 18 errors. These errors were identified due to a lack of adequate documentation from the Medicaid providers. Alaska is currently working on the corrective action plan from this cycle.

Alaska is undergoing the next PERM cycle which is known as Reporting Year (RY) 2021. CMS has moved from a federal fiscal year base to a reporting year which aligns with the state fiscal year. The results from the RY 2021 is anticipated to be released in November 2021.

Overall, Medicaid Program Integrity saved the Medicaid program $10.2 million ($8.8 million in recoveries plus $1.4 million in cost avoidance) for a total return on investment of $11.27 for each dollar spent.

<u>Surveillance & Utilization Review Subsystem (SURS) Overpayment Collections</u>
During FY 2019, the Division of Health Care Services - Quality Assurance section completed implementation of a new data profiling and analytics tool from IBM Watson-Health. This new tool represents a significant upgrade in the identification and evaluation of potential Medicaid overpayments. In FY2019 $275,882 was recovered, representing a 200 percent increase over funds

recovered by Quality Assurance in FY 2018. Quality Assurance staff continue to identify additional areas within the department where data analytics using this tool may identify additional overpayments.

5) Home and Community-Based Waivers

AS 47.05.270(a)(5): Reducing the cost of behavioral health, senior, and disabilities services provided to recipients of medical assistance under the state's home and community-based services waiver under AS 47.07.045.

Home and community-based services (HCBS) help people, many of whom have a level of need that would otherwise be provided in an institution such as a nursing facility, to remain in their home or community. HCBS services include 1915(c) waiver services, 1915(k) State Plan Community First Choice (CFC) services, and personal care services. Participation in a waiver or CFC requires the recipient to have a determination made that the recipient would otherwise qualify for placement in an institution. The Centers for Medicare and Medicaid Services allows states to "waive out" of providing institutional care for these recipients by offering them services through federally-approved 1915(c) waivers or the 1915(k) State Plan option that can be targeted to different groups. Personal care services assist recipients who do not necessarily meet an institutional level of care with needed activities of living, such as toileting and dressing, or instrumental activities of daily living, such as shopping and meal preparation.

Because waiver services and CFC services are only available to individuals who require an institutional level of care, and skilled nursing and intermediate care facility services are mandatory services under Medicaid, the waivers help contain Medicaid spending by providing an option to people who otherwise qualify for services provided in an institution. Institutions are the most expensive type of long-term care services. The following table illustrates how the cost of waiver services in FY 2019 compared to what the cost of nursing home and intermediate care facility services would have been if waiver services were not available.

Cost of Institutional Care without Home and Community Based Waiver Services Options

SFY 2019 Costs by Funding Source and Average Cost per Person by Service Type (based on FY 2019 Final Auth Report and number of people for whom services were rendered during FY 2019)

Program	# served	Avg cost per person	Total costs
Home & Community Based Waivers			
ALI Waiver	2,005	$35,505	$71,188,286
APDD Waiver	105	$96,158	$10,096,600
CCMC Waiver	217	$40,775	$8,848,129
IDD Waiver	2,048	$88,769	$181,798,859
ISW Waiver	244	$3,315	$808,916
TOTAL HCB Waivers			$272,740,790
Institutional Placements			
Nursing Home	918	$171,904	$157,807,857
ICF/IID	14	$214,423	$3,001,924
TOTAL Institutional Placements			$160,809,781
TOTAL HCB Waivers and Institutional Placements			**$433,550,571**

Institutional Placements if no HCB Waiver services existed – FY2019			**Total cost based on average cost per person for NH and ICF/IID services**
Nursing Home + ALI, APDD and CCMC Waiver service recipients	3,245		$557,828,427
ICF/IID + IDD and ISW Waiver service recipients	2,306		$494,459,837
TOTAL if HCB Waivers did not exist and individuals eligible for Nursing home or ICF/IID care received services in Institutional Placements (ICF/IID is based on current out of state placement).			**$1,052,288,263**

Data Source: State of Alaska Automated Budget System, Final Auth 19 report, COGNOS

Home & Community-Based Services: Utilization Control and Process Improvement

DHSS continues efforts to improve utilization controls and address fraud and abuse in the provision of waiver and personal care services. Amended regulations took effect at the beginning of the second quarter of FY 2018 that capped the number of hours of day habilitation services available under the waivers at 624 hours per year (12 hours per week on average), with a provision for allowing more day habilitation if risk of institutionalization or health and safety concerns were justified in a support plan. This language was challenged in court; the resulting settlement, signed July 6, 2018, directed the state to provide more detailed standards defining the conditions under which additional day habilitation hours could be approved. DHSS is currently considering the many public comments received on the proposed regulatory and waiver amendments and expects that the amendments will become effective in early 2020.

Home & Community-Based Services: Use of Person-Centered Intake Tool and Options Counseling

In FY 2019 DHSS continued the work of fully implementing the use of a person-centered intake tool and provision of options counseling for individuals seeking receipt of personal care services or enrollment in one of the waiver programs. This project began as a limited two-year pilot back in FY 2014, which demonstrated the value of directing new applicants to Aging and Disability Resource Centers (ADRCs), where they went through a prescreening process and participated in options counselling before referral to the Division of Senior & Disabilities Services (SDS) as a potential Medicaid client. The pilot successfully demonstrated a reduction in the number of inappropriate assessments by screening out people who would not qualify for services, and redirected clients through referrals to other community-based supports that were better suited to meet their needs.

Following completion of the pilot in FY 2016, SDS transitioned individuals seeking services under the Adults Living Independently and the Adults with Physical and Developmental Disabilities waivers to the ADRCs as the new "front door" for those waivers in FY 2017. In FY 2018 DHSS transitioned enrollment in the Children with Complex Medical Conditions waiver through the front door of the ADRCs. In FY 2019 DHSS began transitioning individuals seeking services under the People with Intellectual and Developmental disabilities waiver and the Individualized Support waiver through the Developmental Disabilities Resource Connections "DDRC" as a front door for Developmental Disability Determination Applications and waivers. Streamlining the Front Door for services helps contain Medicaid costs, and allows SDS to better allocate its limited resources and meet its performance measures for timely assessments.

As the table below reflects, the utilization controls and process improvements described in this and the above section contributed to a state GF reduction in spending for waiver services of 2.5 percent in FY 2019 compared to FY 2018, and a 33.2 percent reduction in total spending for personal care services over the same period. With the additional Community First Choice Plan option, providing an additional 6 percent FMAP, the state GF had a net decrease in HCBS spending of 4 percent last year. The overall savings to the State General Fund in FY 2019 compared to FY 2018 spending was $6.5 million.

FY 2018 and FY 2019 Expenditures for Waiver and Personal Care Services

Fund Source	FY 2018	FY 2019	$ Change	% Change
Waivers (*Number increased to 5 in FY 2019 from 4 in FY 2018)				
State GF	$ 130,109,883	$126,813,408	($3,296,475)	-2.5%
Federal	$ 136,433,699	$145,927,382	$9,493,683	7.0%
TOTAL	$ 266,543,582	$272,740,790	$6,197,208	2.3%
Personal Care Services				
State GF	$ 30,757,739	$20,066,857	($10,690,882)	-34.8%
Federal	$ 31,329,077	$21,403,274	($9,925,803)	-31.7%
TOTAL	$ 62,086,816	$41,470,130	($20,616,686)	-33.2%
Community First Choice Plan Option (*Additional 6% FMAP)				
State GF	$ -	$7,521,132	$7,521,132	100.0%
Federal	$ -	$9,505,934	$9,505,934	100.0%
TOTAL	$ -	$17,027,065	$17,027,065	100.0%
Total HCBS				
State GF	$ 160,867,622	$ 154,401,397	($6,466,225)	-4.0%
Federal	$ 167,762,776	$ 176,836,589	$9,073,813	5.4%
TOTAL	$ 328,630,398	$ 331,237,986	$2,607,588	0.8%

1915(i) and 1915(k) Home & Community Based Services State Plan Options

SB 74 authorized DHSS to apply for 1915(i) and 1915(k) home and community based state plan service options. A subsequent in-depth analysis by the consulting firm Health Management Associates (HMA) helped DHSS determine that adding new HCBS services under the 1915(i) option would not be cost effective for Alaska. In lieu of that approach, and based on HMA recommendations, DHSS chose to create a new waiver for people with intellectual and developmental disabilities under existing 1915(c) authority. Also based on HMA recommendations, and with input from stakeholders (the Inclusive Community Choices Council), DHSS developed and implemented the 1915(k) state plan option. Also known as Community First Choice (CFC), the 1915(k) option provides enhanced personal care services for individuals who meet nursing facility-level of care criteria. Federal funding reimbursement is also 6 percent higher for these services than for regular personal care services.

During FY 2018 DHSS crafted the regulations, analyzed the changes necessary for payment systems and internal operations, and developed the related waiver application and state plan amendment for federal approval. Federal approval of both the 1915(k) state plan option and the new 1915(c) Individualized Supports Waiver was granted by the Centers for Medicare and Medicaid Services at the end of FY 2018 (June 2018), and the new programs became operational in FY 2019 when the corresponding state regulations became effective October 1, 2018. Since then, DHSS has been able to receive the additional 6 percent federal match for people who transitioned onto the CFC program. As of October 1, 2019, 389 people have been enrolled on the Individualized Supports Waiver, to receive services through that waiver since the state-funded grant for developmental disabilities was phased out in FY 2018.

DHSS is currently developing amendments to regulations, the 1915(c) waivers, and the Medicaid State Plan that transitions the waiver service of Chore into the Community First Choice program, which will bring in an additional 6 percent in federal match for that service under CFC. The planned effective date for this transition is July 1, 2020.

6) Pharmacy Initiatives.

AS 47.05.270(a)(6): Pharmacy initiatives.

State General Fund (GF) Savings/Cost Avoidance from Pharmacy Initiatives

Program	FY 2019
Cost Savings	
Preferred Drug List	$5,700,000
Cost Avoidance	
Prospective Drug Utilization Reviews (FFY 18)	$12,000,000
Pharmacy Payment Reform: NADAC Implementation	$12,250,000
Opioid utilization decreases	$335,000

Over the past two years negotiated pricing and utilization management within the Pharmacy program contributed to an overall decrease of 0.5 percent in final net program cost per prescription. This net decrease was achieved in spite of experiencing a 0.9 percent overall increase in pharmacy reimbursement per prescription due to steadily increasing drug acquisition costs.

