AK DHSS Annual Medicaid Reform Report

FY2020

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 AS 47.05.270

Adam Crum
Commissioner
Department of Health & Social Services

FY 2020 Annual Medicaid Reform Report

November 16, 2020

I. EXECUTIVE SUMMARY

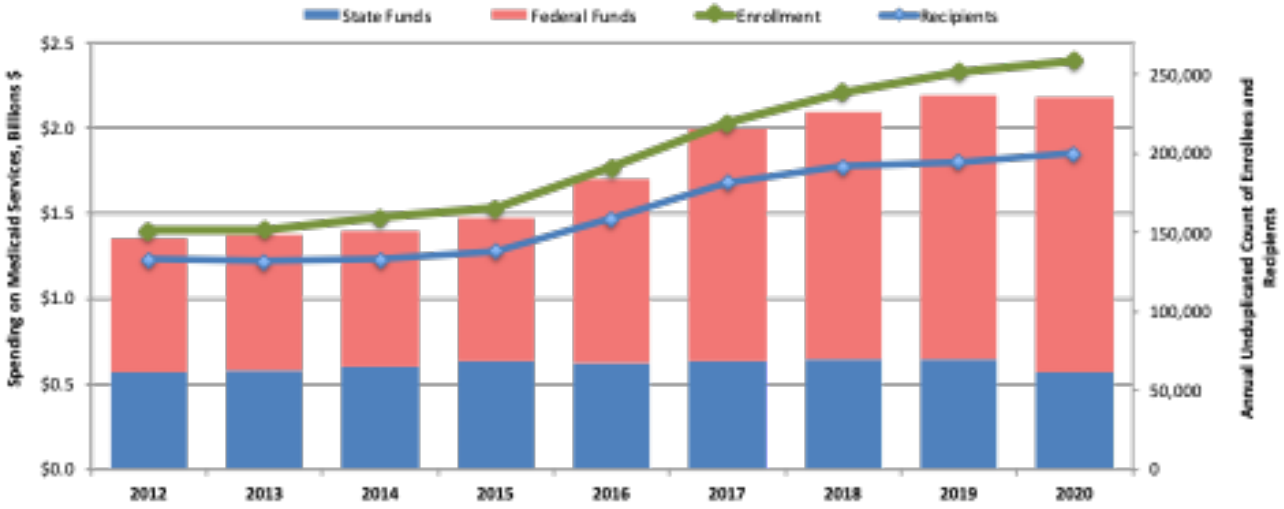
The Medical Assistance Reform Program was established under AS 47.05.270 by Senate Bill 74 (SB 74) in 2016. Under this statute, the Department of Health & Social Services (DHSS) is required to submit an annual report to the Legislature by November 15 of each year on the status and results of Medicaid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

This report identifies $221 million in State General Fund savings and cost avoidance that were achieved in FY 2020. 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.

FY 2020 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	$ 95,118,334
Alaska Medicaid Coordinated Care Initiative (Primary Care Case Management)	$ 1,767,844
Subtotal	**$ 96,886,178**
SB 74 Medicaid Reform GF Cost Avoidance — DOC	
Medicaid enrollment for prisoners; out-of-facility hospital services	$ 4,739,174
GF Savings/Cost Avoidance from Other Medicaid Reforms — DHSS	
Pharmacy Preferred Drug List	$ 4,000,000
Pharmacy Prospective Drug Utilization Reviews	$ 16,500,000
Pharmacy Payment Reform: NADAC Implementation	$ 12,000,000
Subtotal	**$ 32,500,000**
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	$ 541,687
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	$ 8,859,224
Care Management Program	$ 4,080,000
Case Management	$ 1,087,563
Utilization Management Services	$ 19,126,421
Subtotal	**$87,049,227**
TOTAL	**$221,174,579**

The following graphs from the Preliminary Medicaid long-term forecast to be published in January 2021, illustrates how enrollment has grown over the past five years primarily due to Alaska's economic recession and to Medicaid expansion. The COVID-19 public health emergency also resulted in a slight increase in enrollment associated with the Maintenance of Effort requirements for the Enhanced Federal Medical Assistance Percentage (FMAP) of 6.2 percent. DHSS received an additional $36 million in federal reimbursement in SFY 2020 associated with the enhanced FMAP and is estimating another $54 million in SFY 2021. While unduplicated recipient counts and total spending has decreased as a result of Medicaid reform efforts, a number of other factors have contributed to reduced spending and recipient counts in SFY 2020, mostly associated with the adverse impacts of the COVID-19 public health emergency.

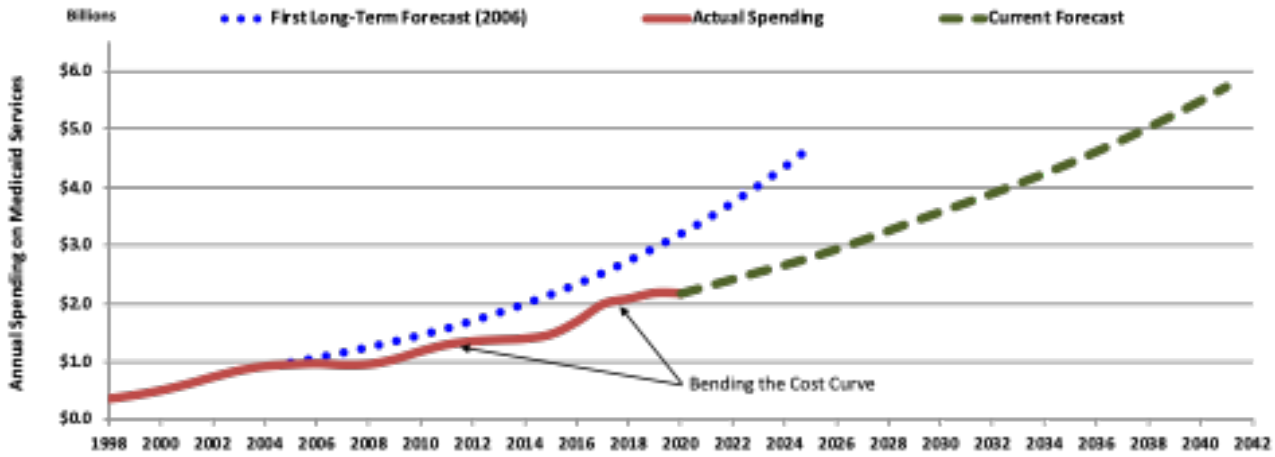
Spending on Medicaid Services, Enrollment in the Medicaid Program, and Recipients of Medicaid Services, Based on Date of Service, FY2012 – FY2020[1]



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 2020). Preliminary Long-Term Forecast of Medicaid Enrollment &Spending in Alaska (MSEA): FY 2021 – FY 2041.

Spending on Medicaid Services, Actuals, Projected in First Long-Term Forecast (February 2006), and Current Forecast[2]



The following is a brief summary of FY 2020 Medicaid activities and accomplishments. Additional details for each are provided later in the report.

Explanation of Benefits: Design for a new electronic Explanation of Medical Benefits (EOMB) portal was completed in FY 2020. The Division of Health Care Services (DHCS) will release the EOMB portal in November 2020. The portal design work has been completed and coding and testing of the new portal is ongoing. The November 2020 release will include basic member functionality and will be followed by a January 2021 supplemental release of additional features. The new EOMB portal will contain claim information for both adults and children and is expected to be a great resource to provide members direct access to their Medicaid claims history.

Telehealth: Medicaid expenditures for services delivered via telehealth increased 522 percent since FY 2016. The top diagnoses/conditions treated via telehealth in FY 2020 were behavioral health, followed by hypertension and delayed milestones in childhood.

Fraud, Waste & Abuse: During FY 2020, Medicaid Program Integrity (MPI) recovered nearly $5.6 million in overpayments paid to providers and six payment suspensions were initiated based on credible allegation of fraud determinations. MPI partnered with the Centers for Medicare and Medicaid Services (CMS) and their Division of State Partnership on a new Medicare-Medicaid data sharing initiative to help identify fraud, waste and abuse that overlaps both programs. MPI also continued to work with the Alaska Health Care Fraud Task Force, focusing on physicians and advanced practice registered nurses suspected of over-prescribing opioids. MPI became a Law Enforcement Liaison with the National Healthcare Anti-Fraud Association (NHCAA) to leverage training opportunities, share the various tools used by partners and to detect and prevent healthcare fraud more effectively.

Overall, Medicaid Program Integrity saved the Medicaid program over $6.4 million for a total return on investment of $5.40 per dollar spent.

[2] Evergreen Economics, (November 2020). Preliminary Long-Term Forecast of Medicaid Enrollment &Spending in Alaska (MSEA): FY 2021 – FY 2041.

Home & Community-Based Services (Long-Term Services and Supports Reforms): Home and Community-Based Services (HCBS) help people 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 experienced modest growth under SB 74. There was a total of $5.5 million in State General Fund/cost avoidance savings due to current care management programs including case management via the Alaska Medicaid Coordinated Care Initiative (AMCCI) also known as the "super-utilizer" initiative, and DHSS' homegrown Care Management Program (CMP).

Redesigning the Payment Process: Payment reform continues for pharmacy and 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 can now report third-year Medicaid program performance on the measures and targets established by the Quality & Cost Effectiveness Targets Stakeholder Workgroup. Results of the third -year performance baseline for services, delivered during state FY 2019, demonstrate that the program met or exceeded annual performance targets for five measures; partially met targets for four measures; is monitoring numbers for one measure; and failed to meet targets for the remaining seven measures.

Travel Costs: In FY 2020, the Medicaid program continued cost containment efforts through a variety of initiatives such as efforts to increase Tribal claiming and continued development of policies and procedures to manage transportation. Total travel expenditures decreased 4 percent from FY 2019 to FY 2020. The COVID-19 public health emergency is likely a major factor in this decrease; Alaska state mandates relating to travel and healthcare had a significant impact on both inter and intra state travel. In a normal year, the Medicaid travel program would most likely have seen an increase in spending as enrollment between 2019 and 2020 increased by 11,226 members, or 4 percent.

Disease Prevention & Wellness: DHSS continues to analyze and revise, as necessary, Medicaid coverage policies to ensure efficient delivery and availability of services, as well as ensure prevention and wellness services are evidence-based. DHSS participated in the Medicaid Innovation Accelerator Program (IAP) for State Medicaid Housing Agency Partnerships and remains prepared to continue its participation in and contribution to the Alaska State Plan for Permanent Supportive Housing as efforts advance.

Behavioral Health System Reform: DHSS applied for a Section 1115 Demonstration Waiver with CMS to establish a network of behavioral health services at the community and regional levels in order 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 component of the 1115 Waiver was approved in September 2019. The SUD (SUD) component of the waiver is currently being implemented and the Behavioral Health component went live with emergency regulations in May 2020. In October 2019, DHSS contracted 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 between 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: Beginning mid-2018, DHSS executed a contract for a patient centered medical home model through Providence Family Medicine Center (PFMC). Now in the second year of a three-year contract, DHSS continues to partner with PFMC to make improvements to existing performance measurements and reporting, fine tune program operations, and identify areas of improvement. DHSS is also exploring new initiatives around the PFMC model to include care for high-needs and vulnerable populations and addressing chronic pain management and opioid use.

Health Information Infrastructure Plan: DHSS is using the Health Information Infrastructure Plan to support care coordination and quality improvement efforts through information technology. The plan includes 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' Tribal Health Unit tracked 4,750 Coordinated Care Agreements (CCAs) between Tribal and non-Tribal providers and saw a total of 96,942 referral requests in FY 2020. DHSS was able to save $95 million in State General Funds in FY 2020 and a total of $248 million in State General Funds from February 2016 through the end of FY 2020.

