# AK DHSS Annual Medicaid Reform Report

# FY2021

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 2021 Annual Medicaid Reform Report



**November 15, 2021**

# I. EXECUTIVE SUMMARY

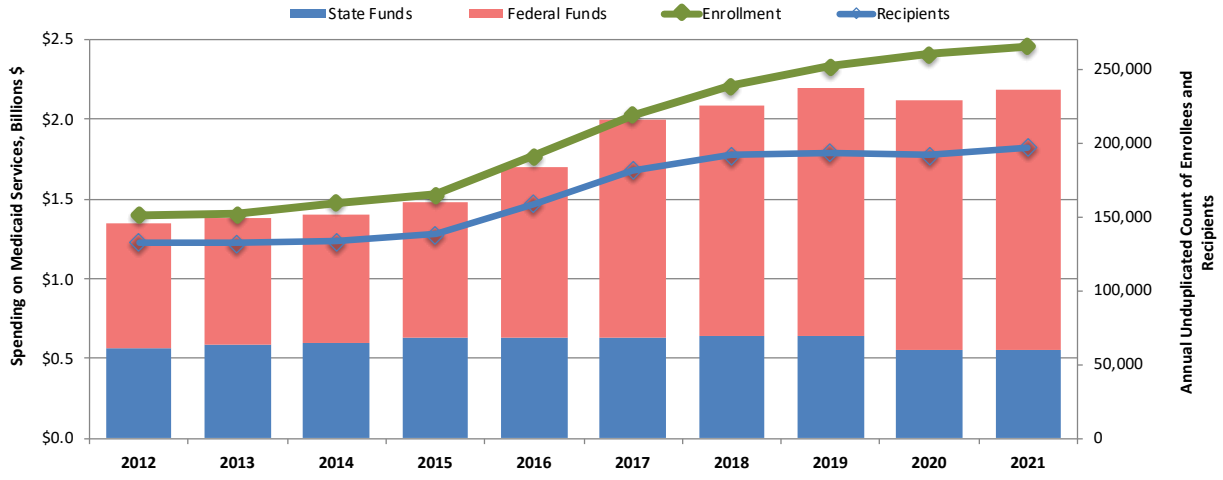
The Medical Assistance Reform Program was established under AS 47.05.270 by Senate Bill 74 (SB 74) in 2016. Under this statute, the Department of Health & Social Services (DHSS) is required to submit an annual report to the Legislature by November 15 of each year on the status and results of Medicaid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

This report identifies $155 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 2021 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 | $57,467,872 |
| Alaska Medicaid Coordinated Care Initiative (Primary Care Case Management) | $1,450,897 |
| **Subtotal** | **$ 58,918,769** |
| **SB 74 Medicaid Reform GF Cost Avoidance — Department of Corrections** | |
| Medicaid enrollment for prisoners; out-of-facility hospital services | **$4,151,498** |
| **GF Savings/Cost Avoidance from Other Medicaid Reforms — DHSS** | |
| Pharmacy Preferred Drug List | $ 6,000,000 |
| Pharmacy Prospective Drug Utilization Reviews | $ 5,500,000 |
| Pharmacy Payment Reform: NADAC | $ 12,000,000 |
| Pharmacy Preferred Drug List Modernization | $ 3,000,000 |
| **Subtotal** | **$ 26,500,000** |
| **GF Savings/Cost Avoidance from On-Going Care Improvement/Cost Containment Initiatives — DHSS** | |
| Home & Community Based Services Utilization Control & Process Improvement | $4,454,569 |
| Surveillance & Utilization Review Subsystem (SURS) Overpayment Collections | $ 75,607 |
| Medicaid Program Integrity Overpayment Collected from Providers | $5,540,658 |
| Medicaid Program Integrity Cost Avoidance | $51,981 |
| Third-Party Liability Contract and HMS Audit Recovery | $9,411,108 |
| Care Management Program | $ 2,738,751 |
| Case Management | $1,450,897 |
| Utilization Management Services | $41,777,361 |
| **Subtotal** | **$65,500,932** |
| **TOTAL** | **$155,071,199** |

The following graphs from the Preliminary Long-Term Forecast of Medicaid Enrollment & Spending in Alaska (MSEA) to be published in January 2022, 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 FY 2020 associated with the enhanced FMAP and is estimating another $54 million in FY 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 FY 2020, mostly associated with the adverse impacts of the COVID-19 public health emergency.

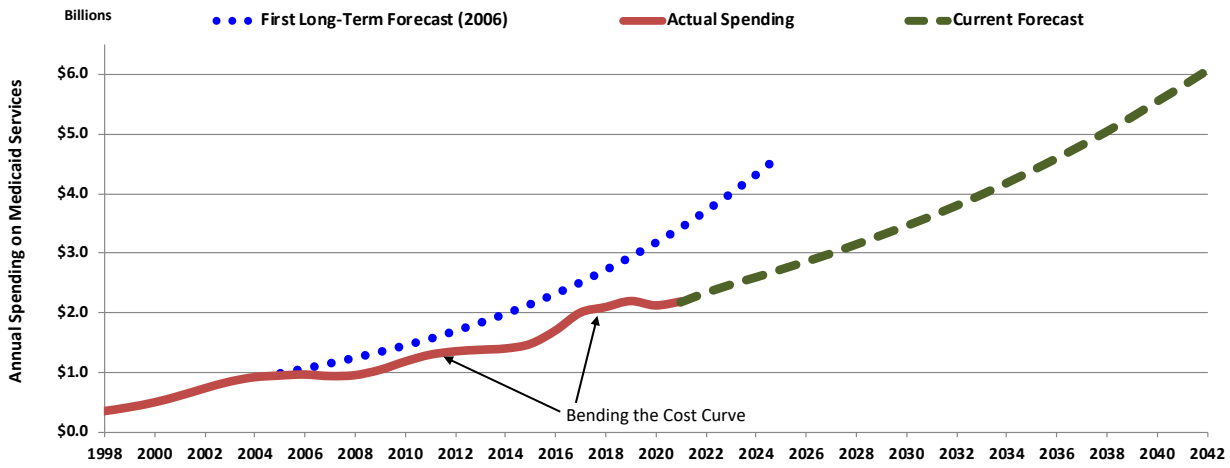
**Spending on Medicaid Services, Enrollment in the Medicaid Program, and Recipients of Medicaid Services, Based on Date of Service, FY 2012 – FY 2021[1]**




[1] Evergreen Economics, (January 2022). Preliminary Long-Term Forecast of Medicaid Enrollment & Spending in Alaska (MSEA): FY 2022 – FY 2042.

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.

**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 2021 Medicaid activities and accomplishments. Additional details for each are provided later in the report.

**A1) Referrals to Community & Social Supports:**
*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.

Similar services have been developed for Anchorage and Matanuska-Susitna Valley residents receiving Supplemental Nutrition Assistance Program (SNAP) benefits through five ongoing Provider Agreements (PAs) with high performing non-profit agencies. Services offered to SNAP Employment and Training participants include case management, support services, supervised job search, work experience, and vocational training courses.

DPA and Department of Labor & Workforce Development (DOLWD) have recently partnered to streamline the referral and communication between DPA and DOLWD, and to increase training enrollment while leveraging Workforce Innovation & Opportunity Act (WIOA) funding.

[2] Evergreen Economics, (January 2022). Preliminary Long-Term Forecast of Medicaid Enrollment & Spending in Alaska (MSEA): FY 2022 – FY 2042.

**A2) Explanation of Benefits:**
A new Explanation of Medical Benefits (EOMB) portal went live in December 2020. The portal allows Medicaid members to review claims paid on their behalf and allows members to report claims issues to the Division of Health Care Services (DHCS). This new portal provides 18 months of claim information for both children and adults. There are currently less than 1,000 members using the new portal. The DHCS is working to expand member awareness through a variety of methods and hopes to serve at least 2,500 members in FY 2022.

**A3) 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.

**A4) Fraud, Waste & Abuse:**
During FY 2021, Medicaid Program Integrity (MPI) recovered over $5.5 million in overpayments paid to providers and five payment suspensions were initiated based on credible allegation of fraud determinations. The MPI office oversaw the first cycle of Alaska Medicaid Provider self-audits which were required by AS 47.05.235. Over 850 self-audits were received and Alaska Medicaid providers self-reported over $800,000 in overpayments. 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 is a Law Enforcement Liaison with the National Healthcare Anti-Fraud Association (NHCAA) in order to leverage training opportunities, share the various tools used by partners, and to detect and prevent health care fraud more effectively.

Overall, MPI saved the Medicaid program over $5.5 million for a total return on investment of $5.35 per dollar spent.

**A5) Home & Community-Based Services (Long-Term Services and Supports Reforms):**
Home and Community-Based Services (HCBS) help people remain in their homes or communities 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. During FY 2021, the health care industry in Alaska was adversely impacted by the COVID-19 pandemic, but it is anticipated expenditures may rebound to pre-pandemic levels.

Waiver services experienced a slight reduction of 0.9 percent, personal care services decreased by 15.9 percent, and CFC services decreased by 4.3 percent in FY 2021, resulting in a decrease of 3.4 precent, or $4,454,570 overall in State General Fund spending.

**A6) Pharmacy Initiatives:**
Over the past two years, negotiated pricing and utilization management within the pharmacy program has made an impact at bending the cost curve, but the continually escalating cost of pharmaceuticals continues to risk strain to the system. 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.

**A7) Enhanced Care Management:**
Current programs experienced modest growth in participation under SB 74. There was a total of approximately $4.2 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' Care Management Program (CMP).

**A8) 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. The Office of Rate Review (ORR) is leading an initiative to implement Diagnosis Related Groups (DRGs) as a value-based payment methodology for inpatient stays at general acute care hospitals. ORR has been assisted by contractor Myers and Stauffer LC. Together they have met regularly over the last year or so with members of the Alaska State Hospital and Nursing Home Association (ASHNHA) and hospitals (as applicable) regarding the DRG Project. The project is targeted for implementation in FY 2023.

**A9) Quality & Cost Effectiveness Targets:**
DHSS can now report fourth-year Medicaid program performance on the measures and targets established by the Quality & Cost Effectiveness Targets Stakeholder Workgroup. Results of the fourth-year performance baseline for services, delivered during state FY 2020, demonstrate that the program met or exceeded annual performance targets for four measures; partially met targets for two measures; is monitoring numbers for three measures; and failed to meet targets for the remaining eight measures.

**A10) Travel Costs:**
In FY 2021, total Medicaid transportation expenditures decreased 43 percent from FY 2020. Travel restrictions due to the COVID-19 public health emergency (PHE) were a major factor in this decrease; Alaska state mandates relating to travel and health care had a significant impact on both inter and intra state travel. Concurrently, the Medicaid program adopted federal telehealth flexibilities related to the PHE which have furthered cost containment efforts while also ensuring recipients are still able to receive needed care as travel limitations persist. Telehealth expenditures have increased 34 percent from FY 2020. However, the combined expenditures for Medicaid transportation and telehealth for FY 2021 decreased 23 percent from the same combined expenditures for FY 2020.