Preferred Drug List and Prospective Drug Utilization Review

Utilizing the current preferred drug list realized approximately $11 million in final direct program savings from negotiated pricing on preferred drugs. This savings is exclusive of the cost avoidance achieved through therapeutic substitution by guided use of preferred agents. Systematic prospective drug utilization reviews resulted in an additional savings of approximately $24 million in pharmacy cost avoidance by preventing dispensing of inappropriate medications. Approximately half of these savings and cost avoidance are general fund.

Use of Generic Drugs

The use of generic drugs provides comparable quality but is typically far less costly than brand name drugs. In Alaska's Medicaid program generic drug utilization exceeded 85 percent at the end of state FY 2019, surpassing the previous year's average of 83.1 percent; generic drug utilization in the program is consistently at or above the national average. The average percentage of generic utilization among all Medicaid fee-for-service programs nationally was 83 percent in FY 2017, while accounting for just 21 percent of the total amount paid for drugs by Medicaid that year.[2]

Pharmacy Payment Reform: National Average Drug Acquisition Costs (NADAC) implementation

Pharmacy reimbursement methodology reform continues to realize significant annual savings. Approximately $24.5 million in pharmacy reimbursement savings was achieved in FY 2019 through utilization of the CMS National Average Drug Acquisition Cost as the State Maximum Allowable Cost. DHSS changed the Medicaid program's pharmacy reimbursement methodology to include the CMS National Average Drug Acquisition Cost pricing benchmark in FY 2015. Total savings is the amount paid compared to the wholesale acquisition cost benchmark, all funding sources. Approximately 50 percent of the FY 2019 savings of the $24.5 million cost avoidance was State General Fund dollars.

Pharmacy Payment Reform: Medicare Payment Allowance Limit

Pharmacy reimbursement methodology reform continues to be at the forefront of research and implementation. The program has been working to update system capabilities to utilize the Medicare Payment Allowance Limit (PAL) in the 'lesser of' logic payment algorithms as a secondary State

[2] https://www.medicaid.gov/medicaid/prescription-drugs/downloads/drug-utilization-review/2017-dur-summary-report.pdf

Maximum Allowable Cost for drugs who have this national benchmark price. Many of these drugs do not have a NADAC benchmark price because they are not generally dispensed by retail pharmacies and are often considered "specialty drugs." Being able to incorporate the Medicare PAL into the payment algorithm expands the capabilities of the program to ensure compliance with the federal covered outpatient drug rule which requires payment of covered outpatient drugs based on acquisition cost and promotes fiscal responsibility of the program. Incorporation of this pricing benchmark is anticipated in FY 2020 due to system dependencies.

Pharmacy Professional Dispensing Fee Study

Regulations were proposed in FY 2018 to provide a mechanism to add pharmacists as an independent provider type separate from pharmacies to recognize state-authorized pharmacist scope of practice, to include independent prescribing of opioid reversal agents and vaccines. Adoption of these regulations, expected during FY 2020, will pave the way to provide a mechanism to reimburse pharmacists for cognitive services, such as drug regimen reviews and situations where a prescription medication was not dispensed due to clinical intervention by the pharmacist. The current reimbursement model only reimburses pharmacists for their professional services if a medication is dispensed, presenting an unintended incentive. Pharmacist cognitive services support transitions of care and chronic care management, including pain management, as well as wellness programs. Expanding the number of available health care professionals with medication expertise to provide clinical services assists with access to care issues in Alaska, where we have difficulty recruiting and retaining health care professionals.

The Pharmacy Professional Dispensing Fee survey that was completed in the fall of 2019 included data collection to inform rate setting for this new provider type and to update the professional dispensing fee reimbursement. While it may appear that adding a new provider type could increase overall Medicaid payments for services, the opportunity for savings and improved quality is high due to the potential for decreased adverse drug events and medication errors, improved health outcomes from medication compliance and minimized side effects, and cost avoidance from pharmacists intervening to advise prescribers on clinically inappropriate medication regimens. Notable returns on this strategy have been documented in evidence-based literature. Furthermore, shifting reimbursement from the payment of inappropriate pharmaceuticals (which results in dollars leaving the state), to payment of local pharmacists for professional services, results in dollars remaining in the state, and can have a net positive impact on healthy individuals, communities, and economies.

Opioid Utilization Initiatives

The opioid crisis continues to place a strain on limited state resources for substance dependence services and chronic pain management. The pharmacy program has observed a three-fold increase in pharmacy reimbursement payments for buprenorphine-based medication-assisted therapy drug products since 2015. Pharmacy reimbursement costs for buprenorphine-based products approached $6 million during FY 2019. The corresponding trend in decreased opioid utilization has helped to blunt the financial impact in the short-term by off-setting part of the increased costs for opioid dependence treatment; however, the rate of increase will continue to outpace the offsets in the near-term. The greater impact is the clinical and personal benefit of decreasing medically unnecessary opioid utilization and providing opportunities to move individuals into recovery.

The Alaska Medicaid Drug Utilization Review (DUR) program has been active in addressing the opioid epidemic in a variety of ways. Highlights are included in the table below:

	Alaska Statewide Opioid Action Plan[3]
The Alaska Medicaid DUR Program continues to utilize quantity limits, early refill, and therapeutic duplication safety edits to promote evidence-based opioid prescribing. The DUR Program continually refines these edits and provides education in conjunction with the DUR Committee to align with state and federal guidelines on opioid prescribing.	Strategy 3.2
The Alaska Medicaid Program implemented a Medication Assisted Therapy Standards of Care program to promote evidence-based prescribing of buprenorphine-based products.	Strategy 2.4, 3.2, 5.2, 5.5
The Alaska Medicaid Program has access to and utilizes the Prescription Drug Monitoring Program (PDMP) when evaluating opioid-related prospective drug utilization, such as prior authorizations, and retrospective drug utilization review activities.	Strategy 3.2
The Alaska Medicaid Program continues to employ a safety edit that alerts the pharmacist when a patient has filled 3 or more naloxone prescriptions in a one year period. This edit prompts conversations between the pharmacist, prescriber, and patient about additional harm reduction opportunities, including decreasing opioid dosing, treatment, etc. to prevent future overdoses and overdose death.	Strategy 2.4, 4.1, 4.2

Efforts by the Alaska Medicaid DUR Program and other state partners has resulted in a decrease in overall opioid prescribing and doses within the Alaska Medicaid population. From Medicaid claims data, the percentage of members who were prescribed opioids with a total morphine milligram equivalent (MME) greater than 90 decreased by approximately 26 percent from the six month period beginning July 2017 to the six month period ending June 2019. Pharmacy reimbursement payments for opioid drug products decreased by $0.67 million in FY 2019 as compared to FY 2017 as a result of opioid utilization initiatives.

DHSS continually tracks evolving clinical guidelines and strategies to address the opioid abuse epidemic. Ensuring medically appropriate use of opioids and preventing non-medical use of opioids minimizes opioid overdose and overdose death, opioid dependence, and neonatal abstinence syndrome. DHSS continues to work with the DUR Committee and other agencies to further refine, frame, and prioritize the initiative work over the next year as well as track success of the various initiatives utilizing process and outcomes measures.

Alternate Payment Models (APM)

Through a grant from the Laura and John Arnold Foundation, DHSS began working with the Oregon Health & Science University's Center for Evidence-Based Policy during FY 2017 to determine the feasibility and DHSS readiness to employ alternate payment models within the Medicaid Pharmacy Program. A particular area of focus is newer high cost specialty medications. The first phase of the

[3] http://dhss.alaska.gov/osmap/Pages/action.aspx

project included research into the landscape of pharmaceutical pricing and reimbursement in Medicaid programs in various states.

During FY 2018, for the second phase of this project, DHSS completed a readiness assessment and identified key directions in scalable areas, such as hemophilia, for the development of standards of care to address cross-sectional impacts of high impact drug classes. The Alaska Medicaid Drug Utilization Review (DUR) Committee approved Standards of Care for hemophilia.

During FY 2019, DHSS explored specific pathways to outcomes based contracting opportunities and secured additional flexibilities by working with legislative partners to obtain authority to pursue such next steps. Additional movement is anticipated in FY 2020 as more manufacturers become willing to participate.

Ambulatory Infusion Center (AIC) Enrollment and Reimbursement

DHSS continues to research the viability of Medicaid reimbursement of infused medications in an Ambulatory Infusion Center (AIC) setting. An increasing number of specialty medications, particularly biological agents, are available for a number of conditions, including Multiple Sclerosis, Psoriasis, Inflammatory Bowel Disease, and Immunodeficiencies. Many of these products have the potential of being administered in the home, which is reimbursed under the current Home Infusion Therapy program. However, to gauge tolerability, many of these drugs require initial doses to be administered in a health care setting for patient safety purposes.

Under the current structure, these medications are administered and reimbursed through physician offices and clinics, hospital-based infusion clinics, and home infusion therapy. Continuity of care, regimen complexity, patient choice, safety, and a number of other factors warranted research into care delivery options. DHSS has researched other state Medicaid programs, clinical literature, and regulatory/accrediting body standards to inform the drafting of regulations for AIC enrollment and payment, in conjunction with providers and a representative of the Alaska State Hospital and Nursing Home Association (ASHNHA). During the research, it was not observed that significant savings would be generated by shifting to Ambulatory Infusion Centers due to a number of factors including, among other things, 340B pricing[4]; however, DHSS continues to consider the enrollment of Ambulatory Infusion Centers as a future opportunity as the FDA continues to approve an increasing number of novel therapies that must be administered in certified centers.

7) Enhanced Care Management

AS 47.05.270(a)(7): Enhanced care management.

The Alaska Medicaid Program includes a number of care coordination and case management programs and initiatives. Current programs are expanding, and new initiatives under SB 74 are under development to enhance care coordination and care management. The following table summarizes State General Fund cost savings/cost avoidance from the various programs.