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	$ 15,901,959	$ 29,285,002	**$ 45,186,961**
2019	$ 26,922,884	$ 45,724,251	**$ 72,647,136**
2020	$ 35,998,891	$ 59,119,442	**$ 95,118,333**
TOTALS	**$ 89,413,272**	**$ 158,320,997**	**$ 247,734,269**

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 where 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 and the Department of Labor and Workforce Development under AS 23.15, the University of Alaska, or other sources.

The Division of Public Assistance (DPA) provides case management services and supports to promote employment and self-sufficiency for families participating 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 options, 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 and Matanuska-Susitna (Mat-Su) Valley residents receiving Supplemental Nutrition Assistance Program (SNAP) benefits. DPA has four ongoing grant agreements with non-profit agencies in Anchorage and has signed two new agreements with agencies in the Mat-Su Valley and Anchorage, with services anticipated to begin in FY 2021. In response to the COVID-19 public health emergency, the SNAP Employment and Training Program initiated grants with existing providers to migrate services to a virtual model in the summer of 2020. The program has also offered a flexible procurement process to allow onboarding of providers during the fiscal year.

The SNAP Employment and Training program will continue its efforts in FY 2021 to engage with a career and technical college to offer a pathway for statewide expansion through the University of Alaska 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 covered 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.

DPA continues to explore an agreement with the Department of Labor & Workforce Development (DOLWD) to participate as a provider through the 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.

The Division of Health Care Services (DHCS) will release a new electronic Explanations of Medical Benefits (EOMB) portal in November 2020. The portal design work has been completed and coding and testing of the new portal is ongoing. The November 2020 release will include basic member functionality and will be followed by a January 2021 supplemental release of additional features.

The new EOMB portal has a direct connection to the Medicaid Management Information System (MMIS) and will provide EOMB functionality for both children and adults. Additionally, the new portal will contain claims information that looks far enough backward to ensure there is no gap between dates of service available in the previous EOMB tool and the new portal[3].

The Division eagerly anticipates the re-release of the new EOMB, as it serves as a tool for member education, but can also act as a catalyst for fraud, waste, and abuse investigations.

3) Telehealth

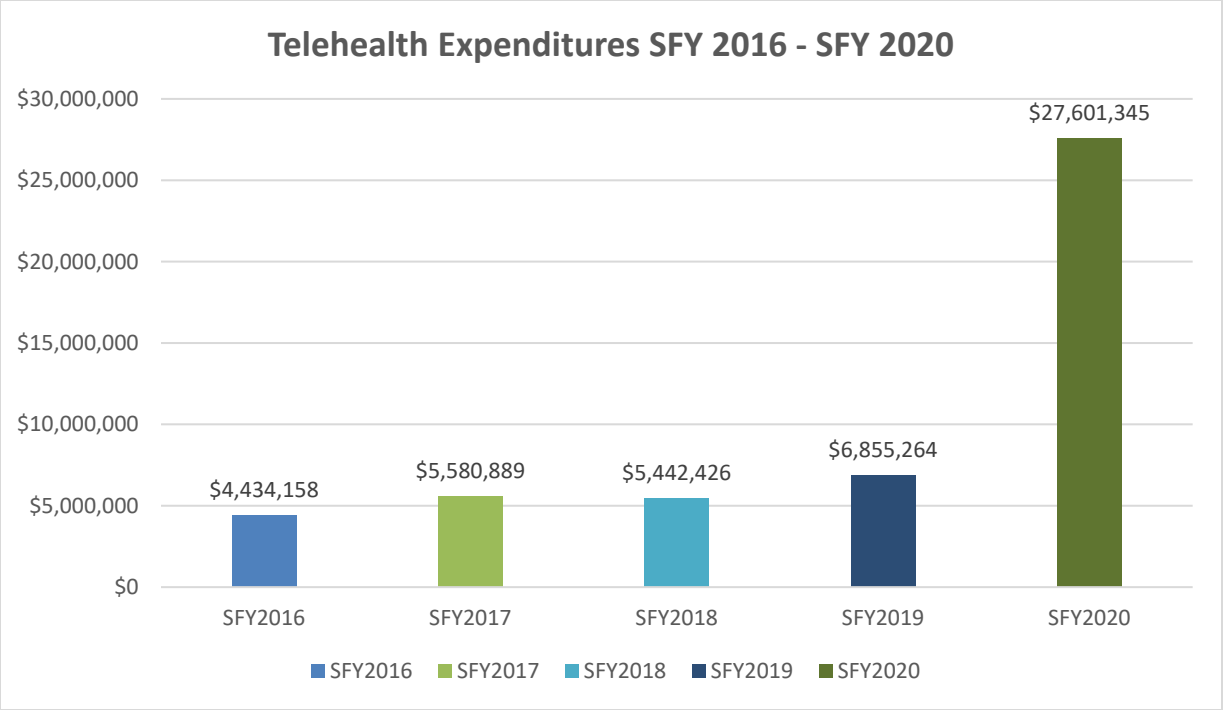
AS 47.05.270(a)(3): expanding the use of telehealth for primary care, behavioral health, and urgent care.

Telehealth is a method of delivering medical services using telecommunication technologies to extend patient care when face-to-face appointments are unavailable. Telehealth is a Medicaid-covered service. Medicaid pays enrolled providers for medical services delivered through telehealth methods if the service is:

1) identified as a covered service on the Telehealth Services Fee Schedule;
2) covered under traditional, non-telehealth methods;
3) provided by a Medicaid-enrolled treating, consulting, presenting, or referring provider; and
4) appropriate to be provided via telehealth per the provider's standards of practice

In FY 2020 the Medicaid program paid $27.6 million in claims for services delivered via telehealth methods, an increase of 303 percent over the amount paid for services delivered via telehealth in FY 2019. The increased use of telehealth has a potential for program savings in transportation costs that are avoided due to services delivered in a recipient's home community via telehealth. The savings in transportation costs has not yet been quantified and will be difficult to analyze until the COVID-19 public health emergency is no longer affecting travel for Alaskans.

[3] The previous EOMB tool ended on August 31, 2019. The new tool will include EOMBs since that time.

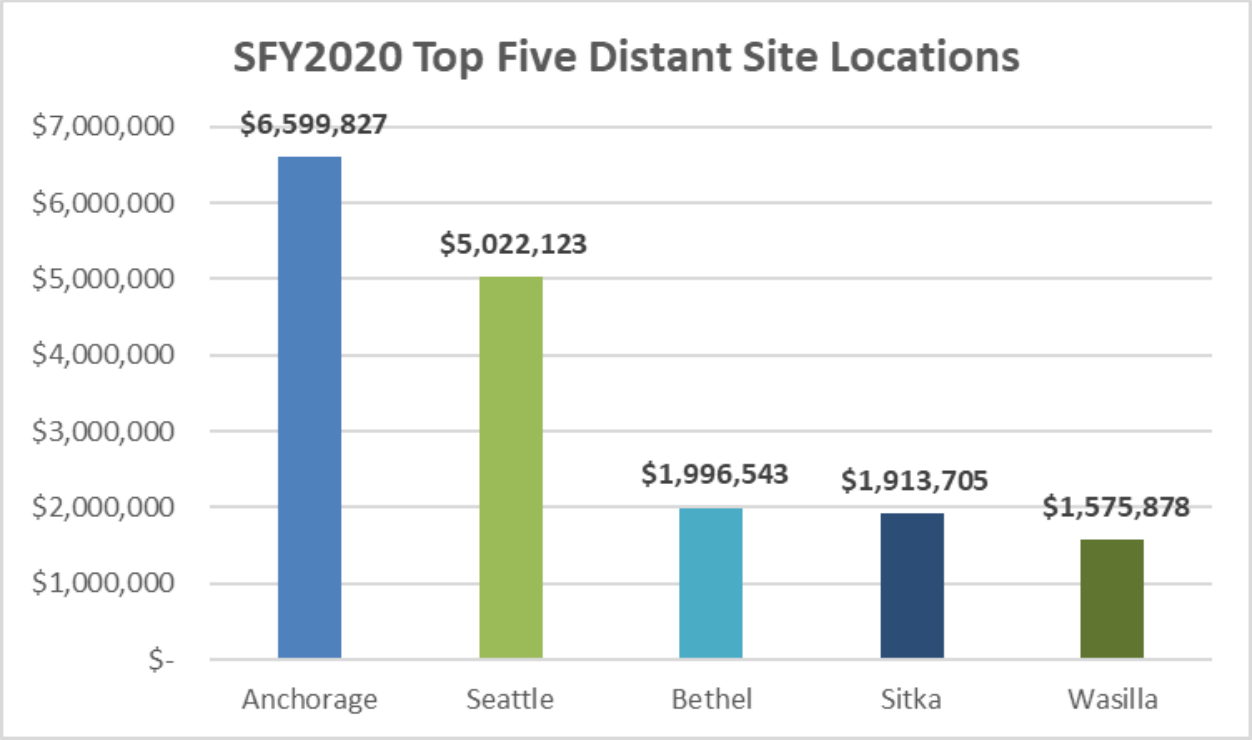


A service delivered via telehealth is reimbursed at the same rate as the same service delivered in a face- to-face setting. Alaska Medicaid currently restricts telehealth coverage to services provided through one of these three methods:

- **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.

The COVID-19 public health emergency has significantly impacted the need of telehealth services in communities around Alaska. DHSS is currently working with providers to determine what needs will be on-going after the public health emergency. This will be followed by 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 35 for additional information about DHSS efforts to improve Medicaid telehealth policy.

In FY 2020 the top five distant site locations (locations of the health care provider delivering the service via telehealth) were Anchorage, Seattle, Bethel, Sitka, and Wasilla.



The following table lists the top disease categories and diagnoses for telehealth-delivered service claims billed in FY 2020. Behavioral health conditions continue to be the leading diagnosis for services performed via a telehealth method of delivery.

Top Disease Categories	# of Medicaid Claims	Top Diagnoses in Each Category
Mental, Behavioral and Neurodevelopmental Disorders	80,438	• Post-traumatic stress disorder • Opioid dependence • Mixed receptive-expressive language disorder • Alcohol dependence • Major depressive disorder
Symptoms, Signs, and Abnormal Clinical and Laboratory Findings	5,372	• Delayed milestone in childhood • Cough • Lack of expected normal physiological development in childhood • Rash • Abnormal pain
Diseases of the Musculoskeletal System and Connective Tissue	5,058	• Low back pain • Muscle weakness • Pain in right shoulder • Pain in left knee • Pain in right knee
Factors influencing health status and contact with health services	4,356	• Follow up exam • Observation for suspected exposure to biological agents ruled out • Routine child health exam without abnormal findings • Orthopedic aftercare • Screening exam for mental health and behavioral disorder

