ALASKA DEPARTMENT OF HEALTH ANNUAL MEDICAID REFORM REPORT

FY 2022

Created in compliance with AS 47.05.270 on November 15, 2022

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.

Adam Crum
Commissioner
Department of Health

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I. Executive Summary

Introduction

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 (DOH) 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 $156,018,136 in State General Fund savings and cost avoidance that were achieved in FY 2022. 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. Following are the State General Fund savings and avoided costs resulting from Medicaid Reforms and Cost Containment Initiatives identified throughout the report:

SB 74 Medicaid Reform GF Savings/Cost Avoidance — DOH

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	$7,442,956
Subtotal	**$7,442,956**

GF Savings/Cost Avoidance from Other Medicaid Reforms — DOH

Pharmacy Preferred Drug List	$ 11,200,000
Pharmacy Prospective Drug Utilization Reviews	$ 9,400,000
Subtotal	**$ 20,600,000**

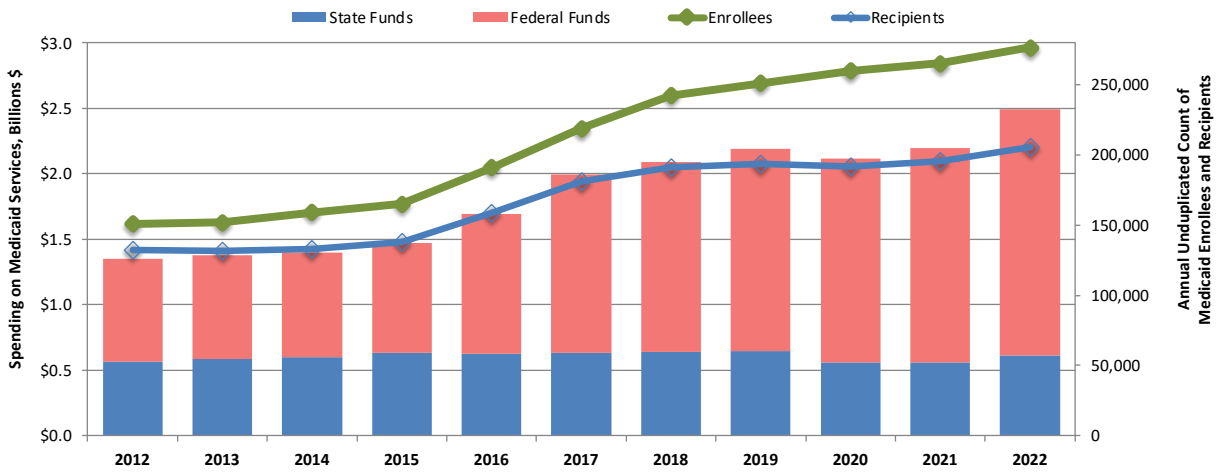
GF Savings/Cost Avoidance from On-Going Care Improvement/Cost Containment Initiatives — DOH

Home & Community Based Services Utilization Control & Process Improvement	$4,973,098
Surveillance & Utilization Review Subsystem (SURS) Overpayment Collections	$75,607
Medicaid Program Integrity Overpayment Collected from Providers	$5,859,920
Medicaid Program Integrity Cost Avoidance	$2,769,669
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	**$69,056,411**
TOTAL	**$156,018,136**

The COVID-19 public health emergency continues an increase in enrollment associated with the Maintenance of Effort requirements for the Enhanced Federal Medical Assistance Percentage (FMAP) of 6.2%. Associated with the enhanced FMAP, DOH received an additional federal reimbursement of $36 million in FY 2020, $64 million in FY 2021, and is estimating another $72 million in FY 2022. While the COVID-19 public health emergency resulted in decreased unduplicated recipient count and spending during FY 2020-2021, in FY 2022 the unduplicated recipient count and total spending has increased.

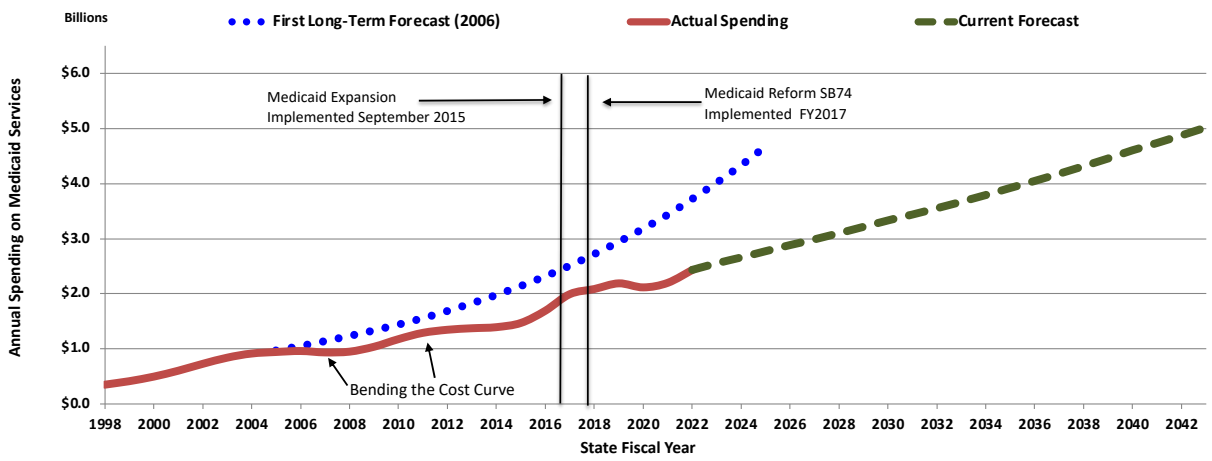
The following graph illustrates how enrollment has grown over the past ten years primarily due to Alaska's economic recession and to Medicaid expansion.

Spending on Medicaid Services, Enrollment in the Medicaid Program, and Recipients of Medicaid Services, Based on Date of Service, FY 2012 – FY 2022



The reforms instituted by the Legislature through SB 74 and other cost saving efforts by DOH 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



Governor Dunleavy's Executive Order 121 split the Department of Health and Social Services (DHSS) into two new departments: the Department of Health (DOH) and the Department of Family and Community Services (DFCS). For the purposes of this report, all references to the former DHSS have been updated to DOH.

The following is a brief summary of FY 2021 Medicaid activities and accomplishments. Additional details for each are provided later in the report.

1) Referrals to Community & Social Supports

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.

Division of Public Assistance and Department of Labor & Workforce Development (DOLWD) partnered in 2022 to streamline the referral and communication between DPA and DOLWD, and to increase training enrollment while leveraging Workforce Innovation & Opportunity Act (WIOA) funding. DPA and DOLWD provide a wide range of technical and practical knowledge as well as support services to Recipients of Temporary Assistance who are interested in employment or training. By utilizing video conferencing technology, DPA and DOLWD can now administer trainings on-demand. Furthermore, critical staff investment, intentional resource allocation, and partnership with an outside consultant allowed DPA

and DOLWD to implement these improvements over a six-month period in order offer beneficiaries a transition that was seamless as possible.

2) Explanation of Benefits

The Explanation of Medical Benefits (EOMB) portal continues to be a resource for Medicaid beneficiaries to review claims activity paid on their behalf. There are currently 1,611 members using the new portal with an increase of 104% during FY 2022. The Division of Health Care Services (DHCS) Quality Assurance team reviews all EOMB portal results and uses these data points to inform case selection for provider investigations.