[4] The 340B Program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. https://www.hrsa.gov/opa/index.html

State General Fund Savings/Cost Avoidance
Due to Current Care Management Programs

Program	FY 2019
Case Management	$633,842
Care Management Program	$785,400
Alaska Medicaid Coordinated Care Initiative	$1,605,000
TOTAL	**$3,024,242**

Case Management

The Medicaid program contracts with a health management firm, Comagine Health, formerly Qualis Health, to provide evidence-based case management services for recipients with the most medically complex and costly conditions. In FY 2019, Comagine Health expanded its services outside of the Anchorage and Matanuska-Susitna Boroughs and included the Fairbanks North Star and Kenai Peninsula Borough. Medicaid recipients may self-refer to the program, or may be referred by a health care provider or agency staff. Case management services include patient assessment, education and referral; medication reconciliation; care coordination; and facilitation of collaborative efforts of the recipient's entire healthcare team. Case management services were provided to an average of 65 Medicaid recipients per month during FY 2019 and yielded a net Medicaid program savings (in the form of avoided costs) of $2.2 million, approximately 30 percent of which, or $.6 million, was State General Funds (GF). The return on investment for this program was $5.26 of every $1.00 spent through avoided inpatient stays and duplication of services.

Care Management Program

Established during the mid-1990s, DHSS's Care Management Program (CMP) addresses inappropriate use of Medicaid-covered services. Medicaid recipients who overuse or misuse Medicaid covered services or who would otherwise benefit from CMP enrollment are identified through post-payment review and are assigned to the program. DHSS also accepts CMP referrals from medical providers. For recipients who are enrolled, participation is mandatory. An initial CMP placement typically lasts 12 months, during which time the recipient is assigned a primary care provider and limited to one pharmacy. All non-emergent care must be delivered by the assigned primary care provider, and all drugs must be dispensed by the selected pharmacy.

The CMP program saved $2.6 million during FY 2019, approximately 30 percent of which, or $.8 million, was general funds (GF). Savings were achieved through cost avoidance due to improved continuity of care that reduced the use of inappropriate services (e.g., use of hospital emergency departments for non-emergent care), visits to multiple providers for the same issue, and duplicative prescriptions. FY 2019 CMP enrollment averaged 311 recipients per month, a four percent increase over FY 2018.

Alaska Medicaid Coordinated Care Initiative/SB 74 Primary Care Case Management

The Alaska Medicaid Coordinated Care Initiative (AMCCI), also known as the "Super-Utilizer" initiative, was launched in December 2014 to enhance care coordination for Medicaid recipients with excessive hospital emergency department (ED) utilization. The project was subsequently expanded to include recipients who over-utilize other medical services.

Recipient participation in this program is voluntary. Enrollees are provided limited case management services including care coordination and coordination of referrals to specialists and social service supports. One task of this initiative was for DHSS to contract with MedExpert to provide these services telephonically. MedExpert's AMCCI contract with the State of Alaska ended August 31, 2019. Of the

more than 200,000 Medicaid recipients eligible to participate in AMCCI, a very limited number took advantage of the services offered by MedExpert.

Cost savings for this initiative is based on the average cost per emergency department (ED) visit multiplied by the number of ED visits avoided for the served population. For FY 2019 the claim value for AMCCI's reduction saved the Alaska Medicaid program more than $5.4 million, approximately 30 percent of which, or $1.6 million, was State General Fund (GF) dollars. When considering overall contract cost and other factors/initiatives that impacted ED use, cost savings or return on investment for the AMCCI was limited.

SB 74, under AS 47.07.030(d), requires DHSS to establish a primary care case management system and enroll Medicaid recipients with multiple hospitalizations. DHSS continues to expand AMCCI participation, with the ultimate goal of including all who are eligible to participate. This will allow for more immediate statewide access to episodic care management services while new care models are tested through the Coordinated Care Demonstration Project established under AS 47.07.039. This is accomplished through Comagine Health. In addition, Comagine Health provides more intensive in-person case management services for 67 of the highest utilizers of ED services.

8) Redesigning the Payment Process

AS 47.05.270(a)(8): Redesigning the payment process by implementing fee agreements that include one or more of the following: (A) premium payments for centers of excellence; (B) penalties for hospital-acquired infections, readmissions, and outcome failures; (C) bundled payments for specific episodes of care; or (D) global payments for contracted payers, primary care managers, and case managers for recipient or for care related to specific diagnosis.

DHSS implemented fee conditions that comply with AS 47.05.270(a)(8)(B) back in 2012, instituting penalties for episodes of care that result in hospital-acquired infections and other hospital-acquired conditions, such as those caused by medical errors.

With the implementation of SB 74, DHSS increased focus on innovative payment model opportunities. Since then DHSS continued work on pharmacy payment reform (see Section II.A.6. Pharmacy Initiatives, pg. 9); and also further developed the demonstration projects authorized under behavioral health system reform (AS 47.05.270(b), 1115 waiver (AS 47.07.036(f)), medical services to be provided (AS 47.07.030(d)(4)), and the Coordinated Care Demonstration Project (AS 47.07.039). Both demonstration projects have the potential to test new payment models, such as bundled payments and capitation payments. The Patient Centered Medical Home demonstration project through Providence Family Medicine Center has utilized a partial capitation payment reimbursement model since its inception in September 2018. The 1115 waiver was approved by CMS in September 2019 and regulations were accepted and filed in October 2019. The AMCCI efforts were increased as the Coordinated Care demonstration has been tested. Please see Section II.A.15 (pg. 23) and Section II.A.6 (pg. 29) for more information on the demonstration projects.

To assist with these payment model reform efforts DHSS contracted with Milliman, Inc., a health care actuarial consulting firm, in a one year contract with three, one year additional extensions possible. The contract is in the third year of the possible four-year contract timeframe. One important tool Milliman, Inc. has provided under this contract is the Medicaid Data Book, which utilizes FY 2015, 2016, and 2017 Medicaid claims data to provide information on spending and utilization by region, eligibility group, and other factors. An on-line pdf version of the data books is available at:
http://dhss.alaska.gov/HealthyAlaska/Pages/Redesign/Redesign_news.aspx

In addition to progress made in these other areas, DHSS engaged a workgroup of provider stakeholders beginning in FY 2018 to help identify alternate provider payment strategies of interest to the provider community. The 18-member Innovative Provider Payment workgroup included representatives from primary care, physician specialists, hospitals, federally qualified health centers, home and community based services and tribal health organizations. The group met March-October, 2018 and discussed models such as bundled payments, shared-savings, health homes, patient-centered medical homes and accountable care organizations.

The workgroup heard a variety of presentations from other providers and technical experts who had experience working with each of the identified models. Members were able to ask questions regarding implementation, administrative challenges and resources necessary to implement the given model. In addition to the technical experts that shared information on the models, Milliman, Inc., completed an assessment of the feasibility of the use of bundled payments and health homes within the Alaska Medicaid program. Using information from the Alaska Medicaid claims system, Milliman, Inc. was able to evaluate which services might work best for a bundled payment option, and which chronic illnesses may be best suited for health homes.

The analysis Milliman, Inc. performed on the potential use of bundled payments in Alaska focused on the use of such payments in Fairbanks and/or Juneau to expand the use of innovative payment strategies in areas of the state not covered by one of the Coordinated Care Demonstration Projects. Milliman, Inc. identified that for a bundled payment option to be successful in either of these locations, the Medicaid program will need to partner with other payers. Their assessment is that additional payers will be necessary to build the volume of services that will attract and sustain provider interest in such a model[5].

Milliman Inc.'s health home analysis identified nine chronic conditions that may be well suited for development of health homes within the Alaska Medicaid program. These conditions include: psychiatric; cardiovascular; gastrointestinal; pulmonary; central nervous system; metabolic; renal; substance abuse; and diabetes. Although Milliman, Inc. found this model has potential in Alaska, the provider workgroup has expressed concerns regarding the complexity of the model's design and the uncertainty about DHSS's ability to support the model long-term.

DHSS intends to implement a Diagnosis Related Group (DRG) based payment methodology for Alaska's hospitals except for Critical Access Hospitals (CAHs). The DRG methodology aligns with DHSS's focus on improving patient care and shifting the focus to the quality of the services provided. The current hospital prospective payment per diem methodology is inconsistent with this goal as it incentivizes quantity of care, instead of quality. A DRG-based payment methodology will enhance DHSS's ability to implement performance review and cost-saving measures, including potentially preventable readmissions and hospital acquired conditions.

[5] Please see Milliman Inc.'s "Bundled Payments: Considerations for the Alaska Medicaid Program" report, included as Appendix A of the FY 2018 Annual Medicaid Reform Report: http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/FY-2018_Annual_Medicaid_Reform_Report_with_Appendices.pdf

9) Quality & Cost Effectiveness Targets Stakeholder Involvement

AS 47.05.270(a)(9): Stakeholder involvement in setting annual targets for quality and cost-effectiveness.

In FY 2017 the Medicaid Redesign Quality and Cost Effectiveness (QCE) Targets External Stakeholder workgroup recommended 18 Medicaid performance measures and corresponding annual and five-year performance targets for the recommended measures. During the course of the QCE workgroup's discussions, one measure was removed from the recommended list and placed on the *Potential Future Measures* list. This action was necessary due to the absence of a reliable data source for the performance measurement. This reduced the final list of performance measures to 17.
After receiving verification from Milliman, baseline calculations were developed by DHSS for the measures[6].

With the baseline validated a year earlier than expected, DHSS was able to calculate first-year performance results in FY 2017, reporting those in the FY 2018 Annual Medicaid Reform Report. The second-year performance results are reported on page 26 of this report.

10) Travel Costs

AS 47.05.270(a)(10): To the extent consistent with federal law, reducing travel costs by requiring a recipient to obtain medical services in the recipient's home community, to the extent appropriate services are available in the recipient's home community.

The Alaska Medicaid program only covers travel costs for medically necessary travel required for the recipient to receive services not otherwise available in the recipient's home community. All non-emergency medically necessary transportation must be authorized by the Medicaid Program in advance. Emergency medical transportation is only covered to the nearest facility offering emergency medical care. Travel segments are arranged to utilize the least costly and most appropriate mode of transportation with the fewest number of overnight accommodation services.

In many rural communities, non-emergent diagnostic and treatment services are unavailable or are available periodically by locum tenens. Travel is not approved when non-emergent services are available via telehealth or are expected to be available locally from a traveling provider, such as a Public Health Nurse, within a 3-month timeframe. Providers are reminded of these travel requirements through remittance advice messages, flyers, training presentations, provider billing manual updates, and newsletter articles. A memorandum from the Director of the Division of Health Care Services offers clarification to providers regarding travel policy and provides guidance for frequently occurring and problematic travel situations. The memorandum includes identification of non-covered services and also reinforces other existing requirements, such as combining multiple appointments into a single travel episode, denial of non-emergent travel when services are available locally within a reasonable time period and ensuring that medical necessity exists for all travel referrals.