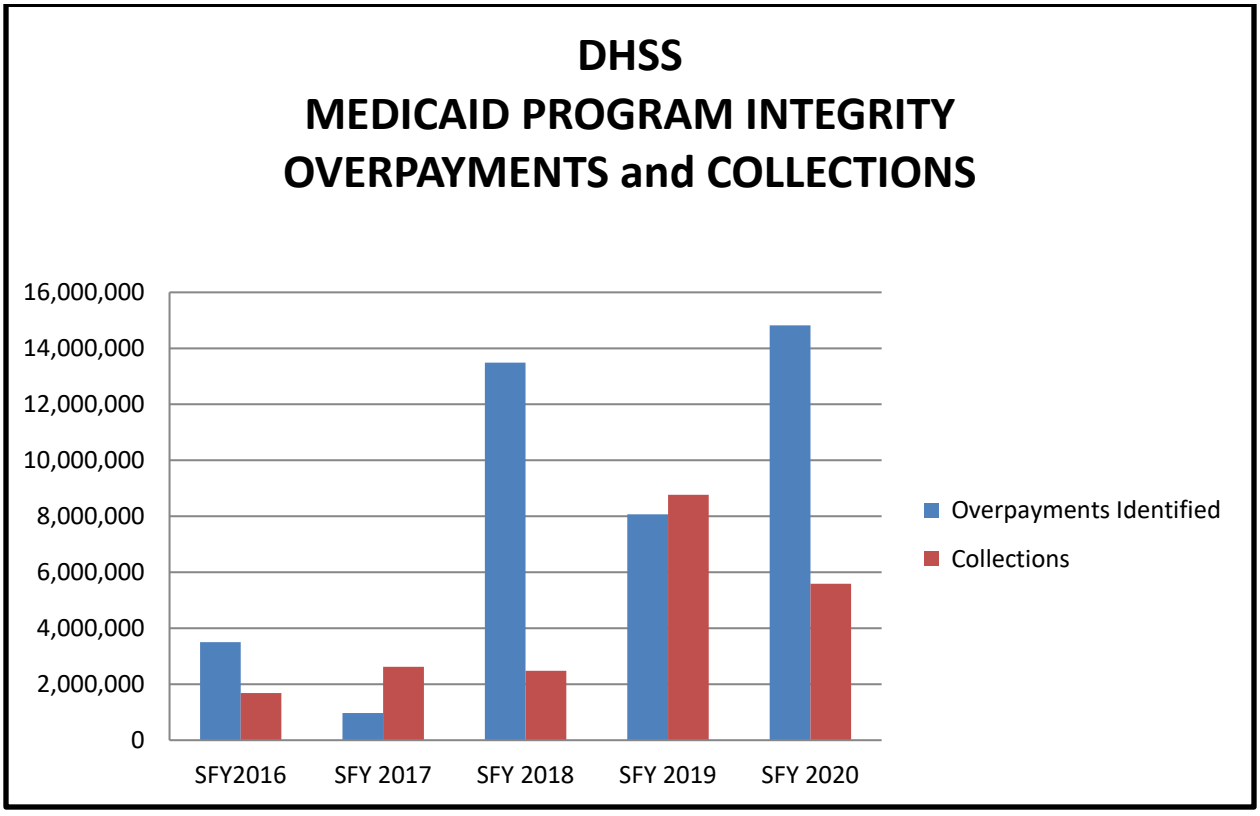
4) Fraud Prevention, Detection, and Enforcement

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

The Medicaid Program Integrity (MPI) 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 of Medicaid providers annually, the MPI 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. MPI also manages the Medicaid Provider self-audit program, which requires all Medicaid providers to conduct a self-audit on a statistically valid sample of claims once every two years. The first audits under this program are due to the department no later than December 31, 2020.

During FY 2020, MPI recovered over $5.6 million in overpayments paid to providers, and six payment suspensions were initiated after credible allegation of fraud determinations were made by MPI working in conjunction with the Medicaid Fraud Control Unit (MFCU) in the Department of Law. MPI collaborated with the MFCU on the successful prosecution of a high-profile dental fraud case in Anchorage.

Also during FY 2020, MPI provided additional clarification on regulations addressing provider recordkeeping and self-audits and partnered with CMS and their Division of State Partnership (DSP) on a new Medicare-Medicaid data sharing initiative to help identify fraud, waste and abuse that overlaps both programs. The DSP has hired contractors to perform data analysis and identify potential problem providers based on their review of both Medicaid and Medicare claims data. Alaska is in the early stages of this process and should have results to report for the next reporting year. MPI continues to work with the Alaska Health Care Fraud Task Force, focusing on physicians and advanced practice registered nurses suspected of over-prescribing opioids. MPI became a Law Enforcement Liaison with the National Healthcare Anti-Fraud Association (NHCAA), to leverage training opportunities, share various tools used by partners, and to detect and prevent healthcare fraud more effectively.



CMS conducts payment error rate measurement (PERM) reviews on all 50 states in 3 "cycles" of about 17 states in each cycle. Alaska's last PERM cycle covered FFY 2017. Although CMS did not release a state specific PERM from the FFY 2017 review, Alaska calculated an error rate of 1.8 percent for Medicaid and 0.7 percent for the Children's Health Insurance Program (CHIP). The calculated error rates are based on the final errors for recovery report for the medical record portion of the review. The report identified a combined 18 errors out of a total sample of 1,256 claims reviewed. The cause of these errors was primarily due to a lack of adequate documentation and instances where no documentation was provided in response to the medical record request. Alaska has completed a corrective action plan from this cycle, which includes additional provider education efforts to help improve Alaska's PERM error rate in the future.

Alaska is undergoing the next PERM cycle which is known as Reporting Year (RY) 2021. CMS has moved from a federal fiscal year base period 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. CMS halted the PERM review for Alaska at the onset of the COVID-19 public health emergency but re-started the review in August of 2020.

Overall, MPI saved the Alaska State Medicaid program $6.4 million - $5.6 million in recoveries and $.8 million in cost avoidance - for a total return on investment of $5.40 for each dollar spent.

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 remain in their homes or communities though they may have a level of need that would otherwise be provided in an institution, such as a nursing facility. HCBS includes Social Security Act Section 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. CMS 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 daily 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 2020 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 2020 Costs by Funding Source and Average Cost per Person by Service Type (based on FY 2020 Final Auth Report and number of people for whom services were rendered during FY 2020)

Program	# served	Avg cost per person	Total costs
Home & Community Based Waivers			
ALI Waiver	2,032	$35,846	$72,839,554
APDD Waiver	114	$89,183	$10,166,814
CCMC Waiver	201	$39,701	$7,980,029
IDD Waiver	2,009	$89,043	$178,887,081
ISW Waiver	387	$8,370	$3,239,221
TOTAL HCB Waivers	4,724		$273,112,699
Institutional Placements			
Nursing Home	989	$156,956	$155,229,609
ICF/IID	14	$216,711	$3,033,953
TOTAL Institutional Placements	1,003		$158,263,562
TOTAL HCB Waivers and Institutional Placements			**$431,376,262**

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	3,336		$523,605,639
ICF/IID + IDD and ISW Waiver service recipients	2,410		$522,273,371
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).			**$1,045,879,010**

Data Source: State of Alaska Automated Budget System, Final Auth 20 report, COGNOS

Status of 1915(i) and 1915(k) Home & Community Based Services State Plan Options: Senate Bill 74 authorized DHSS to apply for Social Security Act 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 the department determine that adding new services under the 1915(i) option would not be cost effective for Alaska. In lieu of that approach, and based on HMA recommendations, the department 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. The Community First Choice (CFC), is the 1915(k) option and provides enhanced personal care services for individuals who meet nursing facility-level of care criteria. Federal funding reimbursement is six 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 CMS 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 six percent federal match for people who transitioned to the CFC program. As of June 30, 2020, 387 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 CFC program, which will bring in an additional six percent in federal match for that service under CFC. The planned effective date for this transition is January 1, 2021.

Other Developments in Home and Community Based Waivers

In FY 2020, the Division of Senior and Disabilities Services (DSDS) continued close monitoring of utilization and costs to the home and community-based waiver program. In FY 2018, in response to escalating costs to the waiver service of day habilitation, DSDS implemented regulations that limit the number of hours of day habilitation services available under the waivers to 624 hours per year (12 hours per week on average). During FY 2019-FY 2020, the division detailed the standards defining the conditions under which additional day habilitation hours could be approved when requested by a recipient. The regulations became effective in October 2020, but the division is opting to suspend implementation until January 2021 due to the COVID-19 related workload.

By the beginning of FY 2020, DSDS had transitioned its "front door" counseling for long-term services and supports to Alaska's Aging and Disabilities Resource Centers (ADRCs). Alaska's ADRCs connect seniors, people with disabilities, and caregivers with long-term services and supports of their choice. The ADRC network serves Alaskans statewide, regardless of age or income level, through regional sites. ADRCs are part of a federal effort to help people easily access the long-term services and supports available in their communities, including transportation, assistive technology, or in-home care. ADRC specialists counsel callers and visitors on long-term supports that fit their individual needs. People choose which services they would like, then the ADRC specialists help people access those services. The State of Alaska administers the ADRC grant through, and in partnership with, the regional sites. Streamlining the front door for services helps contain Medicaid costs, and allows DSDS to better allocate its limited resources and meet its performance measures for timely assessments.

In FY 2020, DSDS began the process of applying to CMS for renewal of four of its five home and community-based waivers that were last renewed in FY 2016. These are the Intellectual and Developmental Disabilities waiver; the Alaskans Living Independently waiver; the Adults with Physical and Developmental Disabilities waiver; and Children with Complex Medical Conditions waiver. The fifth waiver, the Individualized Supports waiver, became effective in 2018 and will be due for renewal in 2023. While no significant changes are expected during the renewal process, each waiver will incorporate updates reflecting regulatory changes the division anticipates being approved in FY 2021. These include a revised definition of our supported employment services and an update to the nursing facility level of care determination process. The latter will streamline and refine division processes and will help ensure these aspects of the waiver process are more efficient and easily understood by recipients and providers.

A review of expenditures for home and community-based services between FY 2019 and FY 2020 shows that overall spending for these services was reduced by two percent, for a savings of $6,552,051. We believe the cost containment, utilization control, and program refinements described above played a significant role in limiting spending for these services. In particular, enrollment of individuals in the CFC program that previously received other home and community-based services has allowed the state to capture a higher federal match and limit the amount of state general fund support needed to meet these individuals' needs. However, it should be noted that the COVID-19 public health emergency limited access and delivery of some services (particularly services provided in congregate settings, such as adult day services) in the latter part of FY 2020 and likely also played a role in reducing spending for part of the year.

FY 2019 and FY 2020 Expenditures for Waiver and Personal Care Services

Fund Source	FY 2019	FY 2020	$ Change	% Change
Waivers				
State GF	$126,813,408	$107,957,619	$ (18,855,789)	-14.9%
Federal	$145,927,382	$165,176,372	$ 19,248,990	13.2%
TOTAL	$272,740,790	$273,133,991	$ 393,201	0.1%
Personal Care Services				
State GF	$20,006,857	$12,530,308	$ (7,476,549)	-37.4%
Federal	$21,403,274	$15,571,433	$ (5,831,841)	-27.2%
TOTAL	$41,470,130	$28,101,741	$ (13,368,389)	-32.2%
Community First Choice Plan Option (* Additional 6% FMAP)				
State GF	$7,521,132	$8,364,820	$ 843,688	11.2%
Federal	$9,505,934	$15,085,383	$ 5,579,449	58.7%
TOTAL	$17,027,065	$23,450,203	$ 6,423,138	37.7%
Total HCBS				
State GF	$154,401,397	$128,852,747	$ (25,548,650)	-16.5%
Federal	$176,836,589	$195,833,188	$ 18,996,599	10.7%
TOTAL	$331,237,986	$324,685,935	$ (6,552,051)	-2.0%

Note: Because providers have up to one full year to submit claims after services are provided, the FY 2020 expenditures may not represent payment for all services provided in FY 2020.

6) Pharmacy Initiatives.

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

Preferred Drug List and Prospective Drug Utilization Review

In the fall of 2019, the Alaska Medicaid Pharmacy Program gained authority through SB 44, signed into law August 8, 2019, to begin updating its preferred drug list (PDL) following each Pharmacy and Therapeutics Committee meeting rather than adopting updates through the regulatory process. The program is collating the data to quantify the financial impact, but preliminary estimates suggest an additional $1.5 million in supplemental rebate savings over the previous year. The additional rebate savings is in addition to the cost avoidance achieved through therapeutic substitution by guided use of preferred agents and medical cost savings, which preliminarily exceeds $1 million, from leveraging advanced therapeutic technology. Systematic prospective drug utilization reviews resulted in an additional savings of over $33 million in pharmacy cost avoidance by preventing dispensing of inappropriate medications. Approximately half of these savings and cost avoidance are State General Fund.

Use of Generic Drugs

The use of generic drugs provides comparable quality but is typically far less costly than brand name drugs. Alaska's Medicaid Pharmacy Program generic drug utilization exceeded 85.7 percent at the end of state FY 2020, surpassing the previous year's final average of 83.5 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 reported as 82 percent in FFY 2018.[4]

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

Pharmacy reimbursement methodology reform continues to realize significant annual savings. Currently in the fifth year of implementation, over $24 million in total pharmacy reimbursement cost avoidance savings is realized annually through utilization of the CMS National Average Drug Acquisition Cost (NADAC) 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 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 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. A significant system update was deployed in FY 2020 that will allow for incorporation of this pricing benchmark in FY 2021.