3) Telehealth

Medicaid expenditures for services delivered via telehealth increased 620% since FY 2018, due primarily to the COVID-19 pandemic. The top service delivered via telehealth in FY 2022 was office visits for established patients. The top diagnoses/conditions were receptive-expressive language disorder, opioid dependence, and post-traumatic stress disorder.

Additionally, the Department of Health is working to implement increased telehealth access through House Bill 265 passed during the 2022 legislative session and signed into law on July 13, 2022.

4) Fraud, Waste, and Abuse

During FY 2022, Medicaid Program Integrity (MPI) recovered over $5.8 million in overpayments paid to providers and initiated seven payment suspensions. During this fiscal year, the Medicaid Program Integrity office issued 89 audits in accordance with Alaska Statute (AS) 47.05.200. MPI also continued to work with the Alaska Health Care Fraud Task Force, and our Unified Program Integrity Contractor on reviews including pharmacy, durable medical equipment, and physicians suspected of over-prescribing opioids. MPI is a Law Enforcement Liaison with the National Healthcare Anti-Fraud Association which allows us to leverage training opportunities, share the various tools used by partners and to detect and prevent healthcare fraud more effectively.

Overall, MPI recovered over $5.8 million and initiated cost avoidance of more than $2.7 million for a total return on investment of $8.00 per dollar spent.

5) Home & Community-Based Services (Long-Term Services and Supports Reforms)

Home and Community-Based Services (HCBS) help people remain in their home or community when their level of need would otherwise be provided in an institution. HCBS services include 1915(c) waiver services, 1915(k) State Plan Community First Choices (CFC), and personal care services. DOH continued efforts to improve utilization controls and address fraud and abuse in the provision of waiver and personal care services. During FY 2022, the healthcare industry in Alaska continued to be adversely impacted by the COVID-19 pandemic, so expenditures did not rebound to pre-pandemic levels. Expenditures for waiver services experienced a slight increase of 4% compared to FY 2021 personal care services decreased by 14% from FY 2021 levels, and CFC services decreased by 8% from FY 2021, resulting in a 2% increase, or just over $5 million, in total spending on long term services and supports.

6) 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. Focusing on evidence-based medicine principles, the flexibility afforded by AS 47.07.065 to update the Preferred Drug List (PDL) 30 days after the publicly held Pharmacy & Therapeutics Committee meetings has driven the program's ability to focus on outcomes beyond absolute drug costs. For example, the program expanded access to long-acting injectable antipsychotic (LAI) medications for any individuals who chose to move away from the inconvenience of daily oral medication.

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.

7) Enhanced Care Management

Current programs experienced modest growth in participation under SB 74. There was a total of approximately $3.4 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 DOH's Care Management Program (CMP).

8) Redesigning the Payment Process

Payment reform continues for the pharmacy program. Further development continues for the authorized demonstration projects including 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 Hospital & Healthcare Association (AHHA), formerly the Alaska State Hospital and Nursing Home Association (ASHNHA) and have achieved consensus on key decision points regarding the DRG Project. Systems work, proposed changes to administrative rules and state plan amendment, and updates to the provider billing manual are in process. The project is targeted for implementation in FY 2024.

9) Quality and Cost Effectiveness Targets Stakeholder Involvement

DOH can now report fifth-year Medicaid program performance on the measures and targets established by the Quality & Cost Effectiveness Targets Stakeholder Workgroup (QCE). Results of the fifth-year performance baseline for services, delivered during state FY 2021, demonstrate that the program met or exceeded annual performance targets for four measures, partially met performance targets for four measures, monitored numbers for three measures, are on hold for one measure, and failed to meet targets for the five remaining measures.

10) Travel Costs

In FY 2022, total Medicaid transportation expenditures decreased 21.5% from FY 2021. Travel restrictions and airline manpower shortages related to the COVID-19 public health emergency (PHE) were still a factor for travel inside and outside of Alaska. 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.

Medicaid Non-Emergent Transportation Expenditures
FY 2021 - FY 2022 Comparison

Service Type	FY 2021	FY 2022
Commercial Flight	$30,950,534.58	$22,679,870.56
Lodging	$7,178,363.98	$6,696,576.31
Ground Transportation	$3,780,277.74	$3,765,871.41
Meals	$1,315,792.31	$1,191,189.39
Other Fees	$1,270,968.00	$1,030,308.00
	$44,495,936.61	**$35,363,815.67**

11) Disease Prevention and Wellness

The Department of Health 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. DOH 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.

In FY 2022, the department highlights for promoting disease prevention and wellness included:

- Publicly noticing the Adult Preventive regulations package for Medicaid
- Engaging the Medicaid Medical Care Advisory Committee (MCAC)
- Participating in national projects

12) Behavioral Health System Reform

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.

13) 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 DOH 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.

14) Emergency Care Improvement

Real-time electronic exchange of patient information between hospital Emergency Departments (ED) is now live in 17 Alaska hospitals and 11 clinics/other entities connected to Collective Medical's Emergency Department Information Exchange (EDIE). Uniform statewide guidelines for prescribing narcotics in an ED have been in place for five years and are helping to combat the opioid epidemic.

15) Coordinated Care Demonstration Project

Beginning mid-2018, DOH executed a contract for a patient centered medical home model through Providence Family Medicine Center (PFMC). The contract term ended September 2022. The DOH is preparing for the third-party actuary review obligated under AS 47.07.039(e) to assess the outcomes of the program. The actuarial review is intended to inform a decision to move forward with a formal recommendation to pursue a primary care case management (PCCM) health home or 1915 (b) waiver program using the insight gained from the demonstration. Further pursuits would target care for high-needs and vulnerable populations while transitioning to a mixed funding model.

16) Health Information Infrastructure Plan

The Health Information Exchange system was established in AS 18.23.3000. In 2022, the Alaska legislature appropriated $6.1 million for the health information exchange (HIE) system, overseen by the Department of Health (DOH). The federal financing participation that supports implementation of health information exchange (HIE) systems known as the American Recovery and Reinvestment Health Information Technology (ARRA HITECH) Act has ended. DOH can obtain enhanced federal funding participation (FFP) if systems support Medicaid business needs and DOH must certify the HIE vendor's system to obtain this FFP.

To ensure best value of this system, DOH released a request for proposal (RFP) in 2022 and is working through the competitive procurement process for the HIE system. The contract is to be awarded and approved by the Centers for Medicare and Medicaid to receive FFP in FY 2023. The health information exchange system supports care coordination, public and behavioral health reporting, and quality improvement efforts across Alaska.

Access to the Alaska Health Information Exchange 2021 Progress & Recommendations Report is available here. A new report will be developed in December 2022.

17) Tribal Medicaid Reimbursement Policy

DOH's Tribal Health Section tracked 7,029 Care Coordination Agreements (CCAs) between Tribal and non-Tribal providers and saw a cumulative total of 168,659 referral requests (in FY 2022, the total referral requests were at 45,458). DOH was able to save $74.4 million in State General Funds in FY 2022 and a total of $375.3 million in State General Funds from February 2016 through the end of FY 2022.

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**
2022	$16,302,909	$58,109,421	**$74,412,331**
TOTALS	**$121,249,118**	**$254,057,259**	**$375,306,378**

II. Reponses to AS 47.05.270(d) Reporting Requirements

A. Status & Realized Cost Savings Related to Reforms

This part of the report (II) 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 DOH 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 four 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.