[6] Please see Milliman Inc.'s "Health Homes: Considerations for the Alaska Medicaid Program" report, included as Appendix B of the FY 2018 Annual Medicaid Reform Report:
http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/FY-2018_Annual_Medicaid_Reform_Report_with_Appendices.pdf

DHSS continued to make improvements during FY 2019 to contain transportation cost growth and maximize federal funding; for example, through employee training in procurement to support contracting for non-emergent travel and beginning project planning to develop a database to track escort transportation associated with EPSDT services to assist with identifying abuse and provide accurate monthly reports. The significant decline in State General Fund spending for transportation services experienced between FY 2016-2018, as noted below, is due to DHSS's implementation of the new Centers for Medicare and Medicaid Services (CMS) Tribal Medicaid reimbursement policy described in Part II.B.14 of this report (pg. 35). Under this new policy three tribal entities now issue transportation authorizations, allowing DHSS to claim 100 percent federal funding reimbursement for transportation services they arrange. DHSS continues to work with additional tribal entities that express interest in providing transportation authorization services.

					2016 to 2017 change		2017 to 2018 change		2016 to 2018 change		2016 to 2019 change		2017 to 2019 change		2018 to 2019 change	
Fund Source	**2016**	**2017**	**2018**	**2019**	**Dollar**	**Percent**	**Dollar**	**Percent**	**Dollar**	**Percent**	**Dollar**	**Percent**	**Dollar**	**Percent**	**Dollar**	**Percent**
Federal Funds	45,318,177.00	84,556,868.00	73,781,312.00	91,239,143.00	39,238,691.00	87%	(10,775,556.00)	-13%	28,463,135.00	63%	$45,920,966.00	101%	45,920,966.00	54%	17,457,831.00	24%
State General Funds	32,831,487.00	7,891,016.00	11,965,716.00	12,473,639.00	(24,940,471.00)	-76%	4,074,700.00	52%	(20,865,771.00)	-64%	($20,357,848.00)	-62%	(20,357,848.00)	-258%	507,923.00	4%
Total Expenditures	78,149,664.00	92,447,884.00	85,747,028.00	103,712,782.00	14,298,220.00	18%	(6,700,856.00)	-7%	7,597,364.00	10%	$25,563,118.00	33%	25,563,118.00	33%	17,965,754.00	28%

In FY 2019 total travel expenditures increased by $18 million compared to FY 2018, an increase of 28 percent. In FY 2019 total travel expenditures continue to follow the trend from FY 2016 with the majority of expenditures being federal funds, with only 4 percent of the increase as General Fund (GF) or $.7 million from FY 2018 to FY 2019. The overall increase expenditure aligns with enrollment growth in Medicaid. The Medicaid program continues to contain costs well below enrollment growth with the measures noted above and was able to attain significant cost savings in State GF due to the Tribal initiative described above.

11) Disease Prevention and Wellness

AS 47.05.270(a)(11): Guidelines for health care providers to develop health care delivery models supported by evidence-based practices that encourage wellness and disease prevention.

Preventive Services Benefit Development

DHSS continues to move toward updating Medicaid coverage policies to ensure efficient delivery and availability, and to ensure wellness and preventive services are evidence-based. DHSS's internal task force is working to refine and modernize Alaska Medicaid wellness benefits to ensure evidence-based coverage for key preventive services based on recommendations from the U.S. Preventive Services Task Force and the Medicaid Evidence-Based Decisions (MED) Project, a collaborative of 19 state Medicaid programs and agencies and the Oregon Health & Science University's Center for Evidence-Based Policy.

A coverage benefit proposal is under review by DHSS leadership. Once approved, regulatory changes will be needed to support any new policies that are adopted. These changes, once fully implemented, will result in the efficient delivery and availability of evidence-based wellness and preventive services.

HIV Health Improvement Affinity Group

The Division of Health Care Services and the Division of Public Health continued their HIV collaboration into FY 2020. The Division of Health Care Services supported Public Health through revised data sets and ongoing support to identify patients through the established data sharing protocols. The Division of Public Health continues to provide investigations, linkage to care, and monitor viral load suppression of Alaska's HIV population. Alaska continues to be a leader for other states to follow regarding collaboration and data sharing between Divisions, and the coordination results in a high percentage of viral suppression among persons with HIV.

CMS Innovation Grant

In FY 2019, DHSS wrapped up work on the Medicaid Innovation Accelerator Program (IAP) for State Medicaid Housing Agency Partnerships. This IAP was a partnership between the Centers for Medicare and Medicaid Services and a number of other federal agencies, including the U.S. Department of Housing and Urban Development (HUD). The final action plan was submitted in May 2018, and the federal plan[7], which includes the work of the Alaska team who will implement the formal Alaska State Plan for Supportive Housing, was released in July 2018. Department of Behavioral Health submitted the final reports to the federal contractors and the services crosswalk and housing assessment were completed.

CDC 6|18 Initiative

The 6|18 initiative targets six high-burden health conditions (tobacco use, hypertension, healthcare-associated infections, asthma, unintended pregnancies, and type 2 diabetes) and offers 18 proven interventions to prevent them by increasing their coverage, access, utilization and quality. Alaska's official partnership with the 6|18 Initiative ended on October 10, 2018, however, the collaboration established between the Division of Health Care Services and the Division of Public Health has continued. The DHCS and DPH project teams continue to meet quarterly to advance additional areas of cooperation/collaboration, including:

- Outreaching to Medicaid members to increase use of tobacco cessation services and medication, including Alaska's Tobacco Quit Line.
- Clarifying and communicating Medicaid coverage of blood pressure monitoring equipment.
- Expanding use of cost-saving pharmacy interventions such as medication therapy management.
- Connecting Medicaid patients with the National Diabetes Prevention Programs (National DPP) and Diabetes Self-Management Education and Support (DSME/S).

12) Behavioral Health System Reform

SB 74 included a series of measures aimed at reforming the behavioral health system.

AS 47.05.270(b) requires DHSS to develop and manage a comprehensive and integrated behavioral health program that uses evidence-based, data-driven practices to achieve positive outcomes for people with mental health or substance abuse disorders and children with severe emotional disturbances.

AS 47.07.036(f) requires DHSS to apply for a section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration projects focused on improving the state's behavioral health system for Medicaid beneficiaries.

AS 47.07.900(4) was amended to remove the requirement that community mental health clinics be a state behavioral health grantee in order to enroll as a Medicaid provider.

A focus on behavioral health system reform was included as part of the Medicaid reform legislation due to a shortage of psychiatric inpatient beds and residential substance use disorder (SUD) treatment programs in Alaska, a fragmented system of community-based behavioral health providers, as well as insufficient treatment services in rural areas. The shortage has been putting a heavy burden on hospitals in urban areas, as well as the entire health care system, and severely limits timely access to care for the Alaskans in need of these services. Inadequate access to the appropriate level of care at

[7] http://campaign.r20.constantcontact.com/render?m=1011269667270&ca=ef44f871-1a1a-4cfd-8852-ec2d0da2fea9

both the preventive, early intervention, and lower acuity end of the continuum of care, and the facility-based treatment end, not only fails to provide timely interventions for patients and burdens providers, it drives higher costs for the Medicaid program. For an example, see the proportion of hospital emergency department service claims for frequent ED users on Medicaid, as well as the proportion of hospital readmissions, attributable to a behavioral health condition in FY 2018 in the tables on pages 31-32.

1115 Waiver: Behavioral Health Demonstration Project

The 1115 waiver will establish a network of behavioral health services at the community and regional level to reduce the need for crisis-driven and urban-based emergency, acute, and residential care by supporting development of missing components of the care continuum. With the assistance of a series of stakeholder workgroups that helped design the demonstration project during FY 2017, DHSS submitted the 1115 waiver application to the Centers for Medicare and Medicaid Services (CMS) on January 31, 2018. Following a federal public comment period, CMS started negotiations with DHSS over implementation plans in March of 2018. The waiver application is available at:
http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/AK_1115_WaiverApplication.pdf

DHSS received approval from the Centers for Medicare and Medicaid Services in two stages. First, in November 2018, the State received approval for the Substance Use Disorder component of the 1115 waiver. Then in September 2019, the State received approval for the Behavioral Health portion of the 1115 waiver. The Substance Use Disorder portion of the waiver is currently being implemented, and the Behavioral Health portion of the waiver will be implemented in State FY 2020. The State will provide Medicaid coverage for 23 new services under the 1115 authority.

The waiver approval is available at:
https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/ak-behavioral-health-demo-ca.pdf

DHSS has made progress on implementation of the SUD component of the 1115 waiver. The following is a summary of activities that occurred between January 1, 2019 and June 30, 2019:

- The Division of Behavioral Health (DBH) issued emergency regulations outlining provider requirements and service criteria and definitions for the new 1115 SUD services. The emergency regulations went into effect July 1, 2019 and were released for public comment on that same date for a 30-day public comment period ending August 8, 2019. Revisions were made to the emergency regulations based on public comment and a final review by Department of Law. The emergency regulations were made permanent on October 11, 2019 and the revisions to the emergency regulations become effective on November 10, 2019.
- DBH drafted sections of an Alaska Behavioral Health Provider Standards and Administrative Procedures Manual related to the new 1115 SUD services. The standards manual details service descriptions, staff qualifications, and service locations, limitations, coding, and rates for all the new SUD services.
- DHSS made considerable progress in contracting with an Administrative Services Organization (ASO) to administer waiver benefits, services, and claims processing. With the final contract signed November 2019, the services will go live in 90-120 days.
- DHSS has held a series of webinars, provider roundtables, and task force discussions to guide implementation of the SUD components of the waiver:
    - Continuum of Care/1115 Task Force: a task force comprised of providers, associations, and Tribes, was formed to provide advice to the state on behavioral health continuum of care issues and overall 1115 waiver goals, planning, and implementation.