**A11) 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.

**A12) Behavioral Health System Reform:**
DHSS applied for a Section 1115 Demonstration Waiver with the Centers for Medicare and Medicaid Services to establish a network of behavioral health services at the community and regional levels to reduce the need for crisis-driven and urban-based emergency, acute, and residential care in Alaska. In FY 2021, both the substance use disorder (SUD) and behavioral health component of the 1115 Waiver were operational. The division is working with an administrative services organization to analyze baseline data through the 1115 SUD Waiver and to monitor for service capacity. The division continues to work with the provider community to implement the new 1115 Waiver behavioral health services.

**A13) Eligibility Verification System**
The Division of Public Assistance implemented the Eligibility Verification System in January 2021 pursuant to Alaska Statute 47.05.105, which requires DHSS to implement an enhanced computerized income, asset, and identity eligibility verification system. The division's Eligibility Technicians conduct searches when clients apply and recertify their benefits with DPA and use the information returned to verify eligibility and follow up with clients on additional verifications that are needed. Results from the search are stored in the clients' case files.

**A14) Emergency Care Improvement:**
Real-time electronic exchange of patient information between hospital Emergency Departments (ED) is now live in 15 hospitals and 9 clinics/other entities. Uniform statewide guidelines for prescribing narcotics in an ED have been in place for four years and are helping to combat the opioid epidemic.

**A15) 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 fourth year of the 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.

**A16) 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.

**A17) Tribal Medicaid Reimbursement Policy**:
DHSS' Tribal Health Unit tracked 5,712 Care Coordination Agreements (CCAs) between Tribal and non-Tribal providers and saw a cumulative total of 132,382 referral requests (in FY 2021, the total referral requests were at 35,440). DHSS was able to save $57.4 million in State General Funds in FY 2021 and a total of $305.2 million in State General Funds from February 2016 through the end of FY 2021.

**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** |
| **2021** | $ 15,532,937 | $ 41,934,935 | **$ 57,467,872** |
| **TOTALS** | **$ 104,946,209** | **$ 200,255,932** | **$ 305,202,141** |

# 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, training leading to employment, and removal of mental and physical health 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.

Similar services have been developed for Anchorage and Matanuska-Susitna Valley residents receiving Supplemental Nutrition Assistance Program (SNAP) benefits. DPA manages five ongoing Provider Agreements (PAs) with high performing non-profit agencies and is continuously working to expand agreements on a statewide level. The agreements are funded through the United States Department of Agriculture (USDA), Food and Nutrition Service, SNAP Employment and Training (SNAP E&T), and providers are reimbursed 50 percent of their costs associated to administer the program. Services offered to SNAP E&T participants include case management, support services, supervised job search, work experience, and vocational training courses (life skills, culinary, Commercial Driver License, carpentry training, master gardener, web design, medical office reception, Personal Care Attendant, construction, flagger's course, etc.).

DPA and Department of Labor & Workforce Development (DOLWD) have recently partnered in an effort to increase training opportunities for recipients of ATAP and SNAP E&T. An ambitious workgroup is underway consisting of leadership and front-line staff from both agencies with a consultant facilitating the weekly meetings. The intended outcome is to streamline the referral and communication between DPA and DOLWD, and to increase training enrollment while leveraging Workforce Innovation & Opportunity Act (WIOA) funding. All recipients of ATAP and SNAP E&T remain eligible for community supports while enrolled.

### *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) launched a new electronic Explanations of Medical Benefits (EOMB) portal in December 2020. The new EOMB portal has a direct connection to the Medicaid Management Information System (MMIS) and provides EOMB functionality for both children and adults.

Additionally, the new portal contains 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].

DHCS is actively working to grow the number of EOMB portal users and hopes to have more than 2,500 registered users by the end of FY 2022.

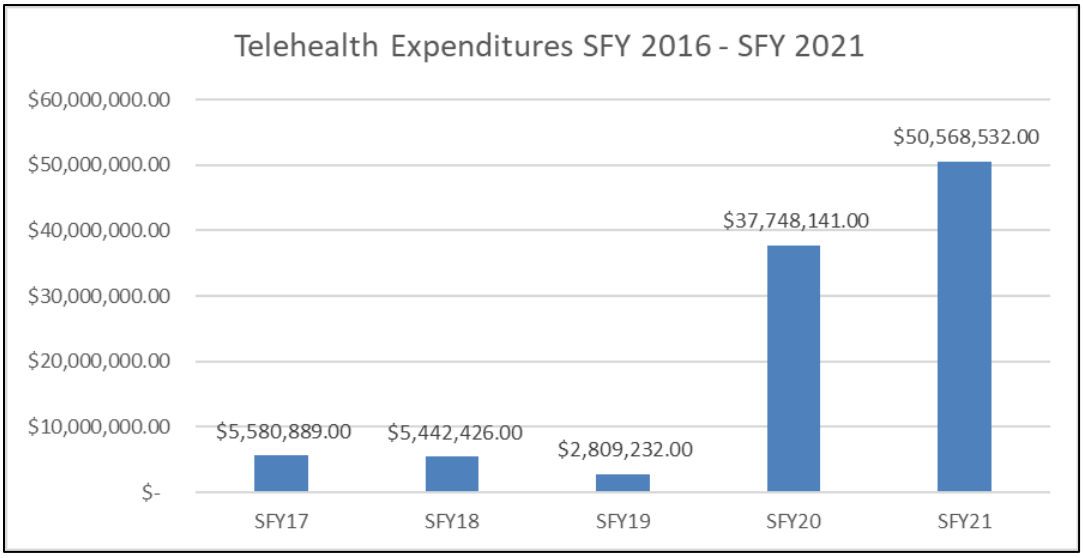
### *3) Telehealth*

*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 2021 the Medicaid program paid $50.6 million in claims for services delivered via telehealth methods, an increase of 134 percent over the amount paid for services delivered via telehealth in FY 2020. 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. However, the combined expenditures for Medicaid transportation and telehealth for FY 2021 decreased 23 percent from the same combined expenditures for FY 2020.




[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.

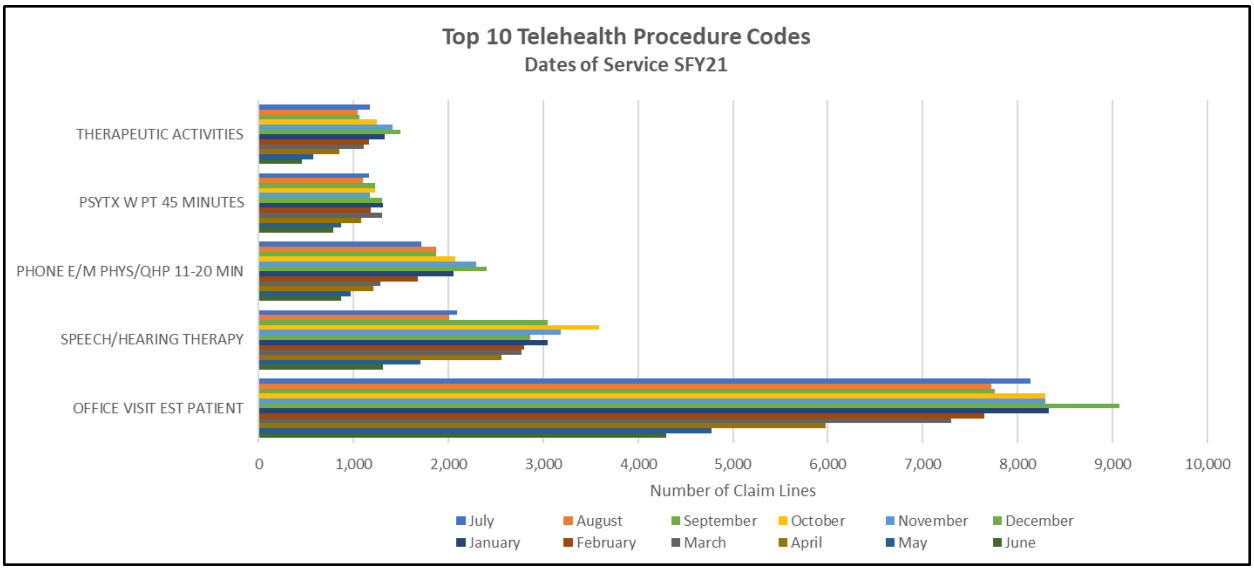
The COVID-19 public health emergency has significantly increased the need for telehealth services in communities around Alaska. DHSS is currently working with providers to determine what needs will be ongoing after the public health emergency ends. This will be followed by updates to Medicaid telehealth 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 38 for additional information about DHSS efforts to improve Medicaid telehealth policy.

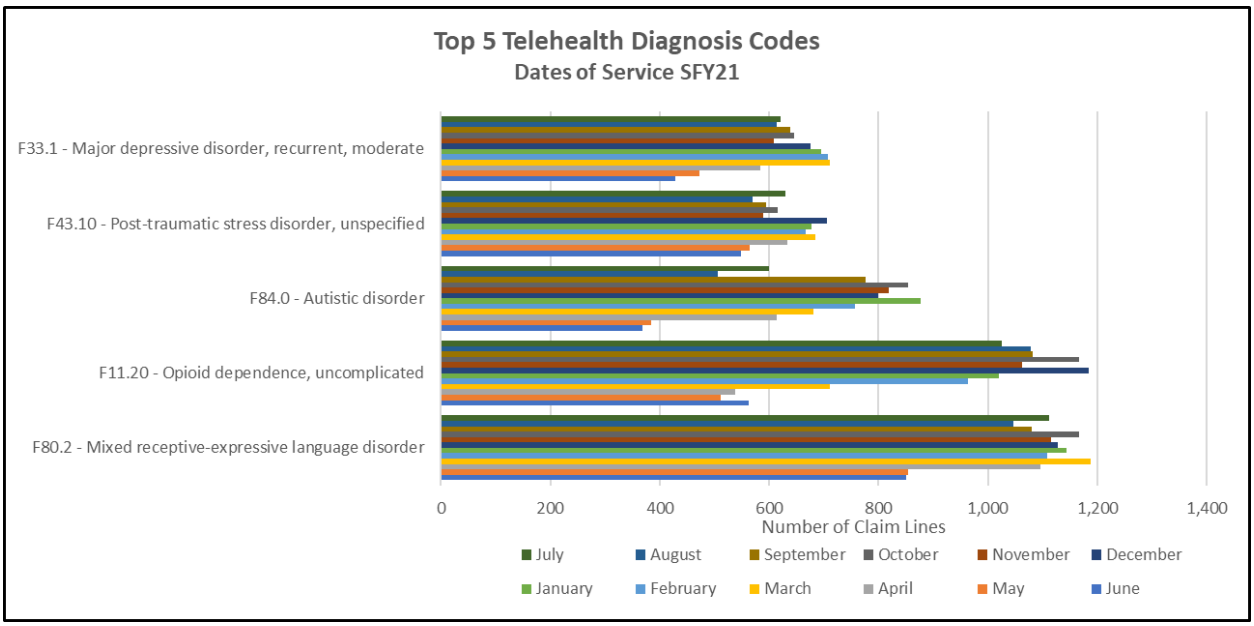
As the public health emergency continues, Medicaid has seen an increase in out-of-state providers enrolling and providing telehealth services to Alaska Medicaid recipients. Out-of-state telehealth services account for less than 1 percent of FY 2021 telehealth expenditures but have increased 2,676 percent from FY 2019 expenditures. Medicaid is monitoring these services to ensure they are in compliance with Alaska regulations and meet the needs of the recipients.