Division of Public Assistance and Department of Labor & Workforce Development (DOLWD) partnered in 2022 to streamline the referral and communication between DPA and DOLWD, and to increase training enrollment while leveraging Workforce Innovation & Opportunity Act (WIOA) funding. DPA and DOLWD provide a wide range of technical and practical knowledge as well as support services to Recipients of Temporary Assistance who are interested in employment or training. By utilizing video conferencing technology, DPA and DOLWD can now administer trainings on-demand. Furthermore, critical staff investment, intentional resource allocation, and partnership with an outside consultant allowed DPA and DOLWD to implement these improvements over a six-month period in order offer beneficiaries a transition that was seamless as possible.

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 EOMB portal contains claims information for both adults and children and is a great resource to provide members direct access to their Medicaid claims history. During the EOMB process members are asked to respond to questions on if they received a specific service on a specific date for a specific provider.

Member responses to these questions led to the recovery of small overpayments in FY 2022 and helped inform the case selection process for opening provider investigations. DHCS expects continued growth of the EOMB portal. In addition, Medicare's Interoperability and Patient Access final rule requires functionality similar to EOMB services under the 21st Century Cures Act.

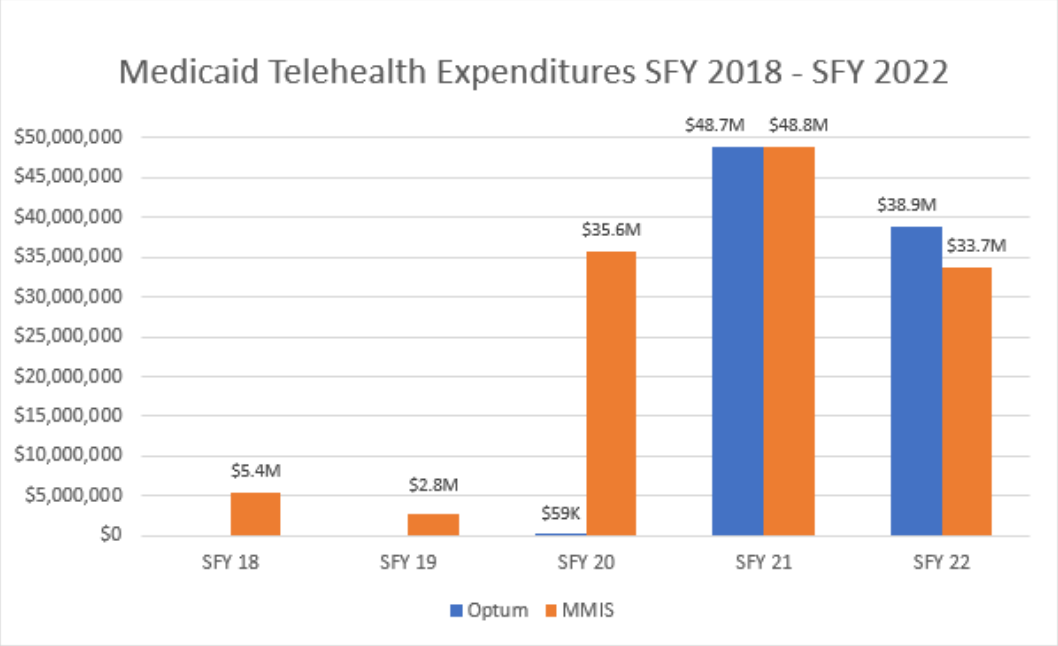
3) Telehealth

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 2022 the Medicaid program paid $33.7 million in claims for services delivered via telehealth methods, a decrease of 30.8% compared to the amount paid for services delivered via telehealth in FY 2021. 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 2022 decreased 25.9% from the same combined expenditures for FY 2021.



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:

1) **Interactive method:** Provider and patient interact in "real time" using video/camera and/or dedicated audio conference equipment.
2) **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.
3) **Self-monitoring method:** The patient is monitored in his or her home via a telehealth application, with the provider indirectly involved from another location.

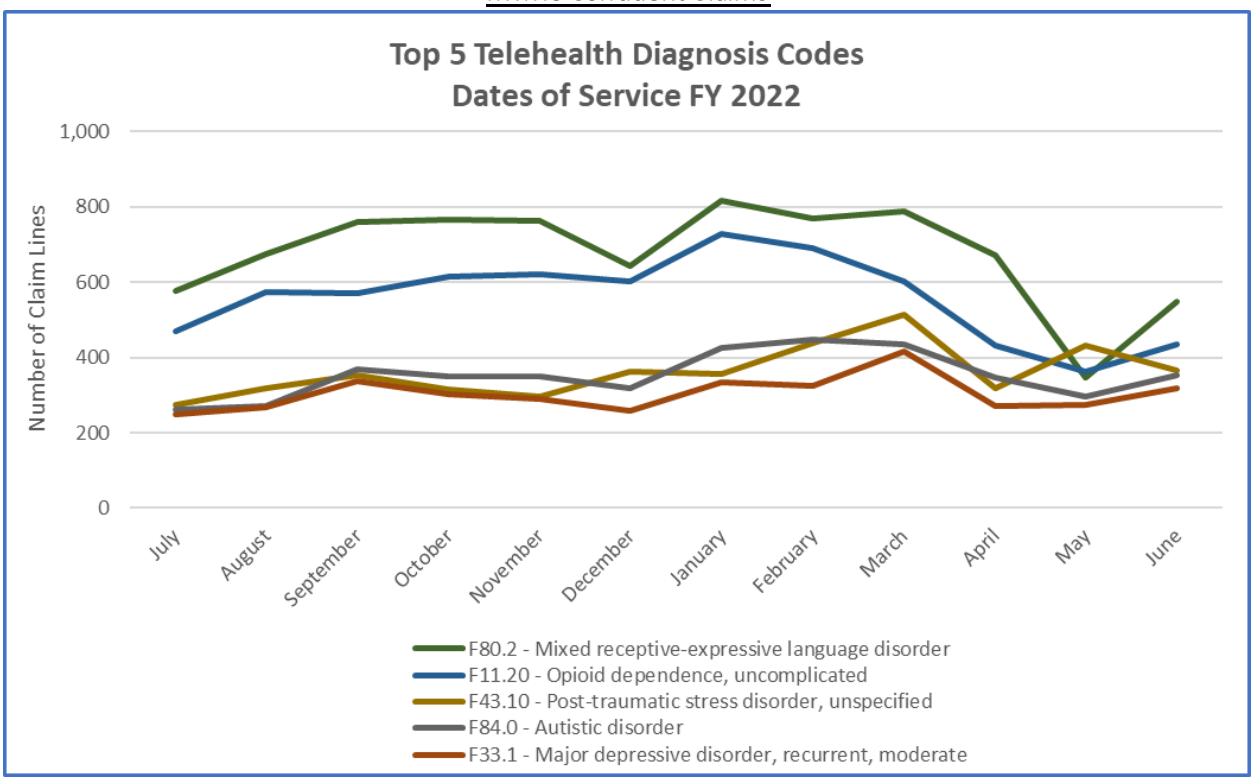
The COVID-19 public health emergency has significantly increased the need for telehealth services in communities around Alaska. DOH is currently working with providers to determine what needs will be ongoing after the public health emergency ends. This will be followed by updates to Medicaid telehealth regulations to ensure reimbursement policies support increased access to care in underserved communities in the most cost-effective manner.