Pharmacy Professional Dispensing Fee Study

Regulations proposed in FY 2018 to provide a mechanism to add pharmacists as an independent provider type separate from pharmacies received a boost, as a result of the COVID-19 public health emergency. System changes allowing the enrollment of pharmacists were completed at the end of FY 2020. The changes allow pharmacist reimbursement for state-recognized scope of practice, to include independent prescribing of opioid reversal agents and vaccines.

Opioid Utilization Initiatives

The opioid crisis continues to place a strain on limited state resources for substance dependence services and chronic pain management. Expanded infrastructure support through other Medicaid divisions continues to address unmet need. As a result, the pharmacy program has observed a six-fold increase in pharmacy reimbursement payments for buprenorphine-based medication-assisted therapy drug products since 2015. Total pharmacy reimbursement costs for buprenorphine-based products approached $9 million during FY 2020. 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

[4] https://www.medicaid.gov/medicaid/prescription-drugs/downloads/drug-utilization-review/2018-dur-ffs-summary-report.pdf

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:

Efforts of the Alaska Medicaid Drug Utilization Review Program	Alaska Statewide Opioid Action Plan[5]
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 three 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.

The Alaska Medicaid Drug Utilization Program continues to promote evidence-based opioid prescribing activities, which has resulted in a decrease in overall opioid prescribing and doses within the Alaska Medicaid population as demonstrated by claims data. The Medicaid program further tightened previous quantity limits, established successively decreasing Morphine Milligram Equivalent (MME) thresholds that would prompt prior authorization reviews, and enhanced cross-agency relationships through the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) activities. Such work resulted in a 19 percent decrease in the total number of opioid utilizers for any duration and for any MME when comparing the first six calendar months of 2019 to the same calendar period in 2020. There was a corresponding 24 percent decrease in the total average daily MME between those two periods. In the same six-month period of 2019, there were 112 individuals who received an average daily MME greater than 200; in the same period in 2020, less than 70 individuals filled claims with an average daily MME greater than 250. This can be attributed

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

to targeted outreach to prescribers and imposing assertive prior authorization requirements for treatment plans to demonstrate need of higher doses. Decreased amounts of unused circulating opioids decrease the risk of incidental access to unsecured opioids, decrease costs for the program, decrease pharmaceutical waste, and decrease risks and sequelae related to an individual's transition from short-term to chronic opioid use.

The Medicaid program and DHSS engaged with the Department of Commerce, Community and Economic Development – Division of Corporations, Business and Professional Licensing (DCCED-CBPL) and the Department of Administration – Division of Retirement and Benefits (DOA-DRB) on specific SUPPORT Act initiatives including identifying critical data analytics and reporting platforms, researching opportunities for diversified sustainable funding, and working with stakeholders on patient-centered care models.

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 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 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 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 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 other factors warranted research into care delivery options. In conjunction with providers and a representative of the Alaska State Hospital and Nursing Home Association (ASHNHA), 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. During the research, it was observed that significant savings would not be generated by shifting to Ambulatory Infusion Centers due to a number of factors including, among other things, 340B pricing[6]; however, DHSS continues to consider the enrollment of Ambulatory Infusion Centers as a future opportunity as the Federal Drug Administration 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 multiple specialized case management and care coordination initiatives charged with improving access to healthcare, promoting healthcare efficiencies, and reducing harmful and costly overutilization and misutilization. Existing programs are undergoing expansion in areas proven to be most effective, and new initiatives authorized in SB 74 continue to be analyzed and developed. The following table recaps State General Fund savings/cost avoidance resulting from these programs.

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

Program	FY 2020
Case Management	$1,087,563
Care Management Program	$4,080,000

Clinical Case Management

Since 1997, the State Medicaid program has contracted with Comagine Health, formerly known as Qualis Health, to provide evidence-based clinical case management services to Alaska Medicaid recipients with complex chronic medical conditions and who have experienced catastrophic injuries and illnesses. Most referrals to clinical case management originated from physicians and other medical providers, DHCS staff, and Comagine utilization management staff. Through this Utilization Review Accreditation Commission (URAC) accredited program, and with the goal of patient self-management, highly complex case management services are provided by registered nurses and licensed clinical social workers. Trained support staff provide related non-clinical case management support services, such as transportation and lodging when travel is required to receive medical care.

Cost savings are achieved through a variety of case management interventions that result in averted, avoided, or decreased cost of services. Interventions include facilitating timely and safe discharge to lower levels of care, implementing home-based services in lieu of hospitalizations or placement in a skilled nursing facility, monitoring home-based treatment plans, educating patients to promote self-care, and coordinating care among the recipient's primary care provider and multiple specialists.

Clinical case management services resulted in savings of $1,087,563 in FY 2020 through avoided inpatient acute care stays and other services and yielded a return on investment (ROI) of $8.26 for every $1.00 spent, a 50 percent increase in ROI from the previous year.

[6] 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

Case Management under the Alaska Medicaid Coordinated Care Initiative (AMCCI)

The Alaska Medicaid program contracts with Comagine Health to provide evidence-based case management services for recipients with the most medically complex and costly conditions. Alaska 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 35 Alaska Medicaid recipients per month during FY 2020 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. The ROI for this program was $5.26 for every $1.00 spent through avoided inpatient stays and duplication of services.

Care Management Program

Established during the mid-1990s, DHSS' Care Management Program (CMP) addresses inappropriate use of Medicaid-covered services. Alaska 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 is 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 $13.6 million during FY 2020, approximately 30 percent of which, or $4.08 million, was State General Funds. 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 2020 CMP enrollment averaged 379 recipients per month, a 21 percent increase over FY 2019.

Additionally, DHCS is actively pursuing an update to the regulations governing CMP (7AAC 105.600), to provide additional tools and flexibilities for the identification of new CMP participants. The regulation updates also pursue additional interventions to address individuals identified for CMP more than once. Additional data patterns surrounding Medicaid funded travel and patient no-shows are also included in the draft regulations under consideration.

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) 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 enactment and 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. 10); 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. 22) and Section II.A.6 (pg. 9) for more information on the demonstration projects.

To assist with these payment model reform efforts, DHSS contracted with Milliman, Inc. (Milliman), a health care actuarial consulting firm. The contract is in the third year of the possible four-year contract timeframe. One important tool Milliman 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 in 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, 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 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 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 identified that for a bundled payment option to be successful in either of these locations, the Alaska Medicaid program will need to partner with other payers. Milliman's assessment indicated that additional payers will be necessary to build the volume of services that will attract and sustain provider interest in such a model[7]. However, DHSS has still been approached by some provider partners who would still like to explore this option.

Milliman'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;

[7] 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

substance abuse; and diabetes. Additionally, a current contractor is exploring if the 1945 state plan option would be a good strategy to utilize for implementing patient centered medical homes.

With the input of stakeholders, DHSS is exploring implementation of a Diagnosis Related Group (DRG) based payment methodology for inpatient hospital services at general acute care hospitals. The DRG payment methodology for inpatient hospital services will support implementation of policies and practices that promote quality, are patient centered, fair to providers, fiscally responsible, and ensure access to care for Alaskans who may require additional resources. The existing per diem methodology reimburses providers based on the volume of services provided, whereas a DRG payment methodology aligns reimbursement with the acuity of the patient and the resources expended by hospitals.

Critical Access Hospitals are excluded from consideration for the DRG payment methodology. A preliminary decision has also been made to exclude psychiatric, rehabilitation, and long-term acute care hospitals, as well as psychiatric and rehabilitation services provided in general acute care hospitals.

A DRG-based payment methodology will enhance DHSS' ability to implement performance review and cost-saving measures, including potentially preventable readmissions and hospital acquired conditions.

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 Alaska Medicaid performance measures and corresponding annual and five-year performance targets for the recommended measures. During the QCE workgroup's discussions, one measure was removed from the recommendation 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[8].

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 in FY 2018, were reported in the FY 2019 Annual Medicaid Reform Report. The third-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 Alaska Medicaid Program in advance. Emergency medical transportation is only covered to the nearest facility offering

[8] 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

emergency medical care or, in the event the member has Indian health benefits, to the nearest Indian health facility that can provide the needed 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 (DHCS) 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.

DHSS continued to make improvements during FY 2020 to contain transportation cost growth and maximize federal funding while still ensuring access to care such as:

- Strengthening coverage guidelines for ambulance providers
- Implementation of multiple ambulance billing policies to limit the number of manually priced claims and create efficiencies with claims processing
- Adoption of new non-emergency medical transportation regulations providing clarity for:
    - Meal reimbursement
    - Escort requirements with emphasis on the department's ability to deny escorts who have a history of not acting in the best interest of the member
    - Non-coverage of rebooking flights that members no show, and
    - Utilization of the least expensive mode of transportation.

The significant decline in State General Fund spending for transportation services experienced between FY 2016-2020, as noted below, is due to DHSS' implementation of the new 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. There have been no additional tribal entities express interest in taking on Medicaid transportation services since 2018.

The Alaska Medicaid program continues to contain costs well below enrollment growth and was able to attain a 20 percent or $2.4 million cost savings in State General Fund (GF) from FY 2019 to FY 2020 largely due to the Tribal initiative described above. In FY 2020 total travel expenditures continue to follow the trend from FY 2016, with most expenditures being federal funds. Only nine percent or $10 million of overall travel costs were State General Fund. Total travel expenditures decreased by $3.7 million compared to FY 2019, a decrease of four percent. The COVID-19 public health emergency is likely a major factor in the decrease in overall utilization of travel, as Alaska state mandates relating to travel and healthcare had a significant impact on both Inter and intra-state travel.

Travel Expenditures

						2016 to 2017 change		2017 to 2018 change		2018 to 2019 change		2019 to 2020 change		2016 to 2020 change	
Fund Source	2016	2017	2018	2019	2020	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	89,981,387	39,238,691.00	87%	(10,775,556.00)	-13%	17,457,831.00	24%	(1,257,756.00)	-1%	44,663,210.00	99%
State General Funds	32,831,478.00	7,891,016.00	11,965,716.00	12,473,639.00	10,005,346.00	(24,940,471.00)	-76%	4,074,700.00	52%	507,923.00	4%	(2,468,293.00)	-20%	(22,826,132.00)	-70%
Total Expenditures	78,149,664.00	92,447,884.00	85,747,028.00	103,712,782.00	99,986,733.00	14,298,220.00	18%	(6,700,856.00)	-7%	17,965,754.00	28%	(3,726,049.00)	-4%	21,837,069.00	28%

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.

DHSS has made progress in disease prevention and wellness in three ways:

1) A more cohesive approach to Affordable Cares Act (ACA) mandated coverage of the US Preventative Services Task Force (USPSTF) Grades A and B screenings is being implemented which will soon be evident in reimbursement of claims.
2) The Medicaid Medical Care Advisory Committee (MCAC) has been revitalized to engage community partners and providers, to develop solid, evidence-based, policy recommendations which make sense to Alaskans in terms of value. Alaska Medicaid continues to participate in the Medicaid Evidence-Based Decisions (MED) Project, along with 21 other states.
3) Renewed commitment to preventing and managing chronic diseases that will result in healthier Alaskans in the future. Analysis of Alaska Medicaid data is under way that will assist DHSS in addressing chronic diseases in Alaska that is both more efficient and effective.

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 SB 74 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 places a heavy burden on hospitals in urban areas, as well as the entire health care system, and severely limits timely access to care for Alaskans in need of these services. Inadequate access to the appropriate level of care at 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 Alaska Medicaid program.

<u>1115 Waiver: Behavioral Health Demonstration Project</u>

The 1115 Waiver establishes 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.