    - Provider Roundtables: a series of provider roundtables were held to solicit feedback on the SUD Implementation Plan. Roundtables were small group discussions that allowed the state to ask questions and receive feedback from those who will be providing SUD waiver services.
    - Provider Trainings: a combination of in-person meetings and webinars were held to provide information on provider enrollment and billing for new services.
    - The state has also created a distribution list and an email account for stakeholder questions, comments, and suggestions.
- DHSS has begun drafting the evaluation design for the waiver, and has been participating in a learning collaborative sponsored by the National Governors Association, who has provided technical assistance in conjunction with the University of Minnesota's State Health Access Data Assistance Center (SHADAC) to assist the state in developing driver diagrams, research questions, hypotheses, and the analytic methods that will be used to evaluate the waiver.

Additionally, with the September approval of the Behavioral Health portion of the waiver, the division is doing the work of soliciting stakeholder input, drafting regulations, and vetting policy recommendations to implement the Behavioral Health services within state FY 2020.

Behavioral Health System Capacity

There are numerous other initiatives underway to support behavioral health system reform, primarily targeted at helping create needed capacity and capabilities in the system. In addition to the SB 74 amendment of AS 47.07.900 to remove the grantee requirement, two more recent bills further open up opportunities to become a Medicaid provider. SB 105, passed by the legislature in 2017, amended AS 47.07.030 to add marital and family therapy services as a Medicaid service, this regulation package is currently out for public comment. SB 169, passed in 2018, further amended AS 47.07.030 to allow any physician to operate a mental health physician clinic and to supervise the provision of care in the clinic via distance delivery. This regulation package has been signed by the Lt Governor.

In FY 2017, DHSS conducted readiness assessments of department staff and the behavioral health provider community to determine capabilities for helping to reform and operate within a reformed system of care. Informatics and financial, clinical, contract, and organizational management are examples of some of the domains covered by the assessments. Training and technical assistance programs to address readiness gaps were implemented, and continued during FY 2019, and will be sustained into the future as the reforms are fully implemented.

An increase in Medicaid Disproportionate Share Hospital (DSH) funding for behavioral health treatment services was funded by the Legislature for FY 2019 and FY 2020. In FY 2019, the preliminary federal DSH allotment to the State for the federal portion of the DSH allotment was $23.4 million. Funds paid to the three historical hospitals that received DSH payments in state FY 2019 equaled $2.8 million, and funds paid to the six new hospitals, including increased services at two hospitals previously receiving DSH funds, equaled $7 million. A total of $9.8 million was paid out for DSH services in FY 2019. (A separate federal allotment of $15.5 million for Institution for Mental Disease DHS payments also is received by DHSS and is not include in the table below.)

Table 1 | 2019 DSH Allotment and Payments

2019 DSH Allotments and Payments					
Hospital	**Community**	**DSH Classification**	**State Funds**	**Federal Funds**	**Total Payment Amount**
Historical Hospitals that Received DSH Payments					
Bartlett Regional Hospital*	Juneau	DET	$ 74,690	$ 74,690	$ 149,380
Fairbanks Memorial Hospital*	Fairbanks	DET	$ 53,332	$ 53,332	$ 106,664
Providence Alaska Medical Center	Anchorage	SPEP	$ 1,265,510	$ 1,265,510	$ 2,531,020
Total			$ 1,393,532	$ 1,393,532	**$ 2,787,064**
New Hospitals that Received DSH Payments in SFY2019					
Alaska Regional Hospital	Anchorage	SATP	$ 1,000,000	$ 1,000,000	$ 2,000,000
Bartlett Regional Hospital	Juneau	MHCA	$ 100,000	$ 100,000	$ 200,000
Central Peninsula Hospital	Soldotna/Kenai	MHCA	$ 300,000	$ 300,000	$ 600,000
Fairbanks Memorial Hospital	Fairbanks	SPEP	$ 1,100,000	$ 1,100,000	$ 2,200,000
Petersburg Medical Center	Petersburg	ICHC	$ 100,000	$ 100,000	$ 200,000
Providence Kodiak Island Medical Center	Kodiak	SATP	$ 150,000	$ 150,000	$ 300,000
Providence Seward Medical Center	Seward	ICHC	$ 500,000	$ 500,000	$ 1,000,000
South Peninsula Hospital	Homer/Kenai	SATP	$ 250,000	$ 250,000	$ 500,000
Total			$ 3,500,000	$ 3,500,000	**$ 7,000,000**
TOTAL Combined 2019 DSH PAYMENTS			$ 4,893,532	$ 4,893,532	**$ 9,787,064**
Federal 2019 SOA DSH Allotment/ State Matching Funds			$ 23,444,809	$ 23,444,809	$ 46,889,618
Unclaimed Federal 2019 DSH Funds			$ 18,551,277	$ 18,551,277	**$ 37,102,554**

** Note that DET DSH allotment and payment amounts are still within the invoicing period for SFY19, so these amounts may change.*

13) Eligibility Verification System

SB 74 established AS 47.05.105, which requires DHSS to implement an enhanced computerized income, asset, and identity eligibility verification system.

The purpose of this system is to verify eligibility, eliminate duplication of public assistance payments, and deter waste and fraud in public assistance programs. At this time last year, as noted in last year's report, DHSS was close to entering into an agreement with the New England States Consortium Systems Organization to procure an Asset Verification System. However, that process had to be cancelled because the statute requires the use of a competitive bidding process.

A Request for Interest (RFI) was released and closed at the end of September 2018. There were three respondents to the RFI. DHSS has chosen to put out a Request for Proposal (RFP) to procure for an Eligibility Verification System to meet the requirements of this legislation and to also meet the requirements for the Centers for Medicare and Medicaid Services (CMS) that takes into account the asset verification system (AVS) that is required by CMS and the National Directory of New Hires (NDNH) that is required by Food Nutrition Services.

The RFP is being finalized and will be sent to CMS for their review and approval. CMS has 60 days to approve the RFP. CMS will also need to approve the draft contract once the responses have been received and reviewed by the PEC, before a contract can be awarded. A state plan amendment will also be submitted in the spring of 2020 to coincide with the intent to award process. The timeline to have an award is by June 2020 if all approvals are obtained by CMS on the schedule provided.

14) Emergency Care Improvement

The Emergency Department Coordination Project (EDCP) was developed in response to SB 74 and is a collaborative effort between DHSS, the Alaska State Hospital and Nursing Home Association (ASHNHA), and the Alaska Chapter of the American College of Emergency Physicians (ACEP). EDCP requires a hospital-based project to reduce the use of emergency department services by Medicaid recipients.

EDCP includes the development and implementation of a system for real-time electronic exchange of patient information among Emergency Departments (EDs). There are currently 14 Alaska hospitals connected to Collective Medical's Emergency Department Information Exchange (EDIE). The current focus is now to get the remaining few hospitals connected and using the exchange. Five non-hospital organizations are also connected including Southcentral Foundation, Alaska Innovative Medicine, Inc., the Anchorage Fire Department, Links High Utilizer Mat-Su (HUMS), and LaTouche Pediatrics.

Connecting clinics and primary care groups to EDIE is also an important goal for increasing the intra-provider communication that supports high quality patient care. ASHNHA has assisted in submitting a grant that will provide funding for two additional clinics to connect to EDIE. Connecting the Alaska Psychiatric Institute (API) to EDIE remains a high priority area for ASHNHA. Although there is interest in moving forward with connecting to EDIE, the changing landscape of the Alaska Psychiatric Institute (API) and potential changes to the electronic medical record (EMR) have caused delays.

A recent highlight has been connecting the EDIE to the Prescription Drug Monitoring Program (PDMP) database. This connection enables providers to have real-time information to quickly identify patients with a high-risk prescription history.

The EDCP also includes a patient education component, to help direct care to the most appropriate setting. Another component of EDCP includes uniform statewide guidelines for prescribing narcotics in an ED. These guidelines have been in place for three years and are helping to combat the opioid epidemic.

Implementation status as of October 2019

Hospital	Status
Alaska Native Medical Center	Live with PDMP
Alaska Psychiatric Institute	Pending
Alaska Regional Hospital	Live with PDMP
Bartlett Regional Hospital	Live with PDMP
Central Peninsula Hospital	Live with PDMP
Cordova Community Medical Center	TBD
Fairbanks Memorial Hospital	Live with PDMP
Kanakanak Hospital/BBAHC	Summer 2020
Maniilaq Medical Center	Summer 2020
Mat-Su Regional Medical Center	Live with PDMP
Mt Edgecumbe Hospital	Summer 2020
Norton Sound Regional Hospital	TBD
PeaceHealth Ketchikan Medical Center	Live
Petersburg Medical Center	Live
Providence Alaska Medical Center	Live with PDMP

Providence Kodiak Island Medical Center	Live with PDMP
Providence Seward Medical Center	Live with PDMP
Providence Valdez Medical Center	Live with PDMP
Samuel Simmonds Memorial Hospital	TBD
South Peninsula Hospital	Live
Wrangell Medical Center	Live
Yukon Kuskowin Delta Regional Hospital	TBD
Clinics /Other	**Status**
Alaska Innovative Medicine	Live
Anchorage Fire Department	Live
Anchorage Neighborhood Health	TBD
LaTouche Pediatrics, LLC - Central Office	Live
LaTouche Pediatrics, LLC - Eagle River	Live
LaTouche Pediatrics, LLC - Huffman	Live
Links HUMS	Live
Southcentral Foundation	Live
Sunshine Community Health Center	In progress

15) Coordinated Care Demonstration Project

SB 74 established the Coordinated Care Demonstration Project (CCDP) under AS 47.07.039. The purpose of the CCDP is to assess the efficacy of various health care delivery models with respect to cost, access, and quality of care. Under the statute, the department is permitted to contract with provider-led entities, Accountable Care Organizations, managed care organizations, primary care case managers, and prepaid ambulatory health plans. The department issued a Request for Proposals (RFP) in FY 2017 soliciting proposals in any of three different health care models:

- Managed Care Organizations
- Case Management Entities
- Provider-Based Reforms

During FY 2018 the department conducted negotiations with four respondents to the RFP, and in June 2018 released Notices of Intent to Award contracts to two, United Healthcare to demonstrate a managed care model in Anchorage and the Mat-Su, and Providence Family Medicine Center (PFMC) to demonstrate a patient-centered medical home model (under the Provider-Based Reform category) in the Anchorage area. The state successfully contracted with PFMC in July of 2018, but postponed negotiations with United Healthcare in mid-2019. The department did an extensive amount of upfront work with United Healthcare but given the State's current fiscal situation this project could not move forward because it was not economically feasible.