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 paid for through the Medicaid Management Information System (MMIS) account for less than 1% of FY 2022 telehealth expenditures but have increased 14.66 times from FY 2019 expenditures. Out-of-state telehealth service volumes have decreased from FY 2021 by 48.5% likely due to the Division of Corporations, Business and Professional Licensing withdrawing disaster declaration flexibilities related to out-of-state licensure and the ability to perform telehealth services from an out-of-state location to a recipient in Alaska. Medicaid is monitoring these services to ensure they are in compliance with Alaska regulations and meet the needs of the recipients.

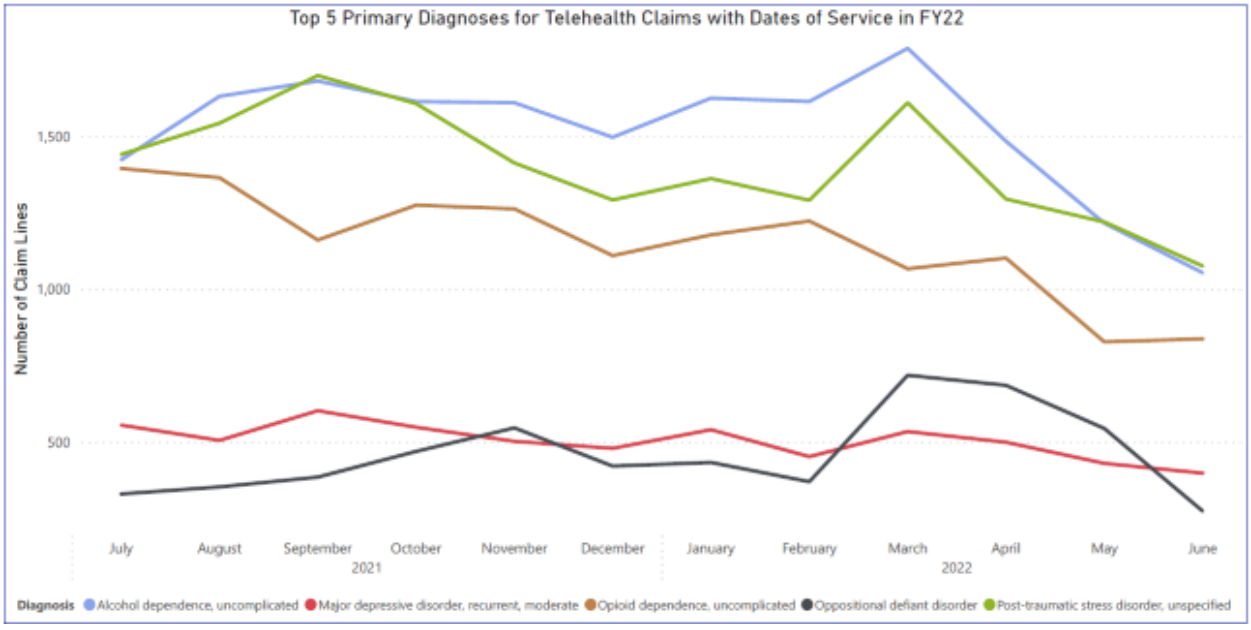
Additionally, the Department of Health is working to implement increased telehealth access through House Bill 265 passed during the 2022 legislative session and signed into law on July 13, 2022.

The following tables lists the top services and diagnoses for telehealth-delivered service claims rendered in FY 2022 separated by fiscal agent:

MMIS Conduent Claims



ASO Optum Claims



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 DOH. MPI Coordinated the Payment Error Rate Measurement (PERM) reporting year (RY) 21 corrective action plan and began the onboarding process for the RY 24 PERM review. MPI also manages the Medicaid provider self-audit program required by AS 47.05.235. The next round of self-audits is due December 31, 2022.

During FY 2022, MPI recovered over $5.8 million in overpayments paid to providers, and seven payment suspensions were initiated. Also, during FY 2022, MPI continued to work with Centers for Medicare & Medicaid Services (CMS) Centers for Program Integrity (CPI) 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 known as Unified Program Integrity Contractors to perform data analysis and identify potential problem providers based on their review of both Medicaid and Medicare claims data. Several leads developed through this partnership resulted in identification of overpayments and one provider was excluded from Alaska Medicaid. MPI continues to work with the Alaska Health Care Fraud Task Force, focusing on physicians suspected of over-prescribing opioids. MPI continued as 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 healthcare fraud more effectively.

The Medicaid program and Children's Health Insurance Program (CHIP) have been identified as programs at high risk of improper payments. CMS measures these improper payments annually through the PERM program. The PERM program reviews three components: 1) Fee-For-Service (FFS) claims, 2) managed care (MC) capitation payments, and 3) eligibility determinations and resulting payments. Alaska does not have managed care.

The CMS conducts the PERM review 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 state fiscal year 2020 and is known as RY 21 since the results of the PERM review were released in November of 2021. Alaska's overall Medicaid error rate was 34.81% including a fee for service error rate of 13.92% combined with a Medicaid eligibility error rate of 24.27%. Alaska's overall CHIP error rate was 64.66% which consisted of a fee for service error rate of 11.81% and a CHIP eligibility error rate of 59.93%.

Overall, Medicaid Program Integrity recovered over $5.8 million and initiated cost avoidance of more than $2.7 million for a total return on investment of $8.00 per 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, these home and community-based services help contain Medicaid spending by providing an option to people who otherwise could receive institutional care. Institutions are the most expensive type of long-term care services. The following table illustrates how the cost of waiver services in FY 2022 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[1][2]

SFY 2022 Costs by Funding Source and Average Cost per Person by Service Type (based on FY 2022 Final Auth Report and number of people for payments were made during FY 2022)

Program	# Served	Avg cost per person	Total costs
Home and Community Based Waivers, ALI Waiver	2,262	$34,403	$77,818,579
Home & Community Based Waivers, APDD Waiver	144	$80,406	$11,578,507
Home & Community Based Waivers, CCMC Waiver	225	$35,957	$8,090,293
Home & Community Based Waivers, IDD Waiver	2,057	$87,793	$180,591,860
Home & Community Based Waivers, ISW Waiver	495	$7,234	$3,580,937

Total HCB Waivers: 5,115 recipients, $281,660,177 total costs.

[1] Data Source: Harmony and COGNOS

[2] Note: During FY 2021, DSDS Medicaid received a 6.2% FMAP increase due to the COVID pandemic. This increase was effective 1/1/20 and is expected to remain in effect through 3/31/21.

Cost of Institutional Care without Home and Community Based Waiver Services Options[3][4]

SFY 2022 Costs by Funding Source and Average Cost per Person by Service Type (based on FY 2022 Final Auth Report and number of people for payments were made during FY 2022)

Program	# Served	Avg cost per person	Total costs
Institutional Placements, Nursing Home	1,062	$158,786	$168,630,498
Institutional Placements, ICF/IID	14	$116,181	$1,626,539

Total Institutional Placements: 1,076 recipients, $170,257,037 total costs

Institutional Placement if No HCB Waiver Services existed — FY 2022	# Served	Total Cost Based on Average Cost per Person for NH and ICF/IID Services
Nursing Home + ALI, APDD and CCMC Waiver service recipients	3,679	$584,172,885
ICF/IID + IDD and ISW Waiver service recipients	2,526	$293,474,106

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): $877,646,991

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

As part of Medicaid reform efforts begun in FY 2016, the Division of Senior and Disabilities Services (DSDS) developed a new home and community-based waiver, the Individualized Supports Waiver, to serve individuals with intellectual and developmental disabilities who were unserved by the existing Intellectual and Developmental Disabilities waiver and to reduce the state's reliance on general funded grants to serve these individuals. The new waiver was approved by CMS in FY 2018 and has gradually increased enrollment since. As of June 30, 2022, 495 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 1915 (k) state plan Community First Choice became effective in October 2018, DOH has been able to receive an additional 6% 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, DOH transitioned the waiver service of Chore into the CFC program on 1/1/21, to take advantage of the additional 6% in federal match for that service.