**Out-of-State Telehealth Expenditures SFY 2019 – SFY 2021**

| State | SFY19 | SFY20 | SFY21 |
|---|---|---|---|
| WA | $ 3,702 | $ 40,842 | $ 127,350 |
| NC | $ 2,073 | $ 33,592 | $ 40,400 |
| OR | | $ 302 | $ 7,320 |
| UT | | | $ 9,874 |
| MN | $ 897 | $ 4,054 | $ 2,544 |
| MT | $ 571 | $ 2,252 | $ 1,001 |
| MA | | $ 84 | $ 2,345 |
| ID | | $ 184 | $ 2,376 |
| CA | | $ 506 | $ 365 |
| CO | | $ 11 | $ 134 |
| OH | | | $ 88 |
| PA | | $ 54 | |
| VA | | | $ 39 |
| NE | | | $ 5 |
| **Grand Total** | **$ 7,244** | **$ 81,881** | **$ 193,840** |

The following table lists the top services and diagnoses for telehealth-delivered service claims billed in FY 2021. Behavioral health conditions continue to be the leading diagnosis for services performed via a telehealth method of delivery.



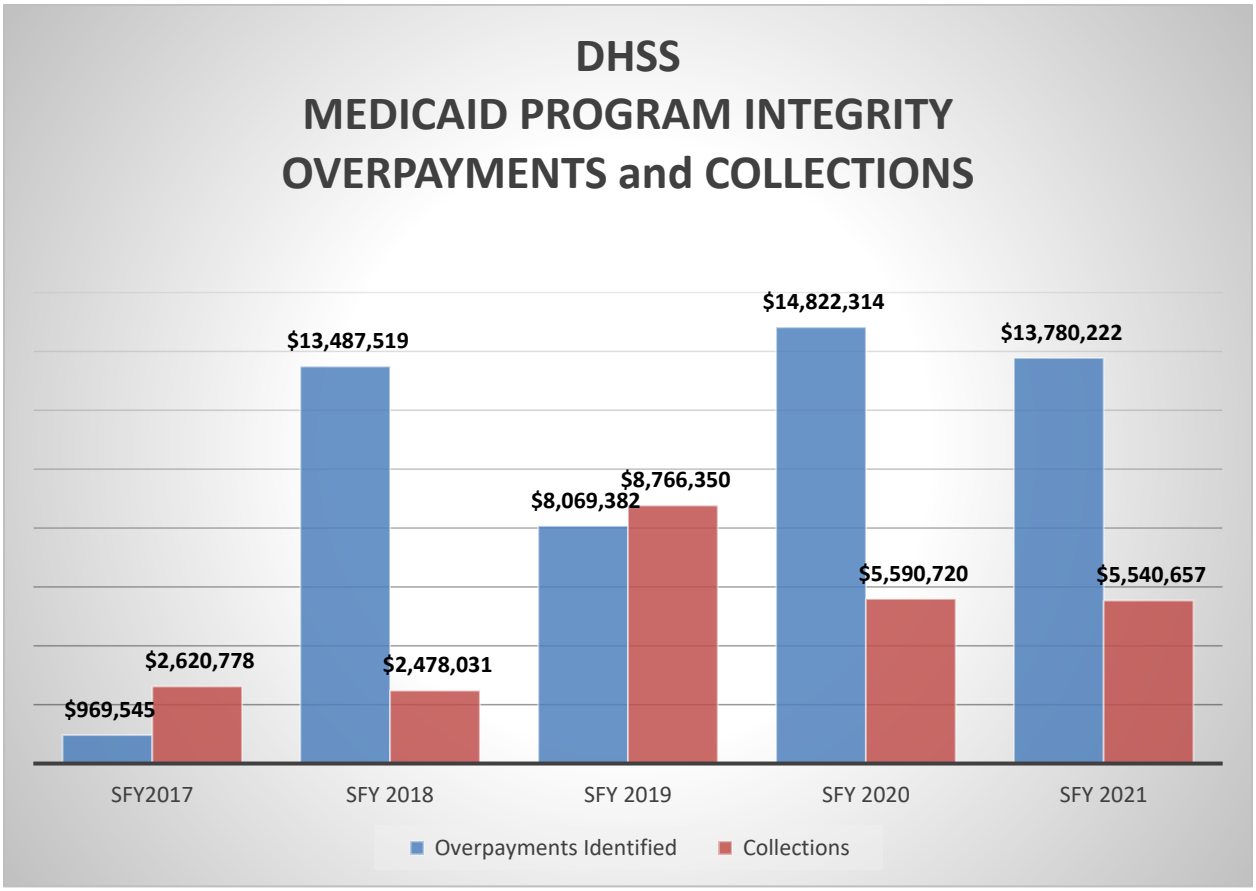
### *4) Fraud Prevention, Detection, and Enforcement*

*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. The MPI office oversaw the first cycle of Alaska Medicaid Provider self-audits which were required by AS 47.05.235. Over 850 self-audits were received and Alaska Medicaid providers self-reported over $800,000 in overpayments

During FY 2021, MPI recovered over $5.5 million in overpayments paid to providers, and five 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

Additionally, during FY 2021, MPI continued to work with the Centers for Medicare & Medicaid Services (CMS) Centers for Program Integrity and their Division of State Partnership (DSP) on a 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. As an example, one lead developed through this partnership resulted in a provider being terminated from the Alaska Medicaid Program due to abusive billing patterns. 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, to leverage training opportunities, share various tools used by partners, and to detect and prevent health care fraud more effectively.




CMS conducts payment error rate measurements (PERM) on all 50 states in 3 cycles, with about 17 states in each cycle. Alaska is a cycle 3 state which means the last Alaska PERM cycle reviewed FY 2020 and is known as reporting year (RY) 21 since the results of the PERM review are scheduled to be released in November of 2021. Cycle 3 states began the PERM review in 2020; however, CMS halted the PERM review at the onset of the public health emergency on April 2, 2020. CMS restarted the review on August 12, 2020, with a 50 percent reduced sample size to help ensure completion within the established timeframe. The results of the RY 21 PERM cycle are scheduled to be released by CMS in mid-November 2021.

Overall, MPI saved the Alaska State Medicaid program over $5.5 million - for a total return on investment of $5.35 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, HCBS 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 2021 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 2021 Costs by Funding Source and Average Cost per Person by Service Type (based on FY 2021 Final Auth Report and number of people for whom services were rendered during FY 2021)

| Program | # served | Avg cost per person | | Total costs |
|---|---|---|---|---|
| Home & Community Based Waivers | | | | |
| ALI Waiver | 2,039 | $35,051 | | $71,468,956 |
| APDD Waiver | 126 | $81,381 | | $10,254,009 |
| CCMC Waiver | 212 | $38,690 | | $8,202,276 |
| IDD Waiver | 2,036 | $87,092 | | $177,319,799 |
| ISW Waiver | 441 | $7,939 | | $3,501,107 |
| TOTAL HCB Waivers | 4,854 | | (58/42) Fed/State | $270,746,147 |
| | | | | |
| Institutional Placements | | | | |
| Nursing Home | 1,037 | $147,815 | (68/32) Fed/State | $153,283,892 |
| ICF/IID | 14 | $185,247 | (56/44)Fed/State | $2,593,453 |
| TOTAL Institutional Placements | 1,051 | | (68/32) Fed/State | $155,877,344 |
| TOTAL HCB Waivers and Institutional Placements | | | (61/39) Fed/State | $426,623,491 |

| Institutional Placements if no HCB Waiver services existed – FY2021 | | Total cost based on average cost per person for NH and ICF/IID services |
|---|---|---|
| Nursing Home + ALI, APDD and CCMC Waiver service recipients | 3,414 | $504,639,543 |
| ICF/IID + IDD and ISW Waiver service recipients | 2,491 | $461,449,339 |
| 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). | | Fed/State $966,088,882 |

Data Source: State of Alaska Automated Budget System, Final Auth 21 report, COGNOS

Status of Home and Community-Based Services (1915(c) Waiver and State Plan Options):

Federal approval of a new 1915(k) state plan Community First Choice option and a new 1915(c) Individualized Supports Waiver was granted by CMS at the end of FY 2018 (June 2018), and corresponding state regulations became effective October 1, 2018. As of June 30, 2021, 483 people were 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. Since CFC became effective, DHSS has been able to receive an additional six percent federal match for people who transitioned to the CFC program because they required an institutional level of care. In addition to previously approved CFC personal care services, DHSS transitioned the waiver service of Chore into the

CFC program on January 1, 2021, which will bring in the additional six percent in federal match for that service.

In mid-March, DHSS submitted waiver renewals to CMS for the four waivers that were set to expire June 30, 2021, and CMS approved all four for another five-year period of July 1, 2021 through June 30, 2026. These waivers included several new and amended performance measures which are used by the Division of Senior and Disabilities Services (DSDS) to monitor and report to CMS on the quality of waiver services.

On October 2020, regulations providing additional clarification on the approval of day habilitation services beyond the regulatory limit became effective, however DSDS is using its authority granted by CMS under Appendix K to suspend implementation as part of its COVID-19 public health emergency response.

As of January 1, 2021, per federal mandate, regulations went into effect that require personal care services providers have and use an Electronic Visit Verification system verifying that qualified personnel rendered the services. This mandate is expected to reduce fraud, waste and abuse of the personal care program over time.

A review of expenditures for HCBS (waiver, CFC, and personal care) between FY 2020 and FY 2021 shows that overall **state and federal** spending for these services was reduced by 2.4 percent or $7,862,579 (see below table). **State general fund-only spending was reduced by $4,454,569 (-3.46 percent).** It should be noted that the COVID-19 public health emergency adversely impacted service utilization and the reported reduction in services may be short term as the demand for these community-based services remains strong.