<u>Patient Centered Medical Home (Providence Family Medicine Center)</u>

The state executed a contract in July 2018 with Providence Family Medicine Center (PFMC) to demonstrate a patient-centered medical home model (PCMH) in the Medicaid program. The project go-live date was September 1, 2018. PFMC provides current Medicaid patients the services of a physician-led interdisciplinary care team (IDCT), which includes primary care-based management for medical assistance services, case management, care coordination, social work, health education, and transitional and follow-up care. The state reimburses PFMC by way of a partial capitation rate for the additional IDCT services and the program is voluntary for patients, who may opt-out of receiving the additional

services at any time. The state is currently working with PFMC to assess the efficacy of the program during the first contract year.

16) Health Information Infrastructure Plan

Section 56 of SB 74 (uncodified) requires DHSS to develop a plan to strengthen the health information infrastructure, including health data analytics capability. The purpose of the plan is to transform the health care system by providing data required by providers for care coordination and quality improvement, and by providing information support for development and implementation of Medicaid reform. The Health Information Infrastructure Plan is required to leverage existing resources, such as the statewide health information exchange, to the greatest extent possible.

DHSS contracted with HealthTech Solutions to provide technical assistance. DHSS also established a stakeholder workgroup that included representatives from health care facilities, provider practices, medical associations, tribal entities, mental health practices, the statewide health information exchange, and DHSS. The contractor facilitated a series of stakeholder workgroup meetings and conducted a gap analysis to inform development of plan recommendations during FY 2017 and FY 2018, and presented their final report to DHSS in August 2018.

DHSS is using the Health Information Infrastructure Plan as a basis for funding requests from the Centers for Medicare and Medicaid Services (CMS) to support care coordination and quality improvement efforts through information technology. These funding requests for Federal Fiscal Year 2020 include:

- Health Information Exchange platform modernization and, enhancement, and support of statewide operational plan
- Medicaid information technology architecture self-assessment
- Document management system for DHSS
- Provider enrollment and management
- Electronic health record adoption
- Public health registry modernization and connection to the Health Information Exchange
- Independent verification and validation services
- Testing and quality assurance services

DHSS anticipates requesting additional federal funding for future activities related to the recommendations in the coming years as information technology infrastructure matures.

Additional Reporting Requirements

This section of the report (II.B) responds to the reporting requirements specified in AS 47.05.270(d)(2) through AS 47.05.270(d)(15).

1) Realized Cost Savings Related to Other Reform Efforts

AS 47.05.270(d)(2)

State General Fund Savings/Cost Avoidance
Due to Other Reform & Cost Containment Efforts

Program	FY2018	FY 2019	Increase / Decrease
Utilization Management	$3,892,146	$6,706,095	$2,813,949
HMS Third-Party Liability & Audit Recovery	$9,000,000	$8,896,765	($103,235)

Tribal Health System Partnerships	$22,500,000	$25,300,000	$2,800,000
DOC Inpatient Care Cost Avoidance	$1,848,234	$2,241,160	$392,926
TOTAL	**$40,038,129**	**$43,144,020**	**$3,105,891**

Utilization Management

DHSS contracts with a health management firm to provide utilization management services, also known as service authorization, for all inpatient hospital stays that exceed three days; inpatient stays and outpatient services for selected procedures and diagnoses, regardless of length of stay; and all outpatient magnetic resonance imaging (MRI), positron emission tomography (PET), magnetic resonance angiography (MRA), and single-photon emission computed tomography (SPECT). During FY 2019, these utilization management services yielded net Medicaid program savings of $22.4 million, approximately 30 percent of which, or $6.7 million, was State General Funds, and a return on investment of $14.14 for every $1.00 spent through the avoidance of unnecessary or untimely medical care.

Healthcare Management Systems Third-Party Liability and Audit Recovery

DHSS contracts with Healthcare Management Systems (HMS) to manage coordination of benefits for Alaska Medicaid recipients with a third party payer. HMS also audits provider claims and associated financial records to identify underpayments and overpayments, and recovers any overpayments made to providers. During FY 2019, third party liability (TPL) recoveries and savings exceeded $29 million, approximately 30 percent of which, or $8.9 million, was State General Funds.

Tribal Health System Partnerships

In FY 2019, DHSS continued the expansion of services in the Tribal health system which includes expanded service provision and payment to over 400 Community, Behavioral, and Dental Health Aides, expanded dental services in certain rural communities, continued tracking of existing long term care beds in the northern and western regions, continued tracking of additional newborn intensive care beds, obstetric services, extended hours for orthopedic surgeries in Anchorage, and additional residential capacity in Anchorage to accommodate recipients on the Alaska Native Medical Center campus. Increased service capacity at tribal health facilities resulted in increased claims for those services by approximately $84.6 million in FY 2019. In lieu of this increased capacity at tribal facilities, these services would have been provided in a non-tribal setting and only reimbursed at 50 percent if Care Coordination Agreements, referrals and electronic exchange of records were not in place and the beneficiary or service was not otherwise eligible for an enhanced federal match rate. The state saved an estimated 30 percent of this total, or approximately $25.3 million in FY 2019.

Medicaid Payment for Inpatient Care for Incarcerated Individuals

DHSS began providing Medicaid reimbursement for inpatient care provided outside correctional facilities for incarcerated individuals in FY 2015. This state policy change was based on earlier policy clarification from CMS, and expansion of Medicaid eligibility to low-income adults in September of 2015 extended coverage to a greater number of those incarcerated. In FY 2019 Medicaid paid claims billed in the amount of $2.2 million for inpatient care for Department of Corrections (DOC) inmates. This represents an increase of $.4 million between FY 2018-2019. In the past these fees would have been paid by DOC with 100 percent general fund dollars. This is a savings for their budget.

2) Achievement of Quality & Cost-Effectiveness Targets

AS 47.05.270(d)(3)

DHSS is able to report second-year performance results on achievement of quality and cost-effectiveness targets established by the stakeholder workgroup, as described in Section II.A.9 on page 16 of this report.

Results of 2018 Second-Year Performance on Quality & Cost Effectiveness Measures

Measure	Met 2018 Performance Target
A.1 Child and Adolescents' Access to Primary Care	N
A.2 Ability to Get Appointment With Provider As Needed	Y
B.1 Follow-up After Hospitalization for Mental Illness	Y
B.31 Alcohol and Other Drug Dependence Treatment[8]	Y
CH.1 Emergency Department Utilization	N
CH.2 Diabetic A1C Testing	Y
CH.3 Hospital Readmission Within 30 days - All Diagnoses	Monitor
C.1 Medicaid Spending Per Enrollee	N
C.2 Hospitalization Chronic Obstructive Pulmonary Disease	P
C.3 Hospitalizations Attributed to Diabetic Condition	Y
C.4 Hospitalizations Attributed Congestive Heart Failure	N
M.1 Live Births Weighing Less Than 2,500 Grams	N
M.2 Follow-up After Delivery	N
M.3 Prenatal Care During First Trimester	N
P.1 Childhood Immunization Status	N
P.2 Well-Child Visits for Children 0-6 by Age	P
P.3 Developmental Screening in the First Three Years of Life	P

Y = Met Performance Goal; N = Did Not Meet Performance Goal; P = Partially Met Performance Goal

Results of the second-year performance baseline for services delivered during state FY 2018, demonstrate that the program met or exceeded annual performance targets for five measures, partially met targets for three measures, are monitoring numbers for one measure, and failed to meet targets for the remaining eight measures.

[8] Measure B.2 Medical Assistance with Smoking and Tobacco Cessation, was moved to the *Potential Future Measures List* by the QCE workgroup in 2018.

There are a variety of factors that could be contributing to not meeting performance measures. One of the most significant is the opioid crisis in Alaska. Opioid use is a statewide concern impacting every age, race and socioeconomic status in Alaska. In 2010-2017, the opioid overdose death rate increased 77 percent.[9] Emergency Medical Services (EMS) calls more than doubled from 2012-2017 and the rates of opioid-related inpatient hospitalizations exceeded $23 million in 2017. This surge in opioid use is a factor in the results of a number of measures including: ability to get an appointment with a provider, follow up after care, emergency department utilization, hospital readmission, and live birth rates. The State of Alaska's Statewide Opioid Action Plan is working to combat this problem.

Another reason for increases in hospitalizations is the growth in population. Alaska saw a 1.9 percent increase in child population, a .9 percent decrease in aged population, and a 10.2 percent increase in adult population, resulting in higher hospitalizations, emergency room visits, and longer wait times.

DHSS has engaged in a number of initiatives aimed at improving the effectiveness of the Alaska Medicaid program and the overall health of Medicaid enrollees. The department's initiative to pursue an 1115 waiver to realign behavioral health services was also authorized under SB 74. Once fully implemented, this initiative should have positive impacts on Medicaid enrollee health.

3) Recommendations for Legislative or Budgetary Changes

AS 47.05.270(d)(4)

DHSS is continually evaluating the Medicaid program's effectiveness and efficiency. In FY 2019 the department's recommendation to streamline its Medicaid accounting structure was adopted by the legislature. This change will improve the budgetary and projection processes through an ease of reporting and cost efficiencies through a reduction in administrative activities.

4) Federal Law Changes that Impact the Budget

AS 47.05.270(d)(5)

The Healthy Kids Act was adopted in federal FY 2018 and it includes returning each state to its original Children's Health Insurance Program (CHIP) federal match through two annual decreases of 11.5% in Federal Medical Assistance Percentage (FMAP) rate changes starting in federal FY 2020. DHSS estimates this will result in a decrease of $3.8 million in federal match during FY 2020 followed by a similar decrease during FY 2021.

The Affordable Care Act for Medicaid expansion established transitional FMAP rates starting at 100% with the implementation of the program in CY2014 and leveling off at 90% in CY2020. DHSS estimates this will result in a decrease of $9.2 million in federal match during FY 2020.