DSDS worked to add controls on the amount of some waiver services. Regulations providing additional clarification on approval of day habilitation beyond the regulatory limit became effective in October

[3] Data Source: Harmony and COGNOS

[4] Note: During FY 2021, DSDS Medicaid received a 6.2% FMAP increase due to the COVID pandemic. This increase was effective 1/1/20 and is expected to remain in effect through 3/31/21.

2020, and regulations adding a phase-out provision to employment services became effective September 2021, however, the division has opted to suspend implementation of both these regulations amendments due to its COVID-19 related workload.

On January 1, 2021, per federal mandate expected to reduce fraud, wase and abuse, regulations went into effect that require personal care services providers have and use an Electronic Visit Verification (EVV) system verifying that personal care services are rendered by qualified personnel. In February 2022, Alaska received approval of certification of the state's EVV system from the Centers for Medicare and Medicaid Services (CMS), which allows Alaska to receive reimbursement for implementation and operational costs associated with EVV. Also, In FY 2022, Alaska began the design, development, and implementation phase of the next services subject to federal EVV requirements, Home Health Care Services, and is on track to meet the January 1, 2023, implementation deadline.

A review of expenditures for home and community-based services (waiver, CFC, and personal care) between FY 2021 and FY 2022 shows that overall spending (GF and FF) for these services increased by 2% or $5,550,069 (see table below). State general fund-only spending for these services was reduced by 4.0% or $4,973,098. The COVID-19 pandemic continued to adversely impact service utilization since the annual growth in overall spending was not as robust as in pre-COVID years; while the Division was approved to allow flexibilities for the delivery of several services, some providers did reduce or curtail services during the height of the public health emergency, and some recipients elected not to participate in some services, particularly those provided in group settings. This minor growth rate may be short term as the demand for these community-based services remains strong and may rebound as the pandemic wanes.

Other initiatives implemented by DSDS during FY 2022 include planning for and the initial distribution of American Rescue Plan Act Section 9817 funds to waiver services providers to reimburse for COVID-related staffing expenditures and developing a training and certification program for direct service professionals.

FY 2021 and FY 2022 Expenditures for Waiver and Personal Care Services

Waiver Services

Fund Source	FY 2021	FY 2022	$ Change	% Change
State GF	$106,756,523	$103,795,084	$(2,961,439)	-3%
Federal	$164,008,288	$177,770,476	$13,762,187	8%
TOTAL	**$270,764,811**	**$281,565,560**	**$10,800,749**	**4%**

Personal Care Services

Fund Source	FY 2021	FY 2022	$ Change	% Change
State GF	$10,690,409	$9,119,545	$(1,570,864)	-15%
Federal	$14,670,096	$12,565,967	$(2,104,129)	-14%
TOTAL	**$25,360,505**	**$21,685,512**	**$(3,674,993)**	**-14%**

FY 2021 and FY 2022 Expenditures for Waiver and Personal Care Services

Community First Choice Services (Additional 6% FMAP)

Fund Source	FY 2021	FY 2022	$ Change	% Change
State GF	$6,811,765	$6,370,970	$(440,795)	-6%
Federal	$13,886,273	$12,751,382	$(1,134,892)	-8%
TOTAL	**$20,698,039**	**$19,122,352**	**$(1,575,687)**	**-8%**

Total Home and Community Based Services

Fund Source	FY 2021	FY 2022	$ Change	% Change
State GF	$124,258,697	$119,285,600	$(4,973,097)	-4%
Federal	$192,564,658	$203,087,825	$10,523,167	5%
TOTAL	**$316,823,355**	**$322,373,425**	**$5,550,069**	**2%**

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. In FY 2022, the Supplemental Rebate Program benefitted from an additional $12.2 million in absolute additional rebate collections as compared to FY 2021.

Systematic prospective drug utilization reviews resulted in an additional savings of over $21 million in pharmacy cost avoidance by preventing dispensing of inappropriate medications. Approximately half of these savings and cost avoidance are State General Fund.

Use of Generic Drugs

The use of generic drugs provides comparable quality but is typically far less costly than brand name drugs. Alaska's Medicaid Pharmacy Program generic drug utilization exceeded 84% at the end of FY 2021. 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 83.5% in FFY 2020. The Medicaid Pharmacy DUR Program continues to research opportunities for additional savings with the broader availability of biosimilar therapeutics during the FY 2023 review cycle.

Opioid Utilization Initiatives and Medication Assisted Therapy (MAT)

The Alaska Medicaid Drug Utilization Program (DUR) continues to promote evidence-based opioid prescribing activities, which has resulted in a decrease in overall opioid prescribing and doses within the Alaska Medicaid population as demonstrated by claims data. The Medicaid program further tightened previous quantity limits, established successively decreasing Morphine Milligram Equivalent (MME) thresholds that would prompt prior authorization reviews, and enhanced cross-agency relationships through the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) activities. 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 in excess of 120. 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 2022 through June 2022, less than 130 unique Medicaid members received opioid prescriptions with a combined daily MME in excess of 120. This reflects a 27.7% reduction in high-dose utilizers as compared to the period inclusive of January 2021 through June 2021. 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. The greatest impact is the clinical and personal benefit of decreasing medically unnecessary opioid utilization and providing opportunities to move individuals into recovery.

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

Efforts of the Alaska Medicaid Drug Utilization Review Program	Alaska Statewide Opioid Action Plan
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.	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 Medicaid program 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. Ongoing work is underway

with DCCED-CBPL to explore opportunities for enhancing the integration of Prescription Drug Monitoring Program (PDMP) information with the Medicaid program to improve outcomes.

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. 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. Pharmacists continue to play a key role in the administration of COVID-19 and other vaccines. Community-based, non-tribal pharmacies have been reimbursed over $1.2 million for COVID-19 vaccine administration. In a 10-state study, hospitalizations during the period between August 2021 and January 2022 were predominantly in unvaccinated individuals (43%) as compared to those who had received three doses (10%). Extrapolating the protective effects of the COVID-19 vaccines, hospital cost avoidance naturally derives from various preventive measures, including easy access to vaccine services in the community. Non-dispensing pharmacist professional service reimbursement continues into FY 2023 and will continue to evolve with further refinement of scope of practice under Board of Pharmacy authority.

To date, Alaska Medicaid has twelve (12) Pharmacy Professional Groups (PPG) enrolled in eight (8) different Alaska communities and over 290 pharmacists.

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 2022
Case Management	$1,087,563
Care Management Program	$2,340,000

Clinical Case Management

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

Cost savings are achieved through a variety of case management interventions that result in averted, avoided, or decreased cost of services. Interventions include facilitating timely and safe discharge to lower levels of care, implementing home-based services in lieu of hospitalizations or placement in a skilled nursing facility, monitoring home-based treatment plans, educating patients to promote self-care, and coordinating care among the recipient's primary care provider and multiple specialists. Clinical case management services resulted in savings of $1,327,469 in FY 2022 through avoided inpatient acute care stays and other services and yielded a return on investment (ROI) of $8.84 for every $1.00 spent, a 2% 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 35 Alaska Medicaid recipients per month during FY 2022 and yielded a net Medicaid program savings (in the form of avoided costs) of $1.85 million, approximately 30% of which, or $.55 million, was State General Funds. The ROI for this program was $8.45 for every $1.00 spent through avoided inpatient stays and duplication of services.