Both the Substance Use Disorder (SUD) and Behavioral Health components of the 1115 Waiver have been implemented. The Behavioral Health component of the 1115 Waiver was implemented through

the release of emergency regulations on May 21, 2020. The regulations were adopted in final version on October 4, 2020.

Activities that occurred between July 1, 2019 and June 30, 2020 to support implementation of the 1115 Waiver include:

- Addition of two chapters 7 AAC 136 for Behavioral Health 1115 Demonstration Waiver and 7 AAC 138 Substance Use Disorder Waiver Services and support the implementation of the 1115 Medicaid Demonstration Waiver which became permanent October 2019.
- The Administrative Services Organization (ASO) was implemented and began processing claims for the 1115 SUD services on February 1, 2020.
- The ASO began claims processing functions for 1115 Behavioral Health Services on May 21, 2020 and select state plan services on July 1, 2020.
- Provider trainings, webinars, and email distributions that provide information related to provider enrollment and billing for new services under the 1115 Waiver.
- DHSS adopted Medicaid Coverage, Behavioral Health Services, Revised Requirements for Behavioral Health Providers in April 2020 which added a new definition for a substance use disorder counselor and allows 1115 Waiver service providers to enroll rendering providers.

Additional regulation packages adopted in support of Medicaid reform efforts of SB 74 between July 1, 2019 and June 30, 2020 include:

- SB 169 (2018) added screening and brief intervention services and an integrated mental health and substance use intake assessment to the list of approved Medicaid services by a Mental Health Physician Clinic. DHSS adopted new requirements for Mental Health Physician Clinics which became effective November 2019.
- SB 105 added licensed Marital and Family Therapists (LMFT) to the list of providers eligible to enroll with the department and bill directly for services rendered and/or be an eligible provider of behavioral health clinic services. DHSS adopted regulations to implement the provisions of SB 105.

As part of SB 74, the Medicaid & Behavioral Health Services Revised Requirements for Behavioral Health Providers allows independent Licensed Clinical Social Workers (LCSW) and psychologists to enroll and bill Alaska Medicaid for services rendered as an individual practitioner.

<u>Behavioral Health System Capacity</u>

There are numerous initiatives underway to support behavioral health system reform, primarily targeted at helping create needed capacity and capabilities throughout the system. A goal of the 1115 Waiver is to serve individuals in their communities or regional hub, which would in turn reduce travel costs. SB 169, passed in 2018, amended AS 47.07.030 to allow a physician to operate a mental health physician clinic and to supervise the provision of care in the clinic via distance delivery.

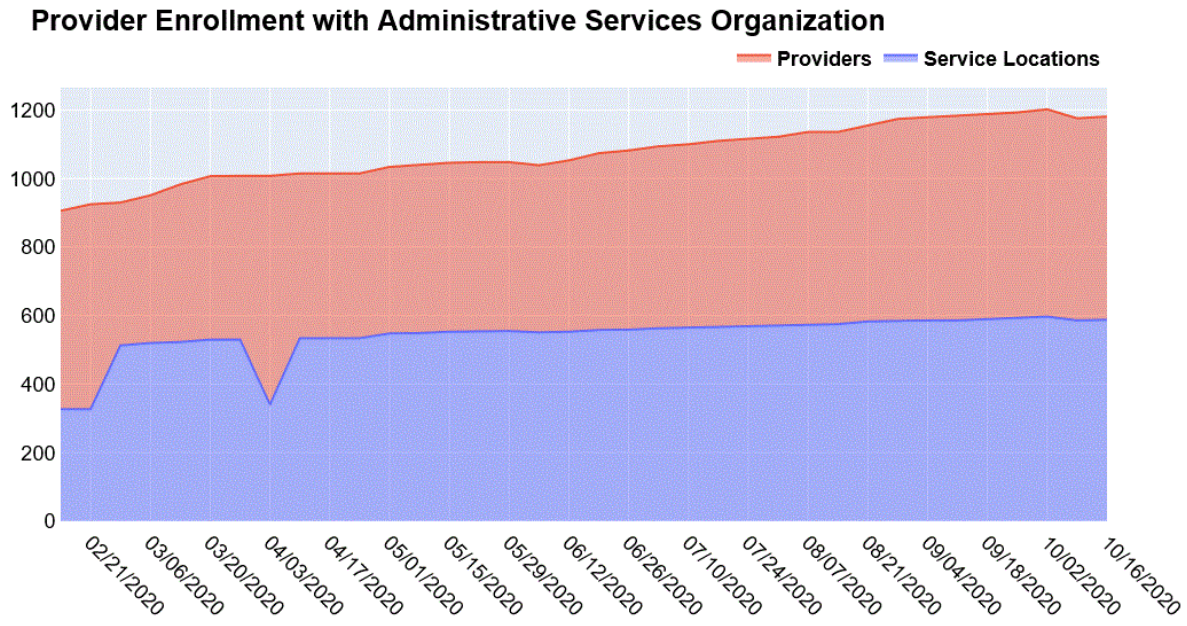
The Division of Behavioral Health continues to collaborate with providers through:

- **Provider Trainings |** A combination of in-person meetings and webinars intended to provide information on provider enrollment and billing for new services.
- **Electronic Updates and Feedback Loops |** An email distribution list is used for 1115 Waiver updates and a dedicated division email account is used for stakeholder questions, comments, and suggestions.
- **Provider Roundtables |** Roundtables are small group discussions that the division can use to ask questions and receive feedback from those who will be providing 1115 Waiver services.

As an example, a series of provider roundtables were held to solicit feedback on the SUD Implementation Plan.

- **Listening Sessions |** A series of focused webinars designed to engage providers dialogue to solicit feedback on the behavioral health and crisis services.

As of October 2020, 1176 providers in 586 service locations have enrolled with the ASO in support of behavioral health reform.



Finally, the division would like to highlight how Medicaid Disproportionate Share Hospital (DSH) funding for behavioral health treatment services that was appropriated by the Legislature for FY 2019 and FY 2020 has increased access to services in hospital settings. The increased funding allowed for six hospitals to qualify for this funding. For a full report of FY 2019 and FY 2020 DSH activities, please see the report to the legislature issued on November 15, 2020.

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.

DHSS completed the procurement for the system with Public Consulting Group in 2020. The system is currently being tested and implemented with an initial release scheduled for November 2020, which will include the CMS required asset verification system. The subsequent release will include the National Directory of New Hires. Additional data sources will be included in the system to provide a one stop portal for eligibility factors to guide Eligibility Technicians on making accurate determinations and requesting further verification when needed. Sources will continue to be added to support all factors of eligibility for Public Assistance programs.

14) Emergency Care Improvement

The Emergency Department Coordination Project (EDCP) 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 was developed in response to AS 47.07.038, which requires a hospital-based project to reduce the use of emergency department services by Alaska 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 focus is to get the remaining few hospitals connected. Six other organizations are also connected including Southcentral Foundation, Alaska Innovative Medicine, Inc., the Anchorage Fire Department, Links ADRC High Utilizer Mat-Su, Sunshine Community Clinic, and LaTouche Pediatrics.

Connecting clinics and primary care groups to EDIE is an important goal for increasing the intra-provider communication that supports high quality patient care. ASHNHA has helped submit 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 and DHSS. There is interest in moving forward with connecting to EDIE and several issues have been worked through over the past year to pave the way for connecting API to EDIE through HealtheConnect. This connection is expected to be completed by the end of 2020.

A big success has been connecting the EDIE to the Prescription Drug Monitoring Program (PDMP) database. With the collaborative efforts of DHSS, DCCED, Collective Medical Technology (CMT is the EDIE vendor) and Appriss (the PDMP vendor) the connection is now working smoothly. 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 has been the implementation of 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 2020

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	In progress
Maniilaq Medical Center	In progress
Mat-Su Regional Medical Center	Live with PDMP
Mt Edgecumbe Hospital	TBD
Norton Sound Regional Hospital	TBD
PeaceHealth Ketchikan Medical Center	Live with PDMP

Petersburg Medical Center	Live
Providence Alaska Medical Center	Live with PDMP
Providence Kodiak Island Medical Ctr.	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 with PDMP
Wrangell Medical Center	Live
Yukon Kuskowin Delta Regional Hospital	In progress
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 ARDC HUMS	Live
Southcentral Foundation	Live
Sunshine Community Health Center	Live

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 department 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 Alaska Medicaid program. The project go-live date was September 1, 2018. PFMC provides current Alaska 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 assessing the suitability of operating the PFMC program under a 1915(b) waiver for the purposes of enhancing federal funding and establishing a model of care replicable by other willing and able Medicaid primary care providers.

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 CMS to support care coordination and quality improvement efforts through information technology. The funding requests for FFY 2021 include:

- Health Information Exchange platform modernization, enhancement, and support of statewide operational plan
- Document management system for DHSS
- Provider enrollment and management
- Electronic health record adoption through the end of the Promoting Interoperability (formerly Meaningful Use) program.
- Public health registry modernization and connection to the Health Information Exchange, prioritizing electronic COVID reporting
- Eligibility and enrollment-related projects, including an enterprise data hub and master client index
- Telehealth, especially considering the COVID-19 public health emergency
- Referral management
- Medicaid Information Technology Architecture-related projects, modernization, and project management

DHSS anticipates requesting additional federal funds for future activities related to the recommendations in the coming years as information technology infrastructure matures. The funding requests will be included in future federal Medicaid Enterprise Systems planning documents.

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		FY 2019	FY2020	Increase / Decrease
Utilization Management		$6,706,095	$19,126,421	$12,420,326
HMS Third-Party Liability & Audit Recovery		$8,896,765	$9,411,108	$514,343
Tribal Health System Partnerships		$25,300,000	$0*	$0*
DOC Inpatient Care Cost Avoidance		$2,241,160	$4,739,174	$2,498,014
TOTAL		**$43,144,020**	**$33,276,704**	**$15,432,683**

* Calculated savings reported for Tribal Health System Partnerships is usually reported as 30 percent of overall increase in expenditures. This percentage would have been paid at 50 percent general funds without the continued partnership with the tribes and if services were provided in non-tribal facilities. Due to the decrease in expenditures in 2020, there is no generated savings to calculate.

Utilization Management

DHSS continues to contract with Comagine Health to fulfill Medicaid utilization control requirements of 42 C.F.R. 456 by providing 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; certain labor and delivery services, based on 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 2020, these utilization management services yielded net Medicaid program savings of $19.1 million, approximately 30 percent of which, or $5.73 million, was State General Funds, and a return on investment of $12.41 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 2020, third party liability (TPL) recoveries and savings exceeded $31 million, approximately 30 percent of which, or $9.3 million, was State General Funds.

HMS Third-Party Liability & Audit Recovery	**SFY 2020**
Recoveries	$7,526,355.87
HIPP Cost Savings	$3,567,305.87
TPL Cost Savings	$19,932,588.00
Total	**$31,026,249.74**
*30% General Funds	**$9,307,874.92**

Tribal Health System Partnerships

For FY 2020, the department continued the expansion of services in the tribal health system which includes expanded service provision and payment to over 350 Community Health Aides and Behavioral 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 normally would result in increased claims for those services. However, due to the COVID-19 public health emergency, claims for these services decreased by approximately $17.2 million in FY 2020. The FY 2019 total was at $478 million and FY 2020 at $460.8 million.

Along with the savings from the decrease in payments, there is also savings generated from the overall expansion of services at tribal facilities. Without the expansion, 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.

Program Expenditures	FY19	FY20	Increase/Decrease
Tribal Health System Partnership	$ 478,050,063.24	$ 460,875,030.19	$ (17,175,033.05)

Medicaid Payment for Inpatient Care for Incarcerated Individuals

DHSS began providing Medicaid reimbursement for inpatient care provided outside of 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 2015 which 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 State General Fund dollars. This is a savings for the DOC budget.