5) Applications for Medicaid Grants, Options, or Waivers

AS 47.05.270(d)(6)

Waivers

DHSS applied to CMS for two new Medicaid waivers during FY 2018, the 1115 waiver for Behavioral Health Reform, and a new 1915(c) waiver for Individualized Supports. The application for the 1115 waiver was submitted to the federal government on January 30, 2018, and DHSS received approval from

[9] "*Opioid Epidemic in Alaska,"* State of Alaska, September 25, 2019, http://dhss.alaska.gov/dph/Director/Pages/opioids/home.aspx

the Centers for Medicare and Medicaid Services in two stages. First, in November 2018, the state received approval for the Substance Use Disorder (SUD) component of the 1115 waiver. Then, in September 2019, the state received approval for the Behavioral Health portion of the 1115 waiver. The SUD portion of the waiver is currently being implemented, and the Behavioral Health portion of the waiver will be implemented in state FY 2020. The state will provide Medicaid coverage for 23 new services under the 1115 authority. Please see Section II.A.12 beginning on page 18 of this report for more information on the 1115 waiver.

CMS approved the new 1915(c) Individualized Supports waiver in June 2018. This waiver serves individuals who had previously received services funded with 100 percent State General Funds through the Community Developmental Disabilities Grant Program. It allows up to 600 people to receive up to $17,500 (indexed to recognize a geographic differential) in waiver services every year. Effective on October 1, 2018, this new waiver joins DHSS's existing four long term services and supports waivers:

- AK.0260.R05.00 – 1915(c) HCBS Waiver for People with Intellectual or Developmental Disabilities
- AK.0261.R05.00 – 1915(c) HCBS Waiver for Alaskans Living Independently
- AK.0262.R05.00 – 1915(c) HCBS Waiver for Adults with Physical and Developmental Disabilities
- AK.0263.R05.00 – 1915(c) HCBS Waiver for Children with Complex Medical Conditions

In addition, three of the four existing waivers (all but the one that serves only adults) were amended in FY 2018 to align with regulations that removed intensive active treatment services for children. Children can now receive this service as part of regular Medicaid under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. EPSDT is a federally required benefit that provides comprehensive and preventive health care services for children.

State Plan Options

DHSS applied for one new Medicaid state plan option during FY 2018, the 1915(k) Community First Choice (CFC) Option; and also submitted a State Plan Amendment request for a new service under an existing state plan option, the Long Term Services and Supports Targeted Case Management (LTSS-TCM) service under the current Targeted Case Management Option.

Community First Choice (1915(k)) was approved by CMS in June 2018 and took effect October 1, 2018, providing personal care and other services to people who meet an institutional level of care. This new option provides an enhanced federal match of 6 percent on CFC services (increasing the standard federal match from 50 percent to 56 percent for those services). The personal care services of roughly 1,000 participants who also receive waiver services were transferred to the Community First Choice program as of October 1, 2018.

The Long Term Services and Supports Targeted Case Management service also took effect October 1, 2018. LTSS-TCM provides case management services for individuals on Community First Choice who require the services of a case manager, but who do not want to receive full waiver services. LTSS-TCM also centralizes initial application and annual support plan development with the case management services. These were formerly waiver services, and this transfer to LTSS-TCM has no effect on applicants or participants. It only affects care coordinators, who will use different billing codes for these services. DHSS does not anticipate any savings as a result of implementing Targeted Case Management; the fiscal note for SB 74 included estimates of costs for new recipients on the Community First Choice program (who must have the LTSS-TCM services in order to access the CFC services), off-set by the savings resulting from the six percent enhanced federal match.

Name	Number of persons Enrolled effective 10/01/2019
Individualized Support Waiver	319
Community First Choice	836

Grants

In May 2018 DHSS received a National Governors Association (NGA) Center for Best Practices grant that provides technical assistance for building data evaluation into the development and implementation of new Medicaid policies. The goal of the policy evaluation process is to identify how a new policy will impact Medicaid enrollees and further the objectives of the Medicaid Program. This is a 12-month project during which NGA will engage with consultants and other national experts in providing the technical assistance.

6) Demonstration Project Results

AS 47.05.270(d)(7)

DHSS is in the process of implementing two demonstration projects under SB 74:

- 1115 Demonstration Waiver for Behavioral Health System Reform, required under AS 47.05.270(b) and AS 47.07.036(f). Please see Section II.A.12 on page 18 of this report for information about this project.

The first phase of the 1115 waiver approved by CMS was inclusive of substance use disorder services, approved for implementation in March of 2019, and went live in July 1, 2019. Results of the phase one implementation are not yet available.

Phase two of implementation is inclusive of behavioral health services and is slated for go-live in late 2019 or early 2020. Preliminary results will not be available until mid-late 2020.

- The Coordinated Care Demonstration Project (CCDP), required under AS 47.07.039. Please see Section II.A.15 on page 23 of this report for information about this project.

As a result of the CCDP solicitation process DHSS selected two distinct proposals to continue on to the contract negotiation phase, which ultimately produced one fully executed contract for a patient centered medical home model through Providence Family Medicine Center (PFMC). A managed care model through United HealthCare was postponed during the negotiation stage and then cancelled the contract in mid-2019 after extensive internal review by the department.

7) Telehealth Barriers, Improvements, and Recommendations

AS 47.05.270(d)(8)

In response to AS 47.05.270 telehealth requirements, DHSS convened a Telehealth Stakeholder Workgroup during FY 2017 comprised of tribal and non-tribal health care providers, representatives from tribal health organizations and professional associations, Medicaid recipients, and state staff

members. The workgroup delivered its report to DHSS early in FY 2018 (August 2017)[10]. A summary of the workgroup's recommendations is presented in the table below[11]. There have been no further workgroups specific to this topic in FY 2019. This was a one time workgroup.

Medicaid Redesign Telehealth Stakeholder Workgroup Recommendations	
Recommendation 1	Reimburse Care Management and Use of Remote Monitoring Strategies in Home Settings
Recommendation 2	Revise Regulations Regarding Prescriptions for Controlled Substances
Recommendation 3	Monitor Medical Board Licensing Regulations Regarding Delivery of Telehealth Services
Recommendation 4	Require All Payers to Reimburse Telehealth at Parity
Recommendation 5	Improve Coordination Between Schools and Providers to Expand the Use of Telehealth
Recommendation 6	Support Collaborative Efforts to Leverage Federal Funding for Internet Coverage in Rural Areas
Recommendation 7	Work with the Health Information Exchange and Department of Commerce to Develop Telehealth Central Network
Recommendation 8	Help Providers Invest in Equipment and Connectivity to Support Telehealth Strategies
Recommendation 9	Develop Baseline Data of Telehealth Utilization and Analyze Use and Need Patterns
Recommendation 10	Continue Medicaid Redesign Telehealth Stakeholder Workgroup

DHSS is currently working on phase one of a two-phase telehealth regulation update project. The initial phase is focused on clarifying current definitions and better defining modes of telehealth delivery. The second phase will focus on identifying and adding services and modes of delivery that will increase access to care in underserved communities in the most cost-effective manner.

Several divisions within DHSS are also evaluating varied telemedicine strategies aimed at improving recipient access to necessary services as they pertain to their specific programs. Efforts within the Division of Senior and Disabilities Services and the Division of Behavioral Health are each exploring ways in which advances in new technology may streamline services and expand access to care. Further development of these strategies is necessary to determine whether the options can reliably provide services long-term and will be cost effective for the program in the long-run.

[10] Telehealth Stakeholder Workgroup Report: Appendix F of FY 2018 Annual Medicaid Reform Report http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/FY-2018_Annual_Medicaid_Reform_Report_with_Appendices.pdf

[11] DHSS Response to Telehealth Stakeholder Workgroup Recommendations: Appendix G of FY 2018 Annual Medicaid Reform Report http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/FY-2018_Annual_Medicaid_Reform_Report_with_Appendices.pdf

8) Medicaid Travel Costs

AS 47.05.270(d)(9)

In FY 2019 total travel expenditures increased by $18 million compared to FY 2018, an increase of 28 percent. In FY 2019 total travel expenditures continue to follow the trend from FY 2016 with the majority of expenditures being federal funds, with only 4 percent of the increase as general fund (GF) or $.7 million from FY 2018 to FY 2019. The overall increase expenditure aligns with enrollment growth in Medicaid. The Medicaid program continues to contain costs well below enrollment growth and was able to attain significant cost savings in state GF due to the tribal initiative.

9) Emergency Department Frequent Utilizers

AS 47.05.270(d)(10)

The following table depicts the number of frequent users of emergency departments in FY 2018 and FY 2019. The threshold for frequent users was five visits within the fiscal year. Medicare crossover claims were excluded from this analysis. The Care Management Program, under 7 AAC 105.600, emphasized emergency department use during FY 2019 and is a contributing factor to the reduced quantity of ER frequent utilizers. Expansion of the Care Management Program in FY 2020 aims to further reduce frequent emergency room utilizers.

Number of Medicaid Recipients Identified as Frequent Emergency Department Users		
FY 2018	**FY 2019**	**Percent Change**
5,457	5,198	-5%

FY 2019 Top Diagnoses at ED Visit of Medicaid Recipients Identified as Frequent ED Users	
Diagnosis	**Number of Claims**
Unclassified (e.g., fever, chest pain)	25,423
Injury	20,408
Behavioral Health Condition	15,871
Respiratory Disease	14,576

10) Hospital Readmissions

AS 47.05.270(d)(11)

Readmission data for FY 2017 – 2019 was recalculated using a new data analytics tool JSURS. This tool provides additional data points and functionality to identify hospital readmissions. This tool was implemented in December 2019 and was used to take a closer look at readmissions than in previous fiscal years.

The following table depicts the number of hospitalized Medicaid recipients who were readmitted to the hospital within 30 days of discharge. Readmissions are counted for the 2-30 day period following a hospital stay to omit hospital-to-hospital transfers that are captured as one-day readmissions.

Of the 1,279 recipients with a readmission in FY 2017, only 157 had a hospitalization and subsequent readmission in FY 2018. Of the 1,363 recipients with readmission in FY 2018, only 155 had a hospitalization and subsequent readmission in FY 2019.