Care Management Program

Established during the mid-1990s, DOH's 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. DOH also accepts CMP referrals from medical providers.

For recipients who are enrolled in CMP, 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 $7.8 million during FY 2022, approximately 30% of which, or $2.34 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 2023 CMP enrollment is expected to achieve a monthly average of 600 recipients, a 25% increase over FY 2022. It is expected that cost-savings/cost avoidance will also increase 25%.

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.

DOH 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, DOH increased focus on innovative payment model opportunities. Since then, DOH continued work on pharmacy payment reform (see Section II.A.6. Pharmacy Initiatives); and 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 11.A.15, Behavioral Health System Reform and Coordinated Care Demonstration Project respectively for more information on the demonstration projects. With the input of stakeholders, DOH, is moving to implement in FY 2024 a Diagnosis Related Groups (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 and are patient centered, fair to providers, and fiscally responsible. The existing per diem methodology reimburses providers based on the volume of services provided, where as a DRG payment methodology aligns reimbursement with the acuity of the patient and the resources expended by hospitals. Critical Access Hospitals are excluded from considerations for the DRG payment methodology. 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 DOHs' ability to implement performance review and cost-saving measures, including potentially preventable readmissions and hospital acquired conditions.

9) Quality and Cost Effectiveness Targets Stakeholder Involvement

AS 47.05.270(a)(9)

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 DOH for the measures. With the baseline validated a year earlier than expected, DOH was able to calculate first-year performance results in FY 2017, reporting those in the FY 2018 Annual Medicaid Reform Report. The second-year, third-year, and fourth-year performance results subsequently followed. The fifth-year performance results are reported in Section II.B.2 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 generally 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. Published travel guidance offers clarification to providers regarding travel policy and provides guidance for frequently occurring and problematic travel situations. The guidance includes identification of non-covered services and also reinforces other existing requirements, such as combining multiple appointments into a single travel episode when feasible, 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.

During FY 2022, DOH worked to streamline administrative requirements for the non-emergent transportation program while still maintaining state and federal medical justification requirements. This was attained by:

- Implementing the One and Done travel authorization pilot project that allowed a provider to submit a single request for conditions that require recurring travel for treatment and follow-up care, such as dialysis and chemotherapy patients, rather than individual requests for each travel, each month. The pilot project eliminated the need for more than 500 separate travel requests in FY 2022 and additional recurring services are being added to the, now permanent, program each quarter.
- Publishing clear documentation requirements to ensure medical necessity while eliminating repetitive and unnecessary steps in the authorization process.

The Alaska Medicaid transportation program saw a 17.5% increase in State General Fund (GF) from FY 2021 to FY 2022 largely due to an increase in emergent transportation events. DOH believes this was largely due to the COVID-19 public health emergency (PHE) and will not be an ongoing norm in the Medicaid program. In FY 2022, total emergent and non-emergent travel expenditures continue to be significantly lower than years prior to the PHE, with most expenditures being federal funds. Only 11.3%, or $7.7 million, of overall travel costs were State General Fund. Total travel expenditures increased by $14.2 million compared to FY 2021.

Health Care Medicaid Services Travel Expenditures Chart

	FY 2019	FY 2020	FY 2021	FY 2022
State (Unrestricted Designated, Other)	$12,468,545	$10,009,864	$6,553,613	$7,702,505
Federal	$91,244,238	$89,934,732	$47,627,371	$60,631,601
All Transportation	**$103,712,782**	**$99,944,596**	**$54,180,984**	**$68,334,106**

11) Disease Prevention & 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.

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

1) Publicly noticing the Adult Preventive regulations package for Medicaid, which is in final stages of review and expected to be adopted by 2023. These regulations would more extensively cover Affordable Care Act (ACA) mandates including the US Preventative Services Task Force (USPSTF). Grades A and B recommended counseling and screenings is being implemented which will soon be evident in reimbursement of claims.
2) Utilizing the Medicaid Medical Care Advisory Committee (MCAC) to engage with community partners and providers, to develop solid, evidence-based, policy recommendations which make

sense to Alaskans in terms of value. In September 2022, the MCAC made recommendations to DOH to improve telehealth, post-acute care options, behavioral health continuum of care, and podiatry services.

3) Participating in national projects to prevent and manage chronic diseases that will result in healthier Alaskans in the future. The Division of Public Health and the Division of Health Care Services are jointly participating in a *Case for Coverage* project, hosted by the National Association of Chronic Disease Directors in collaboration with the CDC, Division of Diabetes Translation, and the Kem C. Gardner Policy Institute. The goal of the project is to assess the potential impact of the National Diabetes Prevention Program on diabetes prevention and overall incidence of diabetes as it relates to public health and Medicaid expenditures.

12) Behavioral Health System Reform

AS 47.05.270(b) requires DOH 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 DOH 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 Waivers

Section 1115 of the Social Security Act gives the Centers for Medicare and Medicaid Services (CMS) the authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. A Section 1115 Waiver demonstration gives states additional flexibility to (re)design and improve Medicaid services and programs and then evaluate the impact of the new service approaches adopted by the proposed waiver.

The Alaska 1115 Waiver demonstration 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 misuse disorder (SUD) and behavioral health (BH) components of the 1115 Waiver have been implemented creating 23 lines of service under the waiver authority.

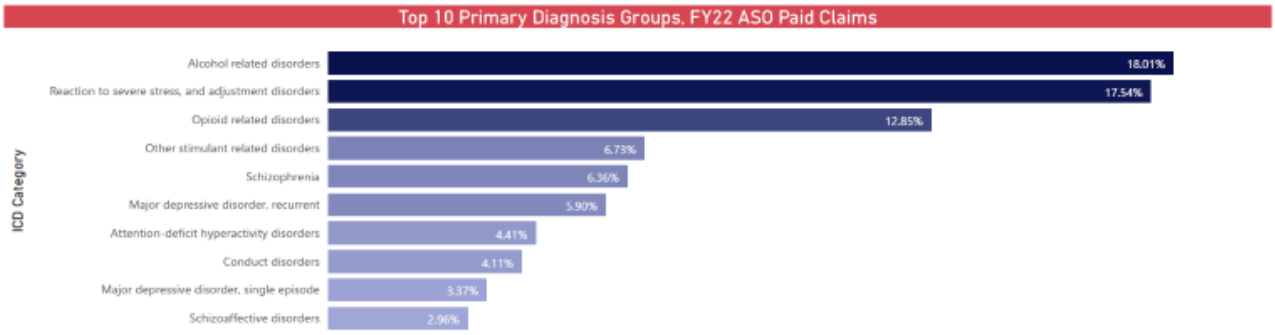
The Division has contracted with an outside evaluator to measure outcomes of the 1115 Waiver, and the initial findings include (it is possible that the ongoing COVID-19 PHE may have contributed to the observed changes):

- Beneficiaries treated in a facility of 16 beds or more (IMD) for SUD increased by over 50%.
- Availability of SUD providers more than doubled.
- ED visits and inpatient stays for SUD declined by 63% and 86%, respectively.
- Readmissions among beneficiaries with an SUD declined by 10%.