2) Achievement of Quality & Cost-Effectiveness Targets

AS 47.05.270(d)(3)

DHSS can now report third-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 2019 Third-Year Performance on Quality & Cost Effectiveness Measures

Measure	Met 2019 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	P
B.31 Alcohol and Other Drug Dependence Treatment[9]	Y
CH.1 Emergency Department Utilization	N
CH.2 Diabetic A1C Testing	P
CH.3 Hospital Readmission Within 30 days - All Diagnoses	Monitor
C.1 Medicaid Spending Per Enrollee	N
C.2 Hospitalization Chronic Obstructive Pulmonary Disease	Y
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	Y
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 third-year performance measures for services delivered during state FY 2019 demonstrate that the program met or exceeded annual performance targets for five measures, partially met targets for four measures, are monitoring numbers for one measure, and failed to meet targets for the remaining seven measures.

[9] 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 attributed to not meeting performance measures:

- Alaska had a 7.1 magnitude earthquake November 30, 2018. Services were abruptly interrupted and rescheduled as Alaska met the emergent needs from the earthquake.
- Enrollment increased 5.34 percent from FY 2018 to FY 2019; resulting in higher hospitalizations, emergency room visits, and increase of initial services.
- The continued opioid crisis in Alaska. This surge in opioid use has a factor in the results in several measures including ability to get an appointment with a provider, follow up after care, emergency department utilization, hospital readmission, and live birth rates.

3) Recommendations for Legislative or Budgetary Changes

AS 47.05.270(d)(4)

DHSS is continually evaluating the Alaska 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 has improved the budgetary and projection processes through an ease of reporting and cost efficiencies through a reduction in administrative activities.

The ability to make changes to Alaska's Medicaid program, in particular to eligibility, is constrained by the federal public health emergency that is in place in response to COVID-19 and the Maintenance of Effort requirement to maintain current recipient eligibility. Additionally, the Commissioner's office has contracted with a Medicaid strategist that is creating a global roadmap for further Medicaid reforms. Due to the COVID-19 public health emergency, the project was extended, and recommendations should be finalized by the end of 2020.

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 includes returning each state to its original Children's Health Insurance Program (CHIP) federal match through two annual decreases of 11.5 percent in Federal Medical Assistance Percentage (FMAP) rate changes starting in federal FY 2020 and followed by a similar decrease during federal FY 2021. Previous budget estimates used for the development of the FY 2020 budget were modified to reflect impacts associated with the COVID-19 public health emergency including additional changes that occurred in federal legislation.

The Affordable Care Act for Medicaid expansion established transitional FMAP rates starting at 100 percent with the implementation of the program in CY 2014 and leveling off at 90 percent in CY 2020. Previous budget estimates used for the development of the FY 2020 budget were modified to reflect impacts associated with the COVID-19 public health emergency.

The Families First Coronavirus Response Act (FFCRA) was signed into law on March 18, 2020 and it resulted in an Enhanced FMAP increase of 6.2 percent retroactive to January 1, 2020. It also provided an indirect increase of 4.34 percent in FMAP for the Children's Health Insurance Program (CHIP). DHSS received an additional $36 million in federal reimbursement in SFY 2020 associated with the enhanced FMAP and is estimating another $54 million in SFY 2021.

AK Department of Health and Social Services Federal Medical Assistance Percentage Rates

COVID ENHANCED FMAP EFFECTIVE 01/1/2020 TO LAST DAY OF QUARTER WHEN NATIONAL EMERGENCY IS ENDED

Federal Medical Assistance Percentage (FMAP) for the Title IV-E* Maintenance Expenditures

Direct Services	FY 2019	FY 2020	FY 2021	COVID (1/1/20-TBD)	Enhanced FMAP
Title IV-E Maintenance Payments*	50.00%	50.00%	50.00%	6.20%	56.20%

FOOTNOTE: * Title IV-E programs include Title IV-E Adoption Assistance; Foster Care; and Guardianship Assistance payments

Federal Medical Assistance Percentage (FMAP) for the Medicaid Programs

Direct Services	FY 2019	FY 2020	FY 2021	COVID (1/1/20-TBD)	Enhanced FMAP
Regular Medicaid*	50.00%	50.00%	50.00%	6.20%	56.20%
Indian Health Services (IHS)	100.00%	100.00%	100.00%	0.00%	100.00%
Breast & Cervical Cancer (BCC)	65.00%	65.00%	65.00%	4.34%	69.34%
Family Planning	90.00%	90.00%	90.00%	0.00%	90.00%
1915(K) Community Choice**	56.00%	56.00%	56.00%	6.20%	62.20%
Medicaid Expansion***	93.50%	91.50%	90.00%	0.00%	90.00%
Expansion IHS	100.00%	100.00%	100.00%	0.00%	100.00%
Children's Health Insurance Plan (CHIP) as of 10/01/2020****	88.00%	76.50%	65.00%	4.34%	69.34%

FOOTNOTE: *Medicaid FMAP is based on a formula for a federal fiscal year and published annually.
FOOTNOTE: **1915(k) state plan option is 6% additional federal share over Medicaid FMAP
FOOTNOTE: ***Medicaid Expansion FMAP is based on a calendar year and reported as SFY average
FOOTNOTE: **** CHIP EFMAP is indirectly impacted by COVID enhanced FMAP = 4.34%

Administrative Services	FY 2019	FY 2020	FY 2021	COVID (1/1/20-TBD)	Enhanced FMAP
Medicaid and Expansion admin	50.00%	50.00%	50.00%	0.00%	50.00%
Professional admin services (i.e. SPMP/PASRR)	75.00%	75.00%	75.00%	0.00%	75.00%
Systems - Maintenance and Operations	75.00%	75.00%	75.00%	0.00%	75.00%
Systems - Development	90.00%	90.00%	90.00%	0.00%	90.00%
Electronic Health Record (EHR) Payments	100.00%	100.00%	100.00%	0.00%	100.00%
CHIP admin **	88.00%	76.50%	65.00%	4.34%	69.34%

FOOTNOTE: * CHIP FMAP decreased on 10/01/19 to 76.5% and on 10/01/20 to 65%
FOOTNOTE: ** CHIP EFMAP is indirectly impacted by COVID enhanced FMAP = 4.34%

Under the 21st Century Cures Act of 2016, states were required to implement electronic visit verification (EVV) systems for all Medicaid-funded personal care services by January 1, 2019. The systems will allow the state to improve health and welfare of recipients of personal care by validating delivery of services. In 2018, Congress passed an addendum that changed this initial implementation date to January 1, 2020, also allowing states to request a good faith exception to extend by one *additional* year if they could demonstrate active progress toward implementation of these systems. Alaska applied for and was

granted a good faith exception. In FY 2020, DSDS began work on the contracts with vendors that will develop EVV in Alaska and provide independent validation and verification of the project's progress. Successful implementation of EVV will reduce waste, fraud, and abuse; provide robust data to monitor compliance; and improve quality of care. The cost of developing the EVV was funded through a capital budget appropriation of $4,931,100 in FY 2020, with 90 percent of those costs borne by the federal government for system development. For FY 2021, DSDS received an operating budget increment of $550,000 ($412,500 federal and $137,500 State General Funds) for operations and maintenance costs for EVV.

5) Applications for Medicaid Grants, Options, or Waivers

AS 47.05.270(d)(6)

Waivers

DHSS did not apply for any new Medicaid waivers in FY 2020.

State Plan Options

DHSS did not apply for new state plan options in FY 2020.

Grants

DHSS did not apply for new Medicaid grants in FY 2020.

COVID Flexibilities

In the context of the COVID-19 public health emergency, DHSS requested and received approval to waive certain Medicaid requirements.

The department has applied for and been approved for the following:

- 1135 Medicaid waiver - When the President of the United States declares a disaster or emergency and also declares a public health emergency, states can apply for an 1135 waiver under the Social Security Act. This waiver can temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements. By waiving these requirements, states can ensure that sufficient health care services are available to meet the needs of Medicaid recipients during this period of time. It also allows providers who provide services in good faith to be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).
- 1915 (c) Appendix K - Is a standalone appendix that may be utilized by states during emergency situations to request amendment to approved 1915(c) waivers. It includes flexibilities that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency.
- Disaster Relief State Plan Amendment authority - As federal and state policies change, updates to the Title XIX Medicaid State Plan – the written agreement between the state and federal governments outlining the details of the state's Medicaid program - are required to ensure continued compliance. The mechanism for these changes is a "state plan amendment" or a SPA.

Represented in the following chart, are the following flexibilities, under Section 1135 of the Social Security Act[10] during the public health emergency:

[10] https://www.ssa.gov/OP_Home/ssact/title11/1135.htm

DHSS Impact	Federal Regulation or Authority	Explanation of Waived Requirement & Impacts
HCS, DBH, & SDS	42 CFR §440.230(d)	Suspend prior authorization (pre-approval) requirements in fee-for-service Medicaid and extended prior authorizations granted pre-public health emergency.
DBH & SDS	Section 1919(e)(7) of the Act; 42 CFR §483.106(b)(4) & 42 CFR §483.112(c)	Suspend Pre-Admission Screening and Annual Resident Review (PASRR) Level I and Level II assessments for 30 days.
SDS & HCS	42 CFR §4431.221(d)	Give enrollees more than 90-days – up to an additional 120-days – to request a fair hearing for appeals of eligibility or fee for service determinations.
HCS	Medicaid Provider Enrollment Compendium (MPEC)	Provisionally, temporarily enroll providers enrolled with another State Medicaid Agency (SMA) or Medicare for the public health emergency duration.
HCS, DBH & SDS	Section 1135(b)(1) and (b)(2) of the Act	Waive some screening requirements (streamline provider enrollment process) so that the state may provisionally, temporarily enroll providers not enrolled with another SMA or Medicare for the duration of the public health emergency. Postpone provider fingerprint-based background checks, allowing the issuance of a background check approval on a provisional basis. Requires compliance with CMS identified minimum criteria for provider enrollment.
HCS, DBH, & SDS	42 CFR §455.460;	Waive the requirement for payment of an application fee.
HCS, DBH, & SDS	42 CFR §455.432	Waive the requirement that the state conduct site visits on applicants during the Medicaid enrollment process.
HCS, DBH, & SDS	42 CFR §455.412	Waive the requirement that a provider be licensed in the state of Alaska.
HCS, DBH, & SDS	Section 1135 (b)(1)(B) of the Act	Allow DHSS to temporary cessation of revalidation of enrolled providers directly impacted by the public health emergency.
HCS, DBH, & SDS	Section 1135(b)(1)	Allow the provision of services by facilities (e.g., nursing facilities, ICF/IDDs, psychiatric residential treatment facilities, and hospital nursing facilities) in alternative settings under parameters defined by CMS.
Medicaid	Section 1135(b)(5)	Utilize flexibility in meeting the tribal consultation obligation for waivers and state plan amendments in limited circumstances.
SDS	42 CFR §441.301(c)(2)(ix)	Waive the requirement for written consent and beneficiary and provider signature requirements for Home and Community Based Services person-centered

		plans of care. *Allow providers to utilize electronic signatures.*
HCS, DBH, & SDS	42 CFR §441.540(b)(9)	Waive the written consent and beneficiary and provider signature requirement for 1915(k) – Community First Choice services person-centered plans of care. *Allow providers to utilize electronic signatures.*
SDS	Section 1135(b)(1)(B) of the Act	Waive the home and community-based settings criteria for 1915(c) and 1915(k) Services.
SDS	42 CFR §441.501(c)	Postpone for up to 12 months, the requirements that an initial determination of level of care is completed before the start of services and authorizes the annual level of care determinations exceeding the 12-month authorization period will remain in place and services continue until the assessment can occur.
SDS & HCS	Section 1905(a) of the Act	Reimburse through Medicaid for the provision of 1905(a) personal care services rendered by legally responsible individuals (inclusive of legally responsible family caregivers) under specific criteria.
HCS, DBH, & SDS	42 CFR §440.70(f)(1) and (f)(2)	Modify the deadline for the required face-to-face encounter required for Home Health services up to 12 months from the start of services. Modified face-to - face requirements for other services.
SDS	42 CFR §441.480(b)	Reimburse through Medicaid for 1915(k) attendant services and supports rendered by responsible individuals (inclusive of legally responsible family caregivers under specific criteria.
HCS & DBH	42 CFR §440.90(a)	Waive the requirement that services be provided "by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients." In effect, the waiver allows the state and clinic to temporarily designate a practitioner's location as part of the clinic facility to provide services via telehealth.