Number of Hospital Readmissions (2 – 30 days following discharge)		
FY 2017	**FY 2018**	**Percent Change**
1,279	1,363	6.5%
FY 2018	**FY 2019**	**Percent Change**
1,363	1,422	4.3%

FY 2019 Top ICD-10 Diagnoses Classifications for Hospital Readmissions of all Medicaid Recipients	
Diagnosis	**Number of Claims**
Unclassified (e.g., fever, nausea)	309
Behavioral Health Condition	246
Pregnancy, Childbirth, Puerperium and Perinatal	268
Respiratory Disease	160
Circulatory System Diseases	139
Digestive System Diseases	137
Injury	129

11) State General Fund Spending per Recipient
AS 47.05.270(d)(12)

State General Fund spending for the average medical assistance recipient increased by 3.1 percent in FY 2019 compared to FY 2018. In FY 2018 the State General Fund spending averaged $3,129 per recipient and in FY 2019 it averaged $3,227. The increase is attributed primarily to FY 2018 claims pushed forward for payment in FY 2019 due to insufficient funding in FY 2018. In FY 2018 there were 202,806 recipients and State General Fund spending was $634.6 million and in FY 2019 there were 204,980 recipients[12] and State General Fund spending was $661.4 million.[13]

Average State General Fund Spending per Medicaid Recipient

FY 2018	FY 2019	Percent Change
$3,129	$3,227	3.1%

12) Uncompensated Care Costs
AS 47.05.270(d)(13)

The following are the 2012 – 2017 uncompensated care costs incurred by hospitals in Alaska that complete standard Medicare cost reports and for which this information is available (16 hospitals represented). Due to difference in hospital fiscal years the data may represent different periods. For

[12]The number of recipients will differ from the number of enrollees reported elsewhere in this report. Enrollees are counted as recipients only if they receive a Medicaid service at some point during the fiscal year.

[13]State General Fund spending per recipient would have been lower if claims that would normally have been paid at the end of FY 2018 had not been pushed forward for payment in FY 2019 due to insufficient funding in FY 2018. Had those FY2018 claims been paid in FY2018, GF spending per recipient for FY 2019 would have reflected a decrease of 6.6 percent, at $ 3,070 per recipient (based on $623,569,349 GF expenditures for 203,090 recipients). Note that the additional claims paid increase the unduplicated recipient count in FY 2019.

example: 2017 includes data from July 1, 2017- June 30, 2018 for those on state fiscal year and October 1, 2017 – August 30, 2018 for those on federal fiscal year.

Hospital Uncompensated Care Data

Year	Uncompensated Care	% Change
2012	$90,813,377	NA
2013	$95,402,055	5.1%
2014	$112,930,257	18.4%
2015	$95,261,077	-15.6%
2016	$73,066,335	-23.3%
2017	$67,179,090	-8.1%

Source: Alaska State Hospital & Nursing Home Association, October 2019. S-10 worksheet line 30 (cost of non-Medicare bad debt + charity care to uninsured patients), includes cost report data submitted through facility FY2017. Non-tribal hospitals

Note that prior year hospital uncompensated care data reported in the FY 2016 and FY 2017 Annual Medicaid Reform Report may differ from the amounts reported here because this data is revised as updated cost reports are processed.

The following information is provided by the Alaska Division of Insurance in response to the question regarding the change in health insurance premiums.

Year/Market	Member Months	Total Direct Premiums Paid	Premium Per Member Per Month PMPM	PMPM Increase From Previous Year
CY 2014				
Individual Market	266,002	$117,103,505	$440.24	
Small Group Market	205,017	$123,538,386	$602.58	
CY 2015				
Individual Market	326,711	$200,892,206	$614.89	39.67%
Small Group Market	208,435	$133,752,599	$641.70	6.49%
CY 2016				
Individual Market	256,629	$215,793,787	$840.88	36.75%
Small Group Market	202,711	$134,307,229	$662.56	3.25%
CY 2017				
Individual Market	221,398	$208,006,966	$939.52	11.73%
Small Group Market	195,703	$138,548,645	$707.95	6.85%
CY 2018				
Individual Market	228,360	$177,026,963	$775.21	-17.49%
Small Group Market	177,154	$139,226,103	$785.90	11.01%

Source: Alaska Division of Insurance, November 2019

13) Optional Services Expenditures by Fund Source

AS 47.05.270(d)(14)

State FY 2019 spending for provision of optional services is presented in the table on the following page with a breakdown by service category and funding source. Services listed under the Optional category should also be cross referenced with the Affordable Care Act (ACA) required essential health benefits from CMS to fully understand what services are truly optional. The list of essential health benefits with the ACA required benefits can be found here: https://www.healthcare.gov/coverage/what-marketplace-plans-cover/

Note: Totals below may not exactly equal sum of column/row due to rounding

WAIVER OR OPTIONAL SERVICE STATE FISCAL YEAR 2019	STATE SPENDING	FEDERAL SPENDING	TOTAL SPENDING
WAIVER			
ADULT DAY CARE	$2,828,081	$3,113,740	$5,941,821
CARE COORDINATION	$6,256,537	$7,159,286	$13,415,823
CHORE SERVICES	$748,582	$750,859	$1,499,441
DAY HABILITATION	$19,416,524	$20,226,034	$39,642,558
ENVIRONMENTAL MODIFICATIONS	$101,413	$101,413	$202,826
INTENSIVE ACTIVE TREATMENT/THERAPY	$591,974	$643,609	$1,235,582
MEALS	$1,334,303	$1,397,711	$2,732,014
RESIDENTIAL HABILITATION	$66,153,816	$70,124,173	$136,277,989
RESIDENTIAL SUPPORTED LIVING	$23,219,067	$25,216,502	$48,435,569
RESPITE CARE	$6,701,865	$7,174,043	$13,875,907
SPECIALIZED EQUIPMENT AND SUPPLIES	$108,236	$128,619	$236,855
SPECIALIZED PRIVATE DUTY NURSING	$251,213	$357,666	$608,879
SUPPORTED EMPLOYMENT	$4,015,357	$4,015,357	$8,030,714
TRANSPORTATION	$1,248,927	$1,333,746	$2,582,674
TOTAL WAIVER SERVICES	**$132,975,894**	**$141,742,758**	**$274,718,652**
OPTIONAL			
CASE MANAGEMENT SERVICES	$0	$27,863	$27,863
CHIROPRACTIC SERVICES	$28,975	$26,251	$55,226
DENTAL SERVICES.	$10,712,586	$33,596,087	$44,308,673
DRUG ABUSE CENTER	$3,213,488	$22,926,799	$26,140,287
DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES	$3,221,995	$5,281,562	$8,503,557
END STAGE RENAL DISEASE SERVICES	$3,383,130	$3,968,499	$7,351,628
HEARING SERVICES	$1,102,142	$2,321,674	$3,423,816
HOSPICE CARE	$138,543	$241,642	$380,185
INPATIENT PSYCH SERVICE	$173,878	$223,829	$397,707
INTENSIVE CARE FACILITY/INTELLECTUALLY DISABLED SERVICE	$1,127,164	$1,193,346	$2,320,510
MEDICAL SUPPLIES SERVICE	$4,136,038	$4,892,836	$9,028,874
MENTAL HEALTH SERVICE	$16,300,185	$62,036,912	$78,337,097
NUTRITION SERVICES	$5,506	-$2,087	$3,419
OCCUPATIONAL THERAPY	$190,855	$428,816	$619,671
PERSONAL CARE SERVICES	$26,233,398	$29,993,242	$56,226,640
PODIATRY	$49,284	$62,668	$111,952
PRESCRIBED DRUGS	$30,728,559	$98,778,686	$129,507,245
PROSTHETICS & ORTHOTICS	$369,461	$707,165	$1,076,625
PSYCHOLOGY SERVICES	$214,591	$595,157	$809,748
REHABILITATIVE SERVICES	$2,417,738	$5,585,595	$8,003,332
VISION SERVICES	$1,939,124	$3,950,814	$5,889,938
TOTAL OPTIONAL SERVICES	**$105,686,637**	**$276,837,355**	**$382,523,991**
GRAND TOTAL	**$238,662,531**	**$418,580,112**	**$657,242,643**

Waiver Services are the Adult Waiver Services and the Kids Waiver Services combined together.
Optional Services are only Adults Optional services.

14) Tribal Medicaid Reimbursement Policy Savings

AS 47.05.270(d)(15)

On February 26, 2016, the Centers for Medicare and Medicaid Services (CMS) released State Health Official (SHO) letter #16-002 updating its policy regarding circumstances in which 100 percent federal funding is available for services to American Indian/Alaskan Native (AI/AN) "received through" facilities of the Indian Health Service (IHS), including Tribal Health Organizations.

The SHO letter requires care coordination agreements (CCAs) between tribal and non-tribal providers to claim the enhanced federal match for services provided to an AI/AN Medicaid enrollee by a non-tribal provider. DHSS has been working with the Tribal Health Organizations (THOs) to facilitate initiation of CCAs with non-tribal organizations since February 2016. The SHO letter further requires the validation that a referral was made for each episode of care, and that an exchange of electronic health records occurred for each episode of care. There are currently a total of 1,713 CCAs in place between 18 THOs and 137 non-tribal providers. Note that some, but not all, of the THOs have signed an agreement with each of the 137 non-tribal providers.

DHSS's Tribal Section tracks the 1,713 CCAs, and must verify that a valid referral and exchange of health records occurred for each episode of care before the state can claim 100 percent federal funding. The number of referrals requested and verified by DHSS since the new policy was implemented through the end of FY 2019 was 57,030. The number for which sufficient documentation was available to validate the referral was 12,308 or 22 percent of requested referrals. In addition, DHSS must also track the transportation arrangements made by the Alaska Native Tribal Health Consortium, Yukon Kuskokwim Health Corporation, and Tanana Chiefs Conference for AI/AN recipients, which account for approximately 1,000 – 1,200 travel arrangements per week.

State Fiscal Year	Total # of Referrals Requested	# of Referrals that could be Verified	% of Referrals that could be Verified
2017	5,871	1,363	23.2%
2018	19,207	4,231	22.0%
2019	31,952	6714	21.0%
TOTALS	57,030	12,308	22.0%

Based on the efforts described above, DHSS has been able to save $152 million in State General Funds from the February 2016 date of the SHO letter through the end of FY 2019. Alaska is the only state in the nation refinancing claims at this level and has been providing leadership for the other states' Medicaid programs in this area.

State Fiscal Year	State GF Savings: Transportation	State GF Savings: Other Services	Total GF Savings
2017	$ 10,589,538	$ 24,192,302	**$ 34,781,839**
2018	$ 28,863,462	$ 15,901,959	**$ 44,765,420**
2019	$ 45,724,251	$ 26,922,884	**$ 72,647,136**
TOTALS	**$ 85,177,251**	**$ 67,017,145**	**$ 152,194,395**