Activities that occurred within the Division of Behavioral Health (DBH) between July 1, 2021 and June 30, 2022 to support implementation of the 1115 Waiver and expand capacity for State of Alaska behavioral health include:

- Finalized regulations allowing Licensed Professional Counselors (LPC) to enroll as independent providers effective 08/27/2021.
- Increased Independent provider enrollments by 19 new agencies
    - 5 independent Licensed Clinical Social Workers (LCSW)
    - 13 independent Licensed Professional Counselors
    - 1 independent Psychologist
- Provided trainings, webinars, technical assistance teleconferences and email notices with information related to provider enrollment and billing for services under the 1115 waiver.
- Adopted reporting of telehealth services with place of service 10 – Telehealth Provided in Patient's Home. And adopted use of modifier FQ to report telehealth services furnished using audio only technology.
- Moved monitoring of contraindicated services to a post payment review through a second level appeal process to reduce administrative burden on providers.
- Granted a one-year extension of the credentialing period for Qualified Addiction Professionals (QAP) and/or Peer Support Specialists (PSS) who obtained a provisional QAP or PSS approval in calendar years 2019, 2020, and 2021 to ease provider's transition to new lines of service.
- Enacted an application process for one-year extensions for QAP and/or PSS applicants granted a provisional approval in calendar year 2022.

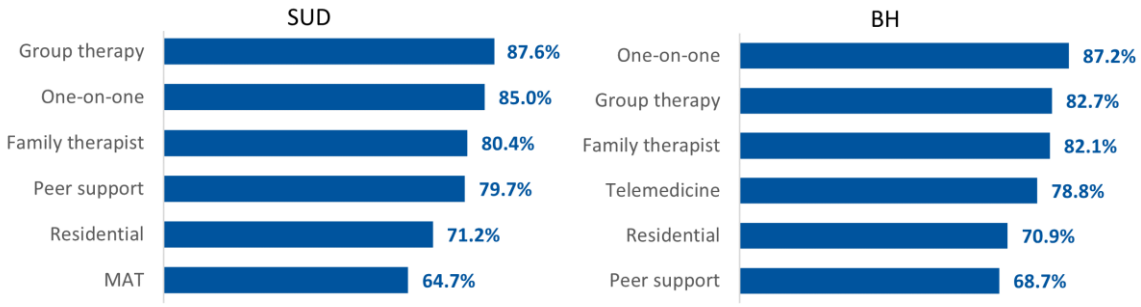
Top 10 ASO Paid Claims by Diagnosis



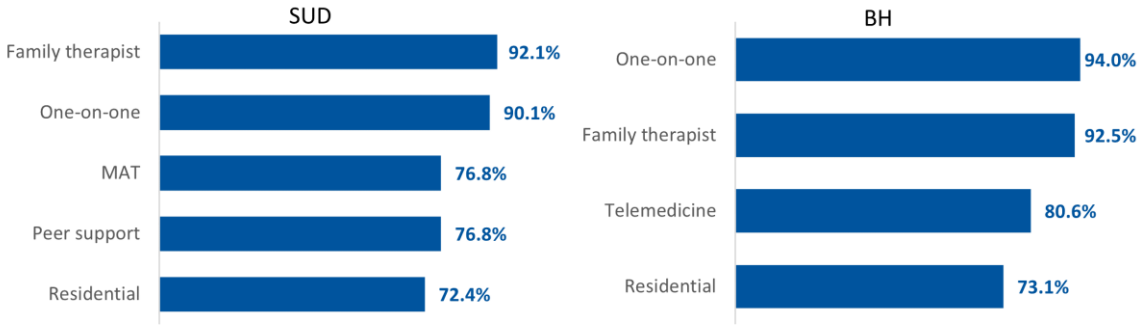
Percentage of Beneficiaries Who Rate the Quality of Their Health Care as Very Good or Excellent

Group	Denominator	Numerator	Rate
Adult	245	170	69.4%
Child	323	251	77.7%

Beneficiary Knowledge of Setting Type—Adults



Beneficiary Knowledge of Setting Type—Children



13) Behavioral Health System Capacity

Services expanded steadily across all three years of waiver implementation, as providers were able to offer new services and expand their capabilities to provide a broader continuum of care throughout the evaluation period, including the addition or expansion of the following:

- American Society of Addiction Medicine (ASAM) Level 1.0, 2.1, 2.5, and 3.1 services
- Broader use of Screening Brief Intervention Referral and Treatment (SBIRT)
- Crisis intervention
- Withdrawal management
- Improved care planning processes
- Case management and intensive case management services
- Counseling and community support services (CCSS)
- Peer support services

- Adult mental health residential
- Community Recovery Support Services (CRSS)
- Support for independent living
- Assertive community treatment-based teams working with Severely Mentally Ill individuals
- The number of beneficiaries who received 1115 services in FY 2022:
- 1115 in general: 12,161
- 1115 SUD specifically: 4,979
- 1115 MH specifically: 8,002

In addition to implementing the 1115 Waiver, DBH contracted with an Administrative Services Organization (ASO) through a competitive bidding process to provide the administrative services necessary to manage Alaska's behavioral health system of care in coordination with the department. In FY 2022 the total dollar amount paid by the ASO for behavioral health Medicaid claims was $251,644,611.93.

14) Emergency Care Improvement

Alaska Emergency Department Information Exchange Project Update

The Emergency Department Coordination Project (EDCP) is a collaborative effort between the Alaska Hospital and Healthcare Association (AHHA) 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 17 Alaska hospitals and 11 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 become onboarded 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 2022

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
St. Elias Specialty Hospital	Live
Wrangell Medical Center	Live
Yukon Kuskokwim Delta Regional Hospital	In Progress

Clinics /Other	Status
Alaska Family Care Associates	In Progress
Alaska Heart and Vascular Institute	Live
Alaska Innovative Medicine	Live
Anchorage Fire Department	Live
Anchorage Neighborhood Health Center	In Progress
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

AS 47.07.039

The purpose of the Coordinated Care Demonstration Project (CCDP) is to assess the efficacy of various health care delivery models with respect to cost, access, and quality of care. Under the statute, DOH is permitted to contract with provider-led entities, Accountable Care Organizations, managed care organizations, primary care case managers, and prepaid ambulatory health plans.

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 reimbursed PFMC by way of a partial capitation rate for the additional IDCT services and the program was voluntary for patients, who were given the option to opt-out of receiving the additional services at any time. The contract term ended September 2022. The state is preparing for a third-party actuarial review as required under AS 47.07.039(e) to assess the success of the demonstration and 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) or a 1915 (b) waiver.

16) Health Information Infrastructure Plan

Section 56 of SB 74 requires DOH 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 System Plan is required to leverage existing resources, such as the statewide health information exchange, to the greatest extent possible.

DOH is actively working with healtheConnect the HIE vendor to develop an annual report for legislators. In addition, DOH contracted with HealthTech Solutions to develop closeout report of the Electronic Health Records (EHR) Incentive Program; an annual update of the State Medicaid Health Information Technology Plan (SMHP) Update, and annual Environment Scan of EHR/HIT across Alaska.

DOH continues to work with CMS to obtain FFP to finance health information exchange systems an infrastructure to meet local, state, and federal needs and requirements.

The funding requests for Federal Fiscal Year 2022 include:

- Health Information Exchange contract with Health Connect and RFP.
- 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) – DOH 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.