Disaster Relief State Plan Amendments

DHSS Impact	Federal Regulation or Authority	Explanation of Waived Requirement & Impacts
Medicaid	42 CFR §430.20	Remove the requirement to submit a State Plan Amendment (SPA) by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020.
Medicaid	42 CFR §447.205	Waive the requirements for public notice of Medicaid SPA changes in statewide methods and standards for setting payment rates.
DPA	Section 1135	Permit Medicaid enrollment for non-Alaska residents who otherwise meet the eligibility criteria.
DPA	42 CFR §§ 435.406, 435.956 and 457.380	Provide for an extension of the reasonable opportunity period for non-citizens to provide proof of satisfactory immigration status.
Medicaid	FFCRA & 42 CFR. §447.55(b)(2),	Permit the suspension of deductibles, copayments, coinsurance, and other cost-sharing under the public health emergency guidelines.
DPA & HCS	1902(a)(10)(A)(ii)(XIII) of the Act	Suspend enrollment fees, premiums, and similar charges for the *Qualified Working Disabled eligibility* category.
SDS & HCS	Section 3715 of the CARES Act	Authorize the provision of 1915(k) Community First Choice Personal Care Services to a recipient in an acute care hospital if the services identified in the individual's plan of care meet several CMS specified limiting factors related to the duplication of services.
DBH	Section 1135 of the Act	Modify the unlicensed mental health provider qualifications to allow students who have completed all coursework except practicum or internship hours to practice.
SDS	Section 1915(k) of the Act	Revise the Community First Choice providers requirement to eliminate certifications for first aid and CPR during the public health emergency. (Modified later in public health emergency)
HCS	42 CFR §440.60	Expand state plan to allow service provision by qualified and enrolled state-licensed pharmacists who are practicing within their authorized scope of practice, statewide standing orders, and the HHS Office of the Assistant Secretary for Health guidance memo.
HCS	Alaska Medicaid State Plan	Increase the number of allowable days included in the dispensing of medications to 68-days, unless the medication is on the 90-day list.
HCS	Alaska Medicaid State Plan	Waive the requirement for long term care facilities to return unused unit doses of medications.

HCS	Alaska Medicaid State Plan	Increase the professional dispensing fees for drugs and provide guaranteed reimbursement for the cost of shipping medications to beneficiaries.
HCS	Alaska Medicaid State Plan	Give providers a pathway to petition for an alternative reimbursement mechanism for pharmacy claims.
SDS	Alaska Medicaid State Plan	Modify the reimbursement of infant learning and long-term services and supports targeted case management services to reflect a per episode rate rather than a monthly rate.
HCS	42 CFR §440.30(b); Alaska Medicaid State Plan	Allow other licensed practitioners operating within their scope of practice as able to prescribe laboratory and radiology and allows coverage of laboratory services outside an office or similar facility.
HCS	42 CFR §440.70; Alaska Medicaid State Plan	Allow the ordering of home health services by other licensed practitioners operating within their scope of practice.

Appendix "K"

DHSS Impact	Federal Regulation or Authority	Explanation of Waived Requirement & Impacts
SDS	1915(c) – Appendix "K"	Increase the cost limits for entry into the *Individualized Supports Waiver* (AK1566) by $5,000.
SDS	1915(c) – Appendix "K"	Waive the settings requirements to restrict outside visitors from visiting recipients in *Residential Habilitation and Residential Supported Living settings*.
SDS	1915(c) – Appendix "K"	Permit recipients to exceed service limitations related to *Respite, Chore and Care Coordination services*.
SDS	1915(c) – Appendix "K"	Expand the settings in which services may be provided. Applies to *Day Habilitation, Residential Habilitation, Respite, Intensive Active Treatment, Residential Supported Living, Adult Day, and Provide-Site-Specific Supported Employment*.
SDS	1915(c) – Appendix "K"	Permit payment for services rendered by family caregivers or legally responsible individuals -Applies to *Chore, Respite, Residential Habilitation (supported living and in-home supports) services, and Day Habilitation.*
SDS	1915(c) – Appendix "K"	Modify direct service worker requirements to extend first aid and CPR training requirements for another year and waive the requirement for new hires during the disaster period. Allows acceptance of provisional background checks past the regularly allowable 30-days. **Modified later** to allow on-line first aid and CPR trainings to meet requirements for initial hires and renewing employees during the disaster period.

		Suspend requirement for proof of CPR hands-on test during the public health emergency.
SDS	1915(c) – Appendix "K"	Extend certifications of providers up to one year and allow the appointment of a temporary home administrator if the program administrator becomes unavailable because of COVID-19.
SDS	1915(c) – Appendix "K"	Modify licensure or other requirements for settings where waiver services are furnished – Applies to *Residential Habilitation & Residential Supported Living.*
SDS	1915(c) – Appendix "K"	Modify process for level of care (LOC) evaluations or re-evaluations to allow telephone or other technological mechanisms, extends the LOC determinations for up to one year, and allows SDS to securely communicate electronically with care coordinators on LOC determinations and support plans.
SDS	1915(c) – Appendix "K"	Increase rates for situations in which the participant or someone in the participant's household is quarantined because of COVID-19. *Applies to Residential Habilitation Group Home, Residential Habilitation Family Home Habilitation, Residential Supported Living, Respite, and Chore services.*
SDS	1915(c) – Appendix "K"	Allow renewal of the person-centered service plan for up to an additional 12-months if the recipient agrees.
SDS	1915(c) – Appendix "K"	Extend the timeline for submission of incident reports to 120 days.
SDS	1915(c) – Appendix "K"	Allow for the provision and reimbursement of *Respite, Day habilitation, and Intensive Active Treatment services* when recipient is in an acute care setting under CMS specified conditions.
SDS	1915(c) – Appendix "K"	Allow retainer payments to providers of *Residential Habilitation Group Home and Family Home Habilitation, Residential Supported Living, Site based Day Habilitation, and Adult Day services.*

The termination dates for the COVID-19 public health emergency-related flexibilities are as follows:

Approval Mechanism	Termination Date
1135 waiver authority	end date of the federal public health emergency
Disaster Relief State Plan Amendment authority	end date of the federal public health emergency
1915(c) Appendix "K" authority	March 5, 2021

6) Demonstration Project Results

AS 47.05.270(d)(7)

DHSS continues to implement 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 Coordinated Care Demonstration Project (CCDP), required under AS 47.07.039. Please see Section II.A.15 on page 22 of this report for information about this project.

7) Telehealth Barriers, Improvements, and Recommendations

AS 47.05.270(d)(8)

- When the COVID-19 public health emergency was declared, Medicaid expanded telehealth services to provide safe treatment options for members and providers. Telehealth treatment guidelines have been relaxed and additional methods of delivery are allowed for the duration of the public health emergency. This includes not restricting patient and provider location, expanding coverage to include telephone and online digital check-ins, and allowing reimbursement for: providers rendering telehealth services from their home without reporting their home address and continuing to bill from their currently enrolled location
- Physician visits in skilled nursing facilities provided via telehealth
- Hospital initial, subsequent, observation, and discharge evaluations provided via telehealth
- Emergency department and critical care services provided via telehealth
- Physical Therapy, Occupational Therapy, and Speech Language Pathology services provided via live interactive modes
- Direct entry midwifery services provided via telehealth
- Federally Qualified Health Centers (FQHC) medical and behavioral health services provided via telehealth, and
- Alternate methods of service delivery for behavioral health services such as text and audio only visits

The goals of this expansion are to:

- Allow for more patients to remain safe at home while still receiving needed medical care.
- Ensure medical providers can maintain a safe distance while still providing their patients with needed care.
- Allow for patients with COVID-19 to remain in isolation and prevent the spread of the disease while still receiving care.

The temporary telehealth expansions were made effective March 20, 2020 and will remain in effect for as long as the U.S. Department of Health and Human Services Secretary's public health emergency remains in effect. CMS is considering making some of these new flexibilities permanent, and DHSS has asked provider partners to provide input on which items they would like to be made permanent.

The Division of Senior and Disabilities Services (DSDS) conducts assessments to determine eligibility for home and community-based waiver services, Community First Choice services, and personal care services. These are typically completed in-person in an applicant's home. Due to increases in the number of applicants from rural Alaska and a reduction in the travel budget for assessors, the DSDS has been integrating telehealth assessments into the assessment workflow for the past few years. Support from the Alaska Mental Health Trust since FY 2016 has enabled the division to hire a telehealth coordinator who has made outreach to providers, particularly rural health clinics, to serve as remote assessment sites. The coordinator has established provider agreements that ensure compliance with HIPAA and other security requirements. Participants in these agreements are reimbursed $71.25 per each completed telehealth assessment to compensate for use of room, equipment, and staff setup and stand-by time.

The COVID-19 public health emergency has accelerated the use of telehealth assessments at the DSDS. Under authority of the Appendix K and Section 1135 allowances, all in-person assessments for home and community-based services have been suspended. While a few telehealth assessments are being conducted in local health clinics, most are now being conducted with applicants in their homes using secure web-based video conferencing systems, such as Zoom. In situations when an internet connection is not available, DSDS works on a case-by-case basis with families, care coordinators, and providers of personal care services to identify creative solutions to getting assessments completed. In FY 2020 almost 500 telehealth assessments were completed for Alaskans with a full range of service needs, including developmental disabilities, mental illness, Alzheimer's disease, dementia, traumatic brain injury and chronic alcoholism.

A telehealth medical care advisory committee (MCAC) with a focus on pediatrics is currently in development. The purpose of the committee includes the interpretation of Medicaid data by clinical professionals with relevant skill, the review of Medicaid standards against current evidence and best practices, and to make recommendations that will result in increased value for Medicaid recipients and sustainable practice for Medicaid providers, including proper provider incentives toward higher value care by how claims are paid. The department anticipates a future MCAC for the adult population.

Recommendations from the MCAC and the 2017 Telehealth Stakeholder Workgroup will be utilized when determining needed updates to Medicaid telehealth regulations to ensure reimbursement policies support increased access to care in underserved communities in the most cost-effective manner.

8) Medicaid Travel Costs

AS 47.05.270(d)(9)

In FY 2020 total travel expenditures decreased by $3.7 million compared to FY 2019, a decrease of four percent. In FY 2020 total travel expenditures continue to follow the trend from FY 2016 with most expenditures being federal funds, with only nine percent of the cost from State General Fund or $10 million for FY 2020. This was a decrease of $2.4 from FY 2019 or 20 percent from State General Fund. There was an overall decrease in expenditures even though Medicaid continues to see enrollment growth. The Alaska Medicaid program continues to contain costs well below enrollment growth and attain significant cost savings in State General Funds due to the Tribal initiative and travel restrictions associated with the COVID-19 public health emergency in FY 2020.

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 2019 and FY 2020. 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 2019	FY 2020	Percent Change
5,198	4,411	-17.8%

FY 2020 Top Diagnoses at ED Visit of Medicaid Recipients Identified as Frequent ED Users

Diagnosis	Number of Claims
Unclassified (e.g., fever, chest pain)	12,714
Behavioral Health Condition	8,583
Injury	6,433
Respiratory Disease	5,305
Musculoskeletal System	3,137
Digestive Disease	3,101

10) Hospital Readmissions

AS 47.05.270(d)(11)

Readmission data was collected using a new data analytics tool J-SURS[11]. 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 two - to 30-day period following a hospital stay to omit hospital-to-hospital transfers that are captured as one-day readmissions.