**FY 2020 and FY 2021 Expenditures for Waiver and Personal Care Services**

| Fund Source | SFY 2020 | SFY 2021 | $ Change | % Change |
|---|---|---|---|---|
| Waivers | | | | |
| State GF | $107,870,696 | $106,756,523 | $ (1,114,173.29) | -1.03% |
| Federal | $165,263,294 | $164,008,288 | $ (1,255,006.07) | -0.76% |
| **TOTAL** | $273,133,991 | $270,764,811 | $ (2,369,179.36) | -0.87% |
| | | | | |
| Personal Care Services | | | | |
| State GF | $12,511,275 | $10,127,756 | $ (2,383,518.97) | -19.05% |
| Federal | $15,590,466 | $13,499,220 | $ (2,091,245.82) | -13.41% |
| **TOTAL** | $28,101,741 | $23,626,976 | $ (4,474,764.79) | -15.92% |
| | | | | |
| Community First Choice Plan Option (* Additional 6% FMAP) | | | | |
| State GF | $8,354,647 | $7,397,770 | $ (956,876.30) | -11.45% |
| Federal | $15,095,557 | $15,033,798 | $ (61,758.92) | -0.41% |
| **TOTAL** | $23,450,203 | $22,431,568 | $ (1,018,635.22) | -4.34% |
| | | | | |
| Total HCBS | | | | |
| State GF | $128,736,617 | $124,282,049 | $ (4,454,568.56) | -3.46% |
| Federal | $195,949,318 | $192,541,307 | $ (3,408,010.81) | -1.74% |
| **TOTAL** | $324,685,935 | $316,823,355 | $ (7,862,579.37) | -2.42% |

Source: Evergreen Economics STAMP report, updated October 2021.

### *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's preliminary estimates suggested an additional $1.5 million in supplemental rebate savings in the year subsequent to the changes which were completed in April 2020. 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. In FY 2021, the Supplemental Rebate Program benefitted from an additional $6 million in absolute additional rebate collections as compared to FY 2020. Normalized against total program costs, this represented an additional $30,000 supplemental rebate collections per $1 million dollars reimbursed to providers by the program for both pharmacy and medical pharmacy claims, or 3 percent of total spend.

Systematic prospective drug utilization reviews resulted in an additional savings of over $11 million in pharmacy cost avoidance by preventing dispensing of inappropriate medications. Approximately half of these savings and cost avoidance are State General Fund. While the savings for prospective drug utilization reviews is approximately one-third the value of the previous year, this change could demonstrate that pharmacy providers and prescribers have a better understanding program parameters

on the front end which makes the patient experience more seamless. Such an explanation is supported by the additional program resources made available to prescribers such as Alaska Medicaid's online drug look-up tool and electronic prior authorization portal. Maturation of electronic prescribing across the state can also be noted as supportive.

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 achieved 83 percent at the end of FY 2020. 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 2019.[4] The Medicaid Pharmacy DUR Program is researching opportunities for additional savings with the broader availability of biosimilar therapeutics during the FY 2022 review cycle.

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

Pharmacy reimbursement methodology reform continues to realize significant annual savings. Currently in the sixth year of implementation, this initiative routinely realizes over $24 million in total pharmacy reimbursement cost avoidance/savings 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 NADAC 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; reimbursement changes for medical pharmacy claims will be incorporated in a FY 2022 regulation project. The Medicare PAL was incorporated into the vaccine regulations that went into effect in January 2021.

Opioid Utilization Initiatives and Medication Assisted Therapy (MAT)

The opioid crisis continues to place a strain on limited state resources for substance dependence services and chronic pain management. The Medicaid Pharmacy program continues to employ strategies, consistent with clinical appropriateness and the SUPPORT Act, to prospectively prevent clinically inappropriate opioid dose escalations, address excessive utilization, and minimize co-prescribing of other medications of concern, such as benzodiazepines.

The Alaska Medicaid Drug Utilization Review (DUR) program's activities addressing the opioid epidemic are highlighted in the table below:

[4] https://www.medicaid.gov/medicaid/prescription-drugs/downloads/2019-dur-ffs-summary-report.pdf

| 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, daily MME limits, early refill, concurrent opioid-benzodiazepine, 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 |
| Alaska Medicaid's Medication Assisted Therapy Standards of Care program promotes 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 |
| The Alaska Medicaid Program enrolls pharmacists who are able to independently dispense naloxone to Medicaid members. | Strategy 3.2, 4.2 |
| The program encourages the use of evidence-based clinical practice with respect to pain management. A University of Washington Medicine Pain and Opioid Consult Hotline is available for Alaskan clinicians to utilize at no charge to them. http://depts.washington.edu/anesth/care/pain/telepain | Strategy 3.2 |

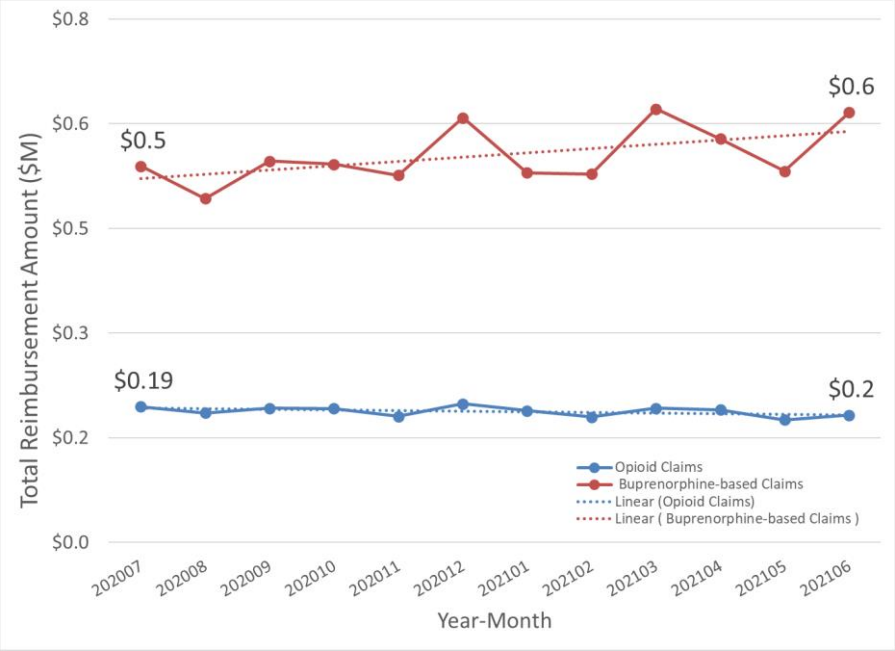
Efforts by the Alaska Medicaid DUR Program and other state partners has resulted in a decrease in overall opioid prescribing and doses within the Alaska Medicaid population.

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

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

Communities Act (SUPPORT Act) activities. Since 2018, Medicaid Pharmacy point-of-sale system claims processing rules and targeted prescriber outreach, sanctioned by the DUR Committee, have been used to employ progressively tighter MME limits; prior authorization is required for any daily MME[6] in excess of 150. Prescribers must provide treatment plans to demonstrate the need for doses in excess of the daily MME threshold. In the six-month period from January 2021 through June 2021, less than 180 unique Medicaid members received opioid prescriptions with a combined daily MME in excess of 120. This is down from 206 members during the period inclusive of April 2020 through September 2020, a 12.6 percent reduction in utilizers. 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. Promoting the selection of alternate therapies for pain management and prevention of conversion to chronic use is a goal of the University of Washington Medicine Pain and Opioid Consult Hotline available to all Alaskan clinicians at no charge.[7] The greatest impact is the clinical and personal benefit of decreasing medically unnecessary opioid utilization and providing opportunities to move individuals into recovery.

In addition to monitoring the prescribing of opioids, the program monitors medications supporting substance use recovery within its member population. Access to treatment continues to grow with a 25 percent increase in providers (50 professionals) prescribing buprenorphine-based therapies from July 2020 to June 2021; members accessing this service increased by 11.7 percent (185 individuals) over the same time period. Total pharmacy reimbursement costs for buprenorphine-based products were $6.6 million during FY 2021, down from $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.




FY21 Total Pharmacy Reimbursement Amount by Month for opioid, buprenorphine-based products. Total all months, opioid claims $2.3 million, buprenorphine-based claims $6.7 million.

[6] MME, morphine milligram equivalent
[7] http://depts.washington.edu/anesth/care/pain/telepain

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 during FY 2020. Following the preliminary work with DCCED-CBPL to explore opportunities for coordinating the Prescription Drug Monitoring Program (PDMP) information at the time of prescription processing, the Medicaid Pharmacy program is incorporating necessary system requirements into an impending Pharmacy Benefit Administration procurement to decrease real-time administrative burden on pharmacy professionals.

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, including those reported by Alaska's 1115 Waiver demonstration program.

Pharmacy Professional Service Reimbursement

*Pharmacist and Pharmacy Professional Group Enrollment*
Pharmacy professional services, from a billing perspective, traditionally have been viewed as being tied to the dispensing of a prescription medication; however, the scope of practice of pharmacist professional services are not always directly tied to a physical product. 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.

Revised vaccine regulations were adopted and became effective in January 2021. During the FY 2021 period, pharmacists independently administered and billed COVID vaccine claims for over 7,300 unique Alaskans enrolled in the Medicaid program. Additional opportunities for non-dispensing pharmacist professional service reimbursement will be incorporated in an FY 2022 regulation project along with dispensing fee reimbursement updates.

To date, Alaska Medicaid has enrolled fourteen (14) Pharmacy Professional Groups (PPG) in ten (10) different Alaska communities and 199 pharmacists.

*Ambulatory Infusion Centers (AIC)*
DHSS continues to move forward to establish the viability of Medicaid reimbursement of infused medications in an accredited Ambulatory Infusion Center (AIC) setting under the supervision of a licensed pharmacist-in-charge in an enrolled Pharmacy Professional Group as compared to a physician/advance practice registered nurse (APRN) office and hospital-based infusion clinic. 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 or APRN 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 Ambulatory Infusion Centers (AIC) enrollment and payment. During the research, it was observed that significant savings would not be generated by shifting to AIC due to a number of factors including, among other things, 340B pricing;[8] however, DHSS continues to consider the enrollment of Ambulatory Infusion Centers, enrolled as Pharmacy Professional Groups, as near-term opportunities as the federal Food & Drug Administration continues to approve an increasing number of novel therapies that must be administered in certified centers and for public health responsiveness purposes.