B. 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 2021	FY 2022	Increase / Decrease
Utilization Management	$41,777,361	$33,269,865	$($8,504,496)
HMS Third-Party Liability & Audit Recovery	$9,411,108	$8,612,492	$($798,616)
Tribal Health System Partnerships	$0*	$27,118,308.82*	$27,118,308.82
DOC Inpatient Care Cost Avoidance	$4,739,174	$4,151,497.93	$(587,677)
TOTAL	**$33,276,704**	**$73,152,163.75**	**$17,227,519.82**

** Calculated savings reported for Tribal Health System Partnerships is usually reported as 30% of overall increase in expenditures. This percentage would have been paid at 50% 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

DOH 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 2022, these utilization management services yielded gross Medicaid program savings of $33.3 million, approximately 30% of which, or $10 million, was State General Funds, and a return on investment of $18.12 for every $1.00 spent through the avoidance of unnecessary or untimely medical care.

Healthcare Management Systems Third-Party Liability and Audit Recovery

DOH 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 2022, third party liability (TPL) realized $28.7 million in recoveries and savings, and approximately 30% of which $8 million was in State General Funds.

HMS Third-Party Liability & Audit Recovery	FY 2022
Recoveries	$13,429,726.38
HIPP Cost Savings	$2,462,852.00
TPL Cost Savings	$12,815,913.72
Total	**$28,708,492.10**
*30% General Funds	**$8,612,547.63**

Tribal Health System Partnerships

In FY 2022, DOH 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.

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% 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 2021	FY 2022	Increase/Decrease
Tribal Health System Partnership	$ 459,089,150.80	$ 549,483,513.52	$ (90,394,362.74)

Medicaid Payment for Inpatient Care for Incarcerated Individuals

DOH 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 2022 Medicaid paid claims billed in the amount of $7.4 million for inpatient care for Department of Corrections (DOC) inmates. This represents an increase of $2.7 million between FY 2019-2021. In the past, these fees would have been paid by DOC with 100% 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)

DOH can now report fifth-year performance results on achievement of quality and cost-effectiveness targets established by the stakeholder workgroup, as described in Section II.A.9 of this report.

Results of 2021 Fifth-Year Performance on QCE Measures

Measure	Met 2021 Performance Target
A.1 Child and Adolescents' Access to Primary Care Practitioners	**Monitor**
A.2 Ability to Get an Appointment with Provider as Needed	**Monitor**
B.1 Follow-up After Hospitalization for Mental Illness	**Partial**
B.3 Initiation and Engagement of Alcohol and Other Drug Dependent Treatment	**Yes**
CH.1 Emergency Department Utilization	**Yes**
CH.2 Comprehensive Diabetes Care	**No**
CH.3 Hospital Readmission Within 30 days - All Diagnoses	**Monitor**
C.1 Medicaid Spending Per Enrollee	**Partial**
C.2 Number of Hospitalizations for Chronic Obstructive Pulmonary Disease	**Yes**
C.3 Number of Hospitalizations for a Diabetic Condition	**Partial**
C.4 Number of Hospitalizations due to Congestive Heart Failure	**No**
M.1 Live Births Weighing Less Than 2,500 Grams	**On Hold**
M.2 Postpartum Care Rate	**No**
M.3 Percent of Newborns Whose Mothers had Prenatal Care During First Trimester	**No**
P.1 Childhood Immunization Status	**No**
P.2 Average Number of Well-Child Visits by Age	**Partial**
P.3 Developmental Screening in First Three Years of Life	**Yes**

Note: Yes = Met Performance Goal; No = Did Not Meet Performance Goal; ***Partial*** *= Partially Met Performance Goal*

Results of the fifth-year performance measures for services delivered during state fiscal year 2021 demonstrate that the program met or exceeded annual performance targets for four measures, partially met performance targets for four measures, monitored numbers for three measures, are on hold for one measure, and failed to meet targets for the remaining five measures.

There are a variety of factors that could be attributed to not meeting performance measures:

- The COVID-19 public health emergency continued throughout SFY 2021.
- Enrollment increased 2.27% from SFY 2020 to SFY 2021; 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.
- The CMS Quality Measure Reporting System came on in 2022, data and reports are not available for SFY 2021.

3) Recommendations for Legislative or Budgetary Changes

AS 47.05.270(d)(4)

The Department of Health 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, cost efficiencies, and a reduction in administrative activities.

The ability to make changes to Alaska's Medicaid program, particularly changes 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%.

4) Changes in Federal Law that Impact the Budget

AS 47.05.270(d)(5)

In FY 2022, Section 9819 of the American Rescue Plan Act of 2021 (ARP) added section 1923(f)(3)(F) of the Social Security Act, resulting in a requirement for the U.S. Centers for Medicare and Medicaid Services (CMS) to recalculate the FFY 2020 and FFY 2021 Disproportionate Share Hospital (DSH) federal allotments to allow states to make the same amount of Total Computable DSH payments as they would have in the absence of the Families First Coronavirus Response Act (FFCRA) federal medical assistance percentage (FMAP) increase.

The Affordable Care Act for Medicaid expansion established transitional FMAP rates starting at 100% with the implementation of the program in CY2014 and leveling off at 90% in CY2020. Budget estimates used for the development of the FY 2022 budget reflect anticipated 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 Federal Medical Assistance Percentage (FMAP) increase of 6.2% retroactive to January 1, 2020. It also provided an indirect increase of 4.34% in FMAP for the Children's Health Insurance Program (CHIP). Resulting from the enhanced FMAP, DOH received an additional federal

reimbursement of $36 million in FY 2020, $64 million in FY 2021, and an estimated $72 million in FY 2022. The public health emergency and enhanced FMAP is still in place as of this report for FY 2023. The current federal reconciliation package under consideration by Congress makes further projections difficult at this time.

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. The second phase of the system was implemented allowing the vendor to aggregate the data coming in from providers in June 2021. The third phase, implemented in August of 2022, ties 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% of those costs borne by the federal government for system development.

AK Department of Health Federal Medical Assistance Percentage Rates

COVID Enhanced FMAP Effective 01/01/2020 to Last Day of Quarter when National Emergency is Ended

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

Direct Services	FY 2019	FY 2020	FY 2021-23	COVID-19 Pandemic (1/1/20-TBD)	Enhanced FMAP
Title IV-E Maintenance Payments*	50.00%	50.00%	50.00%	6.20%	56.20%

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

Federal Medical Assistance Percentage (FMAP) for the Medicaid Programs

Direct Services	FY 2019	FY 2020	FY 2021-23	COVID-19 Pandemic	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%

**Medicaid FMAP is based on a formula for a federal fiscal year and published annually.*

***1915(k) state plan option is 6% additional federal share over Medicaid FMAP.*

****Medicaid Expansion FMAP is based on a calendar year and shown as SFY average.*

***** CHIP EFMAP is indirectly impacted by COVID enhanced FMAP = 4.34%.*

Administrative Services	FY 2019	FY 2020	FY 2021-23	COVID-19 Pandemic	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%	ENDED 12/31/21	0.00%	0.00%
CHIP admin **	88.00%	76.50%	65.00%	4.34%	69.34%

* CHIP FMAP decreased on 10/01/19 to 76.5% and on 10/01/20 to 65%.

** CHIP EFMAP is indirectly impacted by COVID enhanced FMAP = 4.34%.

5) Applications for Medicaid Grants, Options or Waivers