Of the 1,422 recipients with readmission in FY 2019, only 150 had a hospitalization and subsequent readmission in FY 2020.

Number of Hospital Readmissions (2 – 30 days following discharge)

FY 2019	FY 2020	Percent Change
1,422	1,479	4.0%

[11] J-SURS™, which stands for Java-Surveillance and Utilization Reporting Subsystems, from IBM Watson-Health™ is a claims-based data mining solution for program integrity

FY 2020 Top ICD-10 Diagnoses Classifications for Hospital Readmissions of all Medicaid Recipients

Diagnosis	Number of Claims
Unclassified (e.g., fever, nausea)	413
Behavioral Health Condition	254
Pregnancy, Childbirth, Puerperium and Perinatal	245
Circulatory System Diseases	157
Digestive System Diseases	149
Respiratory Disease	142
Injury	140

11) State General Fund Spending per Recipient

AS 47.05.270(d)(12)

State General Fund spending for the average medical assistance recipient decreased by 10.5 percent in FY 2020 compared to FY 2019. In FY 2019 the State General Fund spending averaged $3,227 per recipient and in FY 2020 it averaged $2,887.

In FY 2019 there were 204,980 recipients and State General Fund spending was $661.4 million and in FY 2020 there were 201,846 recipients[12] and State General Fund spending was $582.7 million.[13]

Average State General Fund Spending per Medicaid Recipient

FY 2019	FY 2020	Percent Change
$3,227	$2,887	-10.5%

12) Uncompensated Care Costs

AS 47.05.270(d)(13)

The following are the 2012 – 2018 uncompensated care costs incurred by hospitals in Alaska that complete standard Medicare cost reports and for which this information is available (15 hospitals represented in 2018). Due to difference in hospital fiscal years the data may represent different periods. For example: 2018 includes data from July 1, 2018 – June 30, 2019 for those on state fiscal year and October 1, 2018 – August 30, 2019 for those on federal fiscal year.

[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] The spending percentage change from FY 2019 to FY 2020 would be lower if claims 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 FY 2018 claims been paid in FY 2018, GF spending for FY 2019 would have been $623,569,349 and FY 2020 would have a decrease of 6 percent.

Hospital Uncompensated Care Data[14]

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	$60,091,432	-17.8%
2018	$58,204,495	-3.1%

Percent change since Medicaid expansion (2014 to 2018) -48.5%

The following information is provided by the Alaska Division of Insurance regarding the change in health insurance premiums from CY 2014 – CY 2019.

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%
CY 2019				
Individual Market	217,716	$ 155,611,710	$714.75	-7.80%
Small Group Market	170,315	$ 148,505,355	$871.95	10.95%

Source: Alaska Division of Insurance, October 2020

[14] Alaska State Hospital & Nursing Home Association, October 2020. S-10 worksheet, line 30 (cost of non-Medicare bad debt + charity care to uninsured patients, includes cost report data submitted through facility FY 2018. Non-tribal hospitals.

13) Optional Services Expenditures by Fund Source

AS 47.05.270(d)(14)

State FY 2020 spending for provision of optional services is presented in the table on the following page with a breakdown by service category and funding source.

WAIVER OR OPTIONAL SERVICE STATE FISCAL YEAR 2020	STATE SPENDING	FEDERAL SPENDING	TOTAL SPENDING
WAIVER			
1115 WAIVER SUD	$5,200,333	$2,530,289	$7,730,623
ADULT DAY CARE	$1,827,716	$3,229,870	$5,057,585
CARE COORDINATION	$5,980,266	$8,096,747	$14,077,013
CHORE SERVICES	$556,989	$639,235	$1,196,223
DAY HABILITATION	$14,724,196	$19,676,177	$34,400,374
ENVIRONMENTAL MODIFICATIONS	$155,051	$181,374	$336,426
INTENSIVE ACTIVE TREATMENT/THERAPY	$374,590	$553,124	$927,714
MEALS	$1,045,944	$1,316,065	$2,362,008
RESIDENTIAL HABILITATION	$59,158,198	$81,179,678	$140,337,876
RESIDENTIAL SUPPORTED LIVING	$23,456,253	$28,586,067	$52,042,320
RESPITE CARE	$5,784,807	$7,747,029	$13,531,837
SPECIALIZED EQUIPMENT AND SUPPLIES	$84,187	$125,555	$209,742
SPECIALIZED PRIVATE DUTY NURSING	$409,876	$591,295	$1,001,172
SUPPORTED EMPLOYMENT	$3,371,198	$4,289,118	$7,660,316
TRANSPORTATION	$878,160	$1,220,312	$2,098,472
TOTAL WAIVER SERVICES	**$123,007,765**	**$159,961,936**	**$282,969,701**
OPTIONAL			
CASE MANAGEMENT SERVICES	$0	$62,651	$62,651
CHIROPRACTIC SERVICES	$19,469	$23,912	$43,381
DENTAL SERVICES.	$6,146,638	$23,259,779	$29,406,417
DRUG ABUSE CENTER	$3,138,378	$22,091,413	$25,229,791
DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES	$2,270,302	$4,227,908	$6,498,210
END STAGE RENAL DISEASE SERVICES	$900,051	$1,208,066	$2,108,117
HEARING SERVICES	$889,132	$1,858,163	$2,747,294
HOSPICE CARE	$182,337	$381,073	$563,410
INPATIENT PSYCH SERVICE	$120,312	$134,238	$254,550
INTENSIVE CARE FACILITY/INTELLECTUALLY DISABLED SERVICE	$1,016,154	$1,325,259	$2,341,413
MEDICAL SUPPLIES SERVICE	$3,113,658	$4,496,347	$7,610,005
MENTAL HEALTH SERVICE	$16,320,573	$71,013,760	$87,334,333
NUTRITION SERVICES	$2,543	$2,815	$5,359
OCCUPATIONAL THERAPY	$204,766	$504,468	$709,234
PERSONAL CARE SERVICES	$20,086,620	$28,045,822	$48,132,442
PODIATRY	$37,185	$56,156	$93,340
PRESCRIBED DRUGS	$29,815,344	$106,406,762	$136,222,106
PROSTHETICS & ORTHOTICS	$349,086	$967,743	$1,316,829
PSYCHOLOGY SERVICES	$186,944	$525,710	$712,654
REHABILITATIVE SERVICES	$1,953,426	$5,172,596	$7,126,022
VISION SERVICES	$1,576,556	$3,496,479	$5,073,036
TOTAL OPTIONAL SERVICES	**$88,329,474**	**$275,261,118**	**$363,590,592**
GRAND TOTAL	**$211,337,239**	**$435,223,054**	**$646,560,293**

FOOTNOTES:
Waiver Services are the Adult Waiver Services and the Child Waiver Services combined.
Optional Services are only Adults Optional services.
Totals may not exactly equal sum of column/row due to rounding.

With the creation of Medicaid in 1965, under Title XIX of the Social Security Act, the federal government created a platform designed to give states significant latitude in administering the joint federal/state program. Along with a set of mandatory services, states could opt to include other, optional services in

the Medicaid state plan. Over time, the role of the optional and mandatory services in health care delivery changed significantly (i.e., the increased reliance on prescription drugs – an optional service). Some optional services, such as nursing facilities and medication-assisted treatment, became mandatory. Today, we see that most of the "optional" services are mandatory for at least part of the adult population under the Affordable Care Act. In Alaska, some optional services are included in its behavioral health demonstration waiver (1115 Waiver). As these waivers require cost neutrality, the federal government has determined that such services do not add to the cost of the Medicaid program.

When implementing Medicaid expansion, Alaska opted for an Alternative Benefit Plan (ABP) benchmark methodology, ultimately aligning the ABP's benefits with the Medicaid State Plan's benefits – it became an alignment state. This decision was made, in part, to avoid the need to make significant and time-consuming system changes necessary to allow for two different benefit plans in the MMIS. This decision's effect is that the Essential Health Benefits (EHBs) requirement, imposed on all ABPs by the federal government for the expansion population, also applies to the traditional Medicaid state plan. As such, optional services in the Medicaid state plan used to satisfy the requirement for coverage of services in the EHB's ten categories are no longer technically optional for beneficiaries receiving services under the Medicaid State Plan (e.g., clinic, emergency adult dental, other licensed practitioners, hospice, mental health and substance use disorder inpatient and outpatient treatment, prescription drugs, rehabilitative and habilitative, personal care and preventive services.) While it is technically possible to create and administer separate benefit plans, it would be administratively cumbersome and for reasons discussed below, might not provide savings.

Within the optional services, the top three cost drivers are (1) prescription drugs (~33 percent of State General Fund expenditures for optional services), (2) personal care services (~23 percent of State General Fund expenditures for optional services), and (3) behavioral health services (~22 percent of State General Fund expenditures for optional services). (NOTE: Through the implementation of Alaska's 1115 Behavioral health waiver, optional behavioral health Medicaid services are largely due to sunset in January of 2021.) These three service categories' availabilities serve to prevent the increase in costly institutional placement (e.g., hospital, nursing homes, or correctional facilities) that occurs in their absence. These three service categories provide care at lower costs than the corresponding mandatory service categories (e.g., Inpatient Hospital Services and Nursing Facilities); eliminating these optional services would result in a degradation in the quality of life for beneficiaries and a significant increase in state expenditures on mandatory Medicaid benefits or other state services.

The remaining optional services account for only about one-fifth of the State General Fund spending on Medicaid optional services. As is the case with the "big three" optional services, they typically either directly replace the need for more expensive mandatory services or reduce the needs for additional mandatory services by improving health status. Eliminating these services would not significantly reduce the overall Medicaid budget.

14) Tribal Medicaid Reimbursement Policy Savings

AS 47.05.270(d)(15)

On February 26, 2016, 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 (THO).

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 IHS Medicaid recipient by a non-tribal

provider. The DHCS continues to work with the THOs to facilitate initiation of CCAs with non-tribal organizations. 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 occurs. Currently, the department has a total of 4,750 CCAs in place between 18 THOs and 366 non-tribal providers. Note that some, but not all, of the THOs have signed an agreement with each of the 366 non-tribal providers.

As part of the reclaiming process, the Tribal Health Section within DHCS tracks the care coordination agreements and partners with the THOs to verify referrals and exchange of health records to ensure the state can claim 100 percent federal funding. DHCS has requested and verified 96,942 referrals since the new policy was implemented; 18,590 or 20.65 percent were sufficiently documented. Due to the steady increase of referral requests and required extensive review of medical records, the number of verified referrals showed a decline in FY 2020. The department continues to partner with the THOs to identify ways to increase the percentage of verified referrals.

SFY	Total # of Referrals Requested	Total # of Verified Referrals	Total # of Unverified Referrals	Average Percentage of Verified Referrals	Average Percentage of Unverified
SFY17	5,871	1,363	4,508	23.40%	76.60%
SFY18	19,207	4,231	15,270	22.06%	79.44%
SFY19	31,952	6,714	25,238	21.32%	78.65%
SFY20	39,912	6,282	33,630	15.85%	84.00%
Totals	**96,942**	**18,590**	**78,646**	**20.65%**	**79.67%**

Based on the efforts described above, DHSS has been able to save approximately $248 million in State General Funds from the February 2016 date of the SHO letter through the end of FY 2020. To date, Alaska is still 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.

SFY	State GF Savings (Transportation)	State GF Savings (Other Services)	Totals State GF Savings
SFY17	$ 10,589,538.00	$ 24,192,302.00	$ 34,781,840.00
SFY18	$ 15,901,959.00	$ 29,285,001.33	$ 45,186,960.33
SFY19	$ 26,922,884.00	$ 45,724,251.00	$ 72,647,135.00
SFY20	$ 35,998,890.84	$ 59,119,442.36	$ 95,118,333.20
Totals	**$ 89,413,271.84**	**$ 158,320,996.69**	**$ 247,734,268.53**