As part of the Pharmacy Professional Group enrollment structure established at the end of FY 2020, the FY 2022 regulation project aims to provide additional opportunities to be responsive to evolving needs as a result of the pandemic and beyond. Additional pressures, including increased access to care needs outside of the hospital setting and health care provider resource constraint, have accelerated the need. Alaska experienced a significant loss in the already fragile home infusion infrastructure by the departure of a number of home infusion therapy pharmacy providers in late 2020 which impacted all Alaskans, not just Medicaid members. Efforts as described above help to promote a culture of continuous care innovation for our members and the State as a whole. However, additional legislative and regulatory actions outside of the Medicaid program may be necessary for full implementation.

### *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 health care, promoting health care 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 cost avoidance/savings resulting from these programs.

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

| Program | FY 2021 |
|---|---|
| Case Management | $1,450,897 |
| Care Management Program | $2,738,751 |

[8] 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

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 $1,121,469 in FY 2021 through avoided inpatient acute care stays and other services and yielded a return on investment (ROI) of $8.67 for every $1.00 spent, a 5 percent increase in ROI from the previous year.

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 health care team. Case management services were provided to an average of 30 Alaska Medicaid recipients per month during FY 2021 and yielded a net Medicaid program savings (in the form of avoided costs) of $1.7 million, approximately 30 percent of which, or $.5 million, was State General Funds. The ROI for this program was $8.68 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.

Revised regulations under 7 AAC 105.600 were implemented on January 1, 2021. These updated regulations contain specific data patterns for which CMP placement can be considered. The new regulations indicate placements will now be 24 months of eligibility (versus 12 months prior to January 1) for the initial placement and 36 months for each subsequent placement. Recipients can now also be assigned a dental and behavioral health provider in addition to the previously permitted primary care provider and pharmacy.

For recipients who are enrolled, participation is mandatory. All non-emergent care must be delivered by the assigned providers and all drugs must be dispensed by the selected pharmacy.

The CMP program saved $9.1 million during FY 2020, approximately 30 percent of which, or $2.73 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 2021 CMP enrollment peaked at 459 recipients, a 20 percent increase over FY 2020.

### *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. 9); and also further developed the demonstration projects authorized under behavioral health system reform (AS 47.05.270(b), 1115 Waiver (AS 47.07.036(f)), medical services to be provided (AS 47.07.030(d)(4)), and the Coordinated Care Demonstration Project (AS 47.07.039). Please see Sections II.A.12 and 15, Behavioral Health System Reform (pg. 18) and Coordinated Care Demonstration Project (pg. 22) respectively for more information on the demonstration projects.

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. Preliminary decisions have also been made to exclude psychiatric, rehabilitation, and long-term acute care hospitals in the DRG payment methodology; however, include psychiatric, rehabilitation, substance use disorder, and neonate services provided by general acute care hospitals.

Tribally owned and operated general acute care hospitals not being paid under the state payment methodology are exempted from the DRG payment methodology. Currently, there are not any tribally owned or operated general acute care hospitals being paid under the state payment methodology or that have opted into the DRG payment methodology.

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[9].

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 and third-year performance results subsequently followed. The fourth-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 covers travel costs for medically necessary travel required for the recipient to receive services not otherwise available in the recipient's home community or through telehealth services.

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 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 2021 to contain transportation cost growth and maximize federal funding while still ensuring access to care such as:

- Promoting telehealth services where appropriate.
- Strengthening coverage guidelines for ambulance providers.
- Implementing multiple ambulance billing policies to limit the number of manually priced claims and create efficiencies with claims processing.

The Alaska Medicaid program saw a 34 percent decrease in State General Fund (GF) from FY 2020 to FY 2021 largely due to the COVID-19 public health emergency, as Alaska state mandates relating to travel

[9] See Milliman Inc.'s "Health Homes: Considerations for the Alaska Medicaid Program" report of the FY 2018 Annual Medicaid Reform Report: http://dhss.alaska.gov/HealthyAlaska/Documents/redesign/FY-2018_Annual_Medicaid_Reform_Report_with_Appendices.pdf

and health care had a significant impact on both inter and intra-state travel. In FY 2021, total travel expenditures continue to follow the trend from FY 2016, with most expenditures being federal funds. Only 12 percent, or $6.5 million, of overall travel costs were State General Fund. Total travel expenditures decreased by $45.7 million compared to FY 2020.

**Travel Expenditures**

| Health Care Medicaid Services | FY2018 | FY2019 | FY2020 | FY2021 | FY2020 to FY2021 | |
|---|---|---|---|---|---|---|
| | Prior | | | | Percent | Dollar |
| **Transportation** | **$85,624,665** | **$103,712,782** | **$99,944,596** | **$54,180,984** | **-45.8%** | **$ (45,763,611.78)** |
| State (Unrestricted Designated, Other) | $11,935,111 | $12,468,545 | $10,009,864 | $6,553,613 | -34.5% | $ (3,456,250.45) |
| Federal | $73,689,555 | $91,244,238 | $89,934,732 | $47,627,371 | -47.0% | $ (42,307,361.33) |

### *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 Care 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, and insufficient treatment services in rural areas. Service gaps place 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. Inadequate access to the appropriate level of care at both the preventive, early intervention, and lower acuity end of the continuum of care,

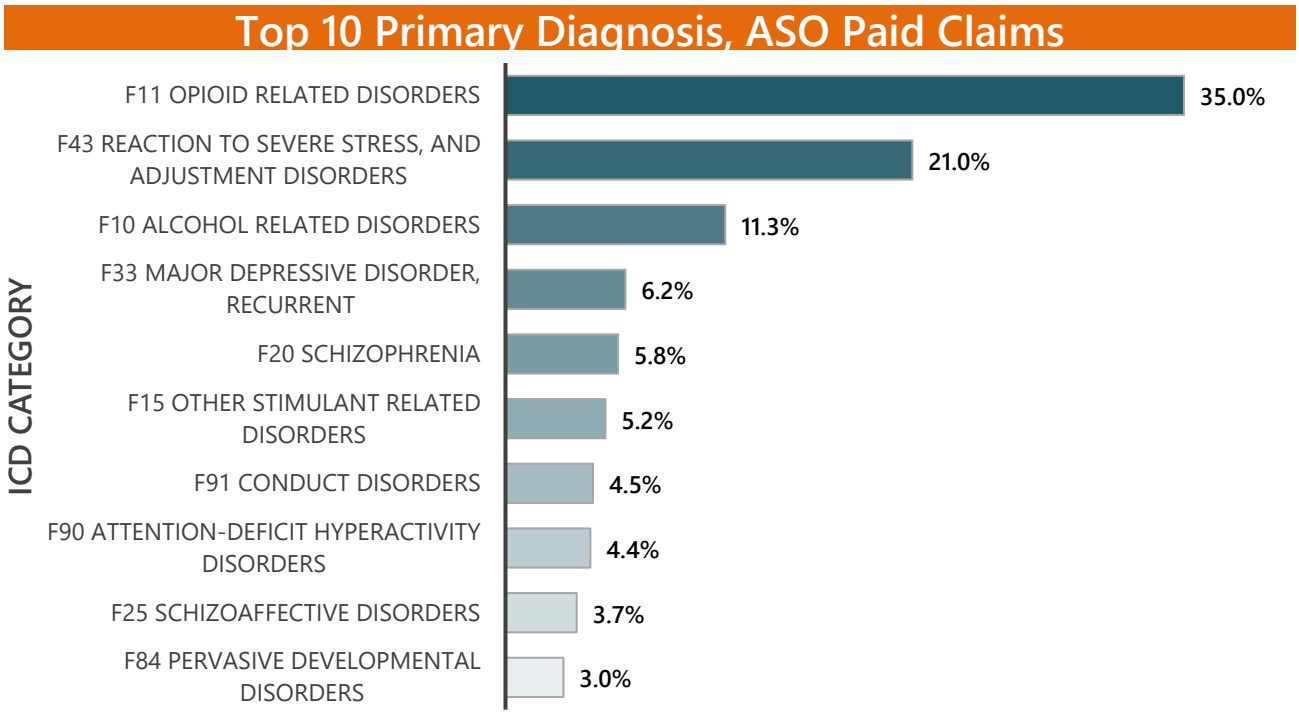
and the facility-based treatment end, fails to provide timely interventions for patients, burdens providers, and contributes to higher costs for the Alaska Medicaid program.

1115 Waiver: Behavioral Health Demonstration Project

The 1115 Waiver establishes a continuum 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. 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 on October 4, 2020.

Activities that occurred within the Division of Behavioral Health (DBH) between July 1, 2020 and June 30, 2021 to support implementation of the 1115 Waiver include:

- The Administrative Services Organization (ASO), Optum, processed and paid $189,974,957 in claims, which averages 8.80 percent of total Medicaid expenditures for FY 2021. *The graphic below shows the top 10 ASO paid claims by diagnosis.*




- Implemented processes and procedures which allowed federal claiming and CMS-64 reporting for claims processed by the ASO. The CMS-64 is a statement of expenditures for which states are entitled to federal reimbursement under Title XIX.
- Sunsetted Behavioral Health Rehabilitation Services, Recipient Support Services, and Comprehensive Community Support Services on March 31, 2021 to satisfy a long-standing CMS requirement.
- Revised service descriptions of Case Management Services and Therapeutic Behavioral Health Services and obtained CMS approval to prevent these services from sunsetting on June 30, 2021.
- Finalized the Section 1115 Behavioral Health Medicaid Waiver Services regulations on October 20, 2020.
- Provided trainings, webinars, and email distributions with information related to provider enrollment and billing for new services under the 1115 Waiver.

Behavioral Health System Capacity

There are numerous initiatives underway to support behavioral health system reform, primarily targeted towards building additional capacity and supporting increased capabilities throughout the system. The 1115 Waiver is intended to serve individuals in their communities or regional hub, which will also reduce travel costs for treatment.

DBH continues to collect baseline data for 1115 Waiver SUD services after a full year of implementation. In FY 2021, over 2,400 Medicaid recipients received SUD services through the 1115 Waiver.

Medicaid Disproportionate Share Hospital (DSH) funding for behavioral health treatment services continues to be offered to hospitals to expand mental health treatment options. DSH payments are designed to offset high levels of uncompensated care costs that are incurred by hospitals. Qualifying hospitals receive a combination of federal and state funding to provide certain services to a disproportionate share of low-income patients. In FY 2021, three hospitals qualified for DSH funding.

### *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. DPA implemented the system in January 2021 with a full roll-out to staff, which included staff training. The system contains the required CMS asset verification system as well as the National Directory of New Hire, Public Assistance Reporting Information System (PARIS), Electronic Death Registration System (eDRS), incarceration, income, Alaska Housing Finance Corporation, identity, Systematic Alien Verification for Entitlements (SAVE), Permanent Fund Dividend, Alaska Department of Motor Vehicles, residency, and household composition checks. Eligibility Technicians conduct searches when clients apply and recertify their benefits with the DPA and use the information returned to verify eligibility and follow up with clients on additional verifications that are needed. Results from the search are stored in the client's case files.

### *14) Emergency Care Improvement*

The Emergency Department Coordination Project (EDCP) is a collaborative effort between 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. There are currently 15 Alaska hospitals and 9 clinics/other entities connected to Collective Medical's Emergency Department Information Exchange (EDIE).

Collective Medical and HealtheConnect have developed an agreement which allows all facilities connected to the Health Information Exchange (HIE) to onboard with EDIE. This allowed Alaska Psychiatric Institute's (API) implementation to proceed. Based on this collaboration, it should be easier to connect tribal hospitals without going through the shared Cerner interface – which has been a barrier.

| EDIE Status Update October 2021 | |
|---|---|
| | |
| **Hospital** | **Status** |
| Alaska Native Medical Center | Live with PDMP |
| Alaska Psychiatric Institute | Live |
| 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 | TBD |
| Maniilaq Medical Center | TBD |
| 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 Kuskokwim Delta Regional Hospital | TBD |
| | |
| **Clinics /Other** | **Status** |
| Alaska Innovative Medicine | Live |
| Anchorage Fire Department | Live |
| Anchorage Neighborhood Health | TBD |
| LaTouche Pediatrics, LLC - Central Office | Live |
| LaTouche Pediatrics, LLC - Eagle River | Live |
| LaTouche Pediatrics, LLC - Huffman | Live |
| Links 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, DHSS is permitted to contract with provider-led entities, Accountable Care Organizations, managed care organizations, primary care case managers, and prepaid ambulatory health plans. In FY 2017, DHSS issued a Request for Proposals (RFP) soliciting proposals in any of three different health care models:

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

During FY 2018 DHSS conducted negotiations with four respondents to the RFP, and in June 2018 released Notices of Intent to Award contracts to 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. DHSS successfully contracted with PFMC in July of 2018, but postponed negotiations with United Healthcare in mid-2019. As previously reported, the department did an extensive amount of upfront work with United Healthcare but given the State's fiscal situation this project could not move forward.

Patient Centered Medical Home Providence Family Medicine Center

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, a two-year time limited program, for the purposes of introducing federal funding and establishing a model of care replicable by other willing and able Medicaid primary care providers. The state exercised the first optional renewal year of the contract, effective October 1, 2021, to facilitate work with PFMC, an actuarial consultant as required under AS 47.07.039(e), and various stakeholders on the design and proposal of the 1915(b) waiver and to explore the potential for future transitions to a Medicaid State Plan Option, such as Health Homes outlined in section 2703 of the Affordable Care Act (ACA).[10]

### *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 contracts with HealthTech Solutions to provide technical assistance to assist in engaging the internal Health Information Technology (HIT) stakeholders to meet federally required plans and project management activities. These technical support activities include the development and implementation of an Electronic Health Records (EHR) Incentive Program Outreach and Marketing Plan; an annual

[10] https://www.medicaid.gov/sites/default/files/2020-02/health-homes-faq-12-18-17.pdf

update of the State Medicaid Health Information Technology Plan (SMHP) Update, and annual development of an Environment Scan program.

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
- Support CMS's Interoperability and Patient Access final rule (CMS-9115-F) – DHSS has awarded a contract to Healthcare Management Systems, Inc (HMS) to provide access to patients to their health information records as part of an Alaska interoperability solution.

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 2020 | FY2021 | Increase / Decrease |
|---|---|---|---|---|
| Utilization Management | | $19,126,421 | $41,777,361 | $22,650,940 |
| 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 gross Medicaid program savings of $41.8 million, approximately 30 percent of which, or $12.5 million, was State General Funds, and a return on investment of $27.22 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, Inc (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 2021, third party liability (TPL) recoveries and savings increased from $31 million for FY 2020 to $48.9 million this year, and approximately 30 percent of which $14.6 million was in State General Funds.

| HMS Third-Party Liability & Audit Recovery | FY 21 |
|---|---|
| Recoveries | $ 26,164,034.86 |
| HIPP Cost Savings | $ 2,114,498.00 |
| TPL Cost Savings | $ 24,026,358.90 |
| **Total** | **$ 48,075,895.76** |
| *30% General Funds | **$ 14,422,768.73** |

Tribal Health System Partnerships

In FY 2021, DHSS 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 continued to decrease in FY 2021 (by approximately $1.7 million). The FY 2020 total was at $460.8 million and FY 2021 at $459.1million.

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 | FY 2020 | FY 2021 | Increase/Decrease |
|---|---|---|---|
| Tribal Health System Partnership | $ 460,875,030.19 | $ 459,089,150.80 | $ (1,785,879.39) |

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 fourth-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 2020 Fourth-Year Performance on Quality & Cost Effectiveness Measures**

| Measure | Met 2020 Performance Target |
|---|---|
| A.1 Child and Adolescents' Access to Primary Care | Monitor |
| A.2 Ability to Get Appointment with Provider As Needed | Monitor |
| B.1 Follow-up After Hospitalization for Mental Illness | P |
| B.31 Alcohol and Other Drug Dependence Treatment[11] | Y |
| CH.1 Emergency Department Utilization | N |
| CH.2 Diabetic A1C Testing | N |
| 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 | N |
| M.3 Prenatal Care During First Trimester | N |
| P.1 Childhood Immunization Status | N |
| P.2 Well-Child Visits for Children 0-6 by Age | P |
| P.3 Developmental Screening in the First Three Years of Life | Y |

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

Results of the fourth-year performance measures for services delivered during state FY 2020 demonstrate that the program met or exceeded annual performance targets for four measures, partially met targets for two measures, are monitoring numbers for three measures, and failed to meet targets for the remaining eight measures.

[11] 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:

- The COVID-19 public health emergency hit Alaska in the middle of FY 2020. Services were abruptly interrupted and rescheduled as Alaska met the emergent needs from the pandemic.
- Enrollment increased 4.48 percent from FY 2019 to FY 2020; while some services were interrupted during the COVID-19 public health emergency.
- The Medicaid Children's Health Insurance Program (CHIP) survey contract changed vendors; this resulted in two measures being placed in monitoring status. The survey questions and methods have changed, and the current results cannot be properly compared to the previous vender's results.

### *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 in order to receive the enhanced FMAP of 6.2 percent. Additionally, the Commissioner's office contracted with a Medicaid strategist to create a global roadmap for further Medicaid reforms, which is attached to this annual report.

### *4) Federal Law Changes that Impact the Budget*

*AS 47.05.270(d)(5)*

The Healthy Kids Act was adopted in FFY 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 CHIP. DHSS received an additional $36 million in federal reimbursement in FY 2020 associated with the enhanced FMAP and is estimating another $64.8 million in FY 2021. The public health emergency and enhanced FMAP is still in place as of this report for FY 2022. The current federal reconciliation package under consideration by Congress makes further projections difficult at this time.

## 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 Medicaid Programs**

| Direct Services | FY 2019 | FY 2020 | FY 2021 | COVID-19 (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-19 (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. The systems will allow the state to improve health and welfare of recipients of personal care by validating delivery of services. Successful implementation of EVV will reduce waste, fraud, and abuse; provide robust data to monitor compliance; and improve quality of care. The system was implemented January 1, 2021 and met the objectives to avoid any financial penalties. More recently, the second phase of the system was implemented allowing the vendor to aggregate the data coming in from providers by July 2021. The third phase, targeted for implementation in April 2022, will tie the verified visit data to the Medicaid Management Information System (MMIS) to ensure claims are validated prior to payment. 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, the Division of Seniors and Disabilities Services (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**

After an extensive public comment period in early 2021, DSDS submitted renewal applications for four of its 1915(c) waivers in late March 2021.

Three waivers received approval by CMS in mid-June for the five-year period of July 1, 2021 through June 30, 2026:

1. People with Intellectual and Developmental Disabilities (IDD) waiver;
2. Adults with Physical and Developmental Disabilities (APDD) waiver; and
3. Children with Complex Medical Conditions (CCMC) waiver) received approval.

The fourth waiver, Alaskans Living Independently (ALI), was approved by CMS in mid-July, with the effective date backdated to July 1, 2021, and running through June 30, 2026. This approval date was later than the first three waivers because CMS requested DSDS to submit an extension request for the fourth waiver application, to accommodate the federal requirement that the unduplicated number of individuals allowed on a waiver not be lower than the current approved unduplicated number of individuals during the COVID-19 public health emergency.

**State Plan Options**

DHSS did not apply for new state plan options in FY 2021.

**Grants**

DHSS did not apply for new Medicaid grants in FY 2021.

In FY 2021, the Division of Behavioral Health (DBH) applied for and received COVID-19 public health emergency funding through the American Rescue Plan Act and through a one-time, supplemental appropriations act for Mental Health and Substance Abuse Block Grants. In total, DBH will receive over $15.3 million to distribute for prevention and early intervention and treatment and recovery related activities, including crisis services, peer support training, youth underage drinking and substance abuse programming, and outreach and linkage for homeless individuals. In addition, DBH received two discretionary grants that total $4.8 million, which will be used to address mental and substance use disorders during the COVID-19 public health emergency. This funding will provide additional resources for behavioral health support across Alaska.

**COVID-19 Funding**

Alaska received multiple allocations of funding for the COVID-19 public health emergency and disaster relief to serve individuals in need of long-term services and supports. The Division of Senior and Disabilities Services (DSDS) received a total of $6,340,000 in funding received through the Families First Coronavirus Response Act (FFCRA), Coronavirus Aid, Relief, and Economic Security (CARES) Act, and Consolidated Appropriated Act.

Over $6 million of this funding was distributed from the Administration on Aging (ACoA) to distribute through the Older Americans Act programs, including $300,000 from the Administration for Community Living (ACL) for Special Programs for the Aging, for the ADRC Assistive Technology Project. The State has until September 30, 2022 to distribute this funding.

To date, the DSDS Grants Unit has distributed a total of over $4 million directly to grantee providers, with about $2.25 million remaining to distribute. Funds distributed include:

- Over $1 million directly to Nutrition, Transportation and Support Services (NTS) grantees for home-delivered meals

- $2.25 million to existing grantees and new grantees through two competitive solicitations (Request for Proposals, or RFPs)
- $250,000 to all six Aging and Disability Resource Centers (ADRC) for Assistive Technology project

DSDS also will be receiving additional funds to distribute through the federal American Rescue Plan Act, which was signed into law in late FY 2021.

**COVID-19 Flexibilities**

In the context of the COVID-19 federal public health emergency (FPHE), DHSS requested and received approval to waive requirements, represented in the charts below, under Section 1135 of the Social Security Act[12]. The charts reflect the authority under which CMS granted each flexibility and the status of each item as active (in use) or dormant (federal authority continues to exist but is not currently utilized by the state).

The termination dates for the COVID-19 FPHE-related flexibilities listed below are as follows:

| | |
|---|---|
| 1135 waiver authority | end of FPHE |
| Disaster Relief SPA | end of FPHE |
| 1915(c) Appendix "K" | six months after termination of the FPHE. |

Additionally, during the COVID-19 public health emergency, DHSS requested and received approval to waive certain Medicaid requirements.

DHSS 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 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 during the public health emergency (PHE):

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

### Section 1135 State-Specific Waivers

| DHSS Impact | Federal Regulation or Authority | Explanation of Waived Requirement & Impacts | Status of Flexibility: Active or Dormant |
|---|---|---|---|
| *DHCS, DBH, & DSDS* | 42 CFR §440.230(d) | Suspend prior authorization (pre-approval) requirements in fee-for-service Medicaid and extended prior authorizations granted pre-PHE. | DHCS: active (partial)<br>DBH: active<br>DSDS: dormant |
| *DBH & DSDS* | 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. | DBH: active<br>DSDS: active |
| *DSDS & DHCS* | 42 CFR §431.221(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. | DHCS: active<br>DSDS: active |
| *DHCS* | Medicaid Provider Enrollment Compendium (MPEC) | Provisionally, temporarily enroll providers enrolled with another State Medicaid Agency (SMA) or Medicare for the PHE duration. | DHCS: active |
| *DHCS, DBH & DSDS* | 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 PHE. 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. | DHCS: active<br>DBH: active<br>DSDS: active |
| *DHCS & DBH* | 42 CFR §455.460; | Waive the requirement for payment of an application fee | DHCS: active<br>DBH: active |
| *DHCS, DBH, & DSDS* | 42 CFR §455.432 | Waive the requirement that the state conduct site visits on applicants during the Medicaid enrollment process. | DHCS: active<br>DBH: active<br>DSDS: active |

| | | | |
|---|---|---|---|
| *DHCS & DBH* | 42 CFR §455.412 | Waive the requirement that a provider is licensed in the state of Alaska. | DHCS: active<br>DBH: active |
| *DHCS & DBH* | Section 1135 (b)(1)(B) of the Act | Allow DHSS to temporarily cessation of revalidation of enrolled providers directly impacted by the PHE. | DHCS: active<br>DBH: active |
| *DHCS, DBH, & DSDS* | 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. | DHCS: active<br>DBH: active<br>DSDS: dormant |
| *Medicaid* | Section 1135(b)(5) | Utilize flexibility in meeting the tribal consultation obligation for waivers and state plan amendments in limited circumstances. | Item specific authority |
| *DSDS* | 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* | DSDS: active |
| *DBH, & DSDS* | 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.* | DBH: active<br>DSDS: active |
| *DSDS* | Section 1135(b)(1)(B) of the Act | Waive the home and community-based settings criteria for 1915(c) and 1915(k) Services. | DSDS: active |
| *DSDS* | 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 that the annual level of care determinations exceeding the 12-month authorization period remain in place and services with | DSDS: dormant |

| | | | |
|---|---|---|---|
| | | continue until the assessment can occur. | |
| *DSDS* | 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. | DSDS: active |
| *DHCS, DBH, & DSDS* | 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 fact to face requirements for other services. | DHCS: active<br>DBH: active<br>DSDS: active |
| *DSDS* | 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. | DSDS: active |
| *DHCS & DBH* | 42 CFR §440.90(a) | Waive the requirement under that regulation 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. | DHCS: active<br>DBH: active |

**Disaster Relief State Plan Amendments**

| DHSS Impact | Federal Regulation or Authority | Explanation of Waived Requirement & Impacts | Status of Flexibility: Active or Dormant |
|---|---|---|---|
| *Medicaid* | 42 CFR §430.20 | Remove the requirement to submit a SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020. | Item specific authority |
| *Medicaid* | 42 CFR §447.205 | Waive the requirements for public notice of Medicaid State Plan Amendment (SPA) changes in statewide methods and | Item specific authority |

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|---|---|---|---|
| | | standards for setting payment rates. | |
| *DPA* | Section 1135 | Permit Medicaid enrollment for non-Alaska residents who otherwise meet the eligibility criteria. | DPA: active |
| *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. | DPA: active |
| *Medicaid* | FFCRA & 42 CFR. §447.55(b)(2), | Permit the suspension of deductibles, copayments, coinsurance, and other cost-sharing under the PHE guidelines. | Medicaid: active |
| *DPA & DHCS* | 1902(a)(10)(A)(ii)(XIII) of the Act | Suspend enrollment fees, premiums, and similar charges for the *Qualified Working Disabled eligibility* category. | DHCS: dormant<br>DPA: dormant |
| *DSDS* | 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 are identified in the individual's plan of care meet several CMS specified limiting factors related to the duplication of services. | DSDS: dormant |
| *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. | DBH: active |
| *DSDS* | Section 1915(k) of the Act | Revise the Community First Choice providers' requirement to eliminate certifications for first aid and CPR during the PHE. (Modified later in PHE) | DSDS: active |
| *DHCS* | 42 CFR §440.60 | Expand state plan to allow service provision by qualified and enrolled state-licensed pharmacists practicing within their authorized scope of practice, statewide standing orders, and the HHS Office of the | DHCS: active |

| | | | |
|---|---|---|---|
| | | Assistant Secretary for Health guidance memo. | |
| *DHCS* | 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. | DHCS: active |
| *DHCS* | Alaska Medicaid State Plan | Waive the requirement for long-term care facilities to return unused unit doses of medications. | DHCS: active |
| *DHCS* | Alaska Medicaid State Plan | Increase the professional dispensing fees for drugs and provide guaranteed reimbursement for the cost of shipping medications to beneficiaries. | DHCS: active |
| *DHCS* | Alaska Medicaid State Plan | Give providers a pathway to petition for an alternative reimbursement mechanism for pharmacy claims. | DHCS: active |
| *DSDS* | Alaska Medicaid State Plan | Modify infant learning and long-term reimbursement and support targeted case management services to reflect a per-episode rate rather than a monthly rate. | DSDS: active (partially) |
| *DHCS* | 42 CFR §440.30(b); Alaska Medicaid State Plan | Allow other licensed practitioners operating within their scope of practice to prescribe laboratory and radiology and allows coverage of laboratory services outside an office or similar facility. | DHCS: active |
| *DHCS* | 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. | DHCS: active |

**Appendix "K" – Waiver Flexibilities**

| DHSS Impact | Federal Regulation or Authority | Explanation of Waived Requirement & Impacts | Status of Flexibility: Active or Dormant |
|---|---|---|---|

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|---|---|---|---|
| *DSDS* | 1915(c) – Appendix "K" | Increase the cost limits for entry into the *Individualized Supports Waiver* (AK1566) by $5,000. | DSDS: dormant |
| *DSDS* | 1915(c) – Appendix "K" | Waive the settings requirements to restrict outside visitors from visiting recipients in *Residential Habilitation, and Residential Supported Living settings*. | DSDS: dormant |
| *DSDS* | 1915(c) – Appendix "K" | Permit recipients to exceed service limitations related to *Respite, Chore, and Care Coordination services*. | DSDS: dormant |
| *DSDS* | 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*. | DSDS: active |
| *DSDS* | 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.* | DSDS: active |
| *DSDS* | 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 online first aid and CPR training to meet requirements for initial hires and renewing employees during the disaster period. Suspend requirement for proof of CPR hands-on test during the PHE. | DSDS: active |
| *DSDS* | 1915(c) – Appendix "K" | Extend certifications of providers up to one year and allow the | DSDS: dormant |

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|---|---|---|---|
| | | appointment of a temporary home administrator if the program administrator becomes unavailable because of COVID-19. | |
| *DSDS* | 1915(c) – Appendix "K" | Modify licensure or other requirements for settings where waiver services are furnished – Applies to *Residential Habilitation & Residential Supported Living.* | DSDS: dormant |
| *DSDS* | 1915(c) – Appendix "K" | Modify process for level of care 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. | DSDS: active |
| *DSDS* | 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.* | DSDS: dormant |
| *DSDS* | 1915(c) – Appendix "K" | Allow renewal of the person-centered service plan for up to an additional 12-months if the recipient agrees. | DSDS: dormant |
| *DSDS* | 1915(c) – Appendix "K" | Extend the timeline for submission of evidence reports to 120 days. | DSDS: dormant |
| *DSDS* | 1915(c) – Appendix "K" | Allow for the provision and reimbursement of *Respite, Day habilitation, and Intensive Active Treatment services* when the recipient is in an acute care setting under CMS specified conditions. | DSDS: dormant |
| *DSDS* | 1915(c) – Appendix "K" | Allow retainer payments to providers of *Residential* | DSDS: dormant |

| | |
|---|---|
| | *Habilitation Group Home and Family Home Habilitation; Residential Supported Living; Site-based Day Habilitation; and Adult Day services.* |

### *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 federal 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. DSDS has continued to integrate telehealth assessments into its workflow for the past few years. Support from the Alaska Mental Health Trust since FY 2016 has enabled the DSDS to maintain on staff 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 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. By the end of FY 2021, approximately 1,400 telehealth assessments and observations had been performed by providers for Alaskans with a full range of service needs, including developmental disabilities, mental illness, Alzheimer's disease, dementia, traumatic brain injury and chronic alcoholism. The positive experiences that providers, recipients of services, and DSDS have had through telehealth are prompting DSDS to explore ways telehealth may be permanently and safely incorporated into regular practice after the public health emergency ends and the authorities that have suspended in-person assessment and visitation requirements, such as the Appendix K, come to an end.

A telehealth medical care advisory committee (MCAC) with a focus on pediatric health care has formed. 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. DHSS anticipates a future MCAC for the adult population.

Recommendations from the MCAC and the Medicaid Task Force Telehealth Workgroup, a state and tribal collaborative, 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 2021 total travel expenditures decreased by $45 million compared to FY 2020, a decrease of 54 percent. In FY 2021, total travel expenditures continue to follow the trend from FY 2018 with most expenditures being federal funds, with the cost from State General Fund of $6.8 million for FY 2021. This

was a decrease of $3.2 million from FY 2020 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 reductions associated with the COVID-19 public health emergency in FY 2021.

### *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 2020 and FY 2021. 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 2020 and is a contributing factor to the reduced quantity of ER frequent utilizers.

In November 2020 DHSS finalized the Care Management Program regulation changes, which were adopted effective January 1, 2021. These new regulations added a new monitoring metric, that identifies anyone who received treatment through an emergency department, three or more times for a non-emergent condition during a 12-month consecutive period, which in part attributes to the decreased number of frequent utilizers. In FY 2022 The Division of Health Care Services (DHCS) continues to use these regulations to further reduce frequent emergency room utilizers.

**Number of Medicaid Recipients Identified as Frequent Emergency Department Users**

| FY 2020 | FY 2021 | Percent Change |
|---|---|---|
| 4,411 | 3,302 | -25.1% |

**FY 2021 Top Diagnoses at ED Visit of Medicaid Recipients Identified as Frequent ED Users**

| Diagnosis | Number of Claims |
|---|---|
| Unclassified (e.g., fever, chest pain) | 10,144 |
| Behavioral Health Condition | 9,211 |
| Injury | 5,244 |
| Digestive Disease | 2,598 |
| Musculoskeletal System | 2,434 |
| Genitourinary System Disease | 1,962 |

### *10) Hospital Readmissions*

*AS 47.05.270(d)(11)*

Readmission data was collected using J-SURS[13]data analytics tool. 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.

[13] 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

Of the 1,347 recipients with readmission in FY 2021, which resulted in a reduction of 132 had a hospitalization and subsequent readmission in FY 2020.

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

| FY 2020 | FY 2021 | Percent Change |
|---|---|---|
| 1,479 | 1,347 | -8.9% |

**FY 2021 Top ICD-10 Diagnoses Classifications for Hospital Readmissions of all Medicaid Recipients**

| Diagnosis | Number of Claims |
|---|---|
| Behavioral Health Condition | 330 |
| Digestive System Diseases | 229 |
| Pregnancy, Childbirth, Puerperium and Perinatal | 189 |
| Injury | 176 |
| Circulatory System Diseases | 175 |
| Certain Infectious and Parasitic Diseases | 151 |
| Respiratory Disease | 94 |

## *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 5.0 percent in FY 2021 compared to FY 2020. In FY 2020 the State General Fund spending averaged $2,887 per recipient and in FY 2021 it averaged $2,743. In FY 2020 there were 201,846 recipients and State General Fund spending was $582.7 million and in FY 2021 there were 201,419 recipients[14] and State General Fund spending was $552.5 million.

**Average State General Fund Spending per Medicaid Recipient**

| FY 2020 | FY 2021 | Percent Change |
|---|---|---|
| $2,887 | $2,743 | -5.0% |

## *12) Uncompensated Care Costs*

*AS 47.05.270(d)(13)*

The following are the 2012 – 2019 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 2019). Due to differences in hospital fiscal years the data may represent different periods. For example: 2019 includes data from July 1, 2019 through June 30, 2020 for those on state fiscal year and October 1, 2019 through August 30, 2020 for those on federal fiscal year.

[14]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.

**Hospital Uncompensated Care Data**[15]

| 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 | $52,038,069 | -13.4% |
| 2019 | $53,674,653 | 3.1% |

% change since Medicaid expansion (2014 to 2019) -52.5%

*Source: Alaska State Hospital & Nursing Home Association, October 2021. S-10 worksheet line 30 (cost of non-Medicare bad debt + charity care to uninsured patients), includes cost report data submitted through facility FY2019. Non-tribal hospitals*

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% |
| **CY 2020** | | | | |
| **Individual Market** | 218,182 | $159,716,084 | $732.03 | 2.40% |

[15] 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.

| | | | | |
|---|---|---|---|---|
| **Small Group Market** | 179,110 | $154,819,740 | $864.38 | -1% |

*Source: Alaska Division of Insurance, October 2021*

### *13) Optional Services Expenditures by Fund Source*

*AS 47.05.270(d)(14)*

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 for opioid use disorder, became mandatory. Today, we see that most of the "optional" services are mandatory for at least part the adult all populations under the Affordable Care Act. In Alaska, some optional services are included in the behavioral health demonstration waiver (1115 Waiver). As these waivers require federal cost neutrality, the federal government has determined that such services do not add to the cost of the Medicaid program.

When implementing Medicaid expansion in 2015, Alaska opted for an Alternative Benefit Plan (ABP) benchmark equivalent methodology, ultimately aligning the ABP's benefits with the Medicaid State Plan's benefits – thus, Alaska became an alignment state. This decision was made, in part, to avoid the need to make significant, time-consuming, and costly 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., pharmacy, 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, costly, and for reasons discussed below, might not provide savings.

Within the Medicaid 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).

Through the authorization of the Alaska 1115 Waiver Demonstration Project, Alaska removed most Behavioral Rehabilitative Services that were considered optional pre-Affordable Care Act. Under the 1115 Waiver authorization, the state must demonstrate that it is meeting the outcomes of the Federal Medicaid program by administering Behavioral Rehabilitative Services that preserve access to care and reduce costs associated with over-reliance on acute care. Additionally, post Affordable Care Act, Mental Health and Substance Abuse Treatments are included in the ten essential health benefits required of Medicaid expansion states choosing to align the ABP with the state plan.

The availability of these three optional service categories serves to prevent the increased use of costly institutional placement (e.g., hospital, nursing homes, or correctional facilities), which that occurs in their absence. These three optional 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.

FY 2021 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 2021 | STATE SPENDING | FEDERAL SPENDING | TOTAL SPENDING |
|---|---|---|---|
| **WAIVER** | | | |
| 1115 WAIVER MH | $4,889,836 | $8,476,938 | $13,366,773 |
| 1115 WAIVER SUD | $3,841,636 | $21,093,849 | $24,935,484 |
| ADULT DAY CARE | $578,133 | $1,724,111 | $2,302,244 |
| CARE COORDINATION | $5,700,045 | $8,931,694 | $14,631,738 |
| CHORE SERVICES | $462,521 | $599,440 | $1,061,961 |
| DAY HABILITATION | $12,260,257 | $18,028,753 | $30,289,010 |
| ENVIRONMENTAL MODIFICATIONS | $106,670 | $136,869 | $243,538 |
| INTENSIVE ACTIVE TREATMENT/THERAPY | $263,432 | $378,622 | $642,054 |
| MEALS | $772,140 | $1,010,985 | $1,783,125 |
| RESIDENTIAL HABILITATION | $59,297,298 | $87,285,944 | $146,583,242 |
| RESIDENTIAL SUPPORTED LIVING | $23,176,407 | $32,461,040 | $55,637,447 |
| RESPITE CARE | $5,279,056 | $7,895,411 | $13,174,467 |
| SPECIALIZED EQUIPMENT AND SUPPLIES | $97,335 | $155,965 | $253,300 |
| SPECIALIZED PRIVATE DUTY NURSING | $282,272 | $709,705 | $991,977 |
| SUPPORTED EMPLOYMENT | $2,219,608 | $3,240,005 | $5,459,613 |
| TRANSPORTATION | $319,014 | $475,527 | $794,541 |
| **TOTAL WAIVER SERVICES** | **$119,545,658** | **$192,604,858** | **$312,150,516** |
| **OPTIONAL** | | | |
| CASE MANAGEMENT SERVICES | $0 | $31,855 | $31,855 |
| CHIROPRACTIC SERVICES | $21,158 | $28,344 | $49,503 |
| DENTAL SERVICES. | $7,325,064 | $27,212,882 | $34,537,946 |
| DRUG ABUSE CENTER | $2,196,448 | $15,816,628 | $18,013,075 |
| DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES | $2,256,746 | $4,726,879 | $6,983,625 |
| END STAGE RENAL DISEASE SERVICES | $1,210,377 | $1,789,380 | $2,999,757 |
| HEARING SERVICES | $960,874 | $2,285,605 | $3,246,479 |
| HOSPICE CARE | $188,726 | $381,879 | $570,605 |
| INPATIENT PSYCH SERVICE | $134,131 | $274,282 | $408,412 |
| INTENSIVE CARE FACILITY/INTELLECTUALLY DISABLED SERVICE | $829,591 | $1,216,547 | $2,046,137 |
| MEDICAL SUPPLIES SERVICE | $2,975,917 | $5,125,377 | $8,101,294 |
| MENTAL HEALTH SERVICE | $14,513,436 | $68,826,918 | $83,340,354 |
| NUTRITION SERVICES | $2,995 | $4,370 | $7,365 |
| OCCUPATIONAL THERAPY | $219,840 | $601,073 | $820,913 |
| PERSONAL CARE SERVICES | $16,594,461 | $26,620,758 | $43,215,219 |
| PODIATRY | $32,955 | $51,114 | $84,069 |

| | | | |
|---|---|---|---|
| PRESCRIBED DRUGS | $32,148,447 | $125,894,344 | $158,042,791 |
| PROSTHETICS & ORTHOTICS | $442,787 | $1,161,789 | $1,604,576 |
| PSYCHOLOGY SERVICES | $224,832 | $698,929 | $923,761 |
| REHABILITATIVE SERVICES | $2,295,619 | $6,543,896 | $8,839,515 |
| VISION SERVICES | $1,608,696 | $4,066,785 | $5,675,481 |
| **TOTAL OPTIONAL SERVICES** | **$86,183,100** | **$293,359,633** | **$379,542,733** |

*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.*

### *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 5,712 CCAs in place between 18 THOs and 440 non-tribal providers. Note that some, but not all, of the THOs have signed an agreement with each of the 440 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 132,382 referrals since the new policy was implemented; 26,317 or 20 percent were sufficiently documented. DHSS continues to partner with the THOs to identify ways to increase the percentage of verified referrals. In FY 2021, the number of verified referrals showed an increase of 6 percent compared to the previous fiscal year.

| FY | Total # of Referrals Requested | Total # of Verified Referrals | Total # of Unverified Referrals | Average Percentage of Verified Referrals | Average Percentage of Unverified |
|---|---|---|---|---|---|
| **FY 2017** | 5,871 | 1,363 | 4,508 | 23% | 77% |
| **FY 2018** | 19,207 | 4,231 | 15,270 | 22% | 78% |
| **FY 2019** | 31,952 | 6,714 | 25,238 | 21% | 79% |
| **FY 2020** | 39,912 | 6,282 | 33,630 | 16% | 84.00% |
| **FY 2021** | 35,440 | 7,727 | 27,713 | 22% | 78.00% |
| **Totals** | **132,382** | **26,317** | **106,092** | **20%** | **80%** |

Based on the efforts described above, DHSS has been able to save approximately $305.2 million in State General Funds from the February 2016 date of the SHO letter through the end of FY 2021. 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.

| FY | State GF Savings (Transportation) | State GF Savings (Other Services) | Totals State GF Savings |
|---|---|---|---|
| **FY 2017** | $ 10,589,538.00 | $ 24,192,302.00 | $ 34,781,840.00 |
| **FY 2018** | $ 15,901,959.00 | $ 29,285,001.33 | $ 45,186,960.33 |
| **FY 2019** | $ 26,922,884.00 | $ 45,724,251.00 | $ 72,647,135.00 |
| **FY 2020** | $ 35,998,890.84 | $ 59,119,442.36 | $ 95,118,333.20 |
| **FY 2021** | $ 15,532,936.95 | $ 41,934,934.94 | $ 57,467,871.89 |
| **Totals** | **$ 104,946,208.79** | **$ 200,255,931.63** | **$ 305,202,140.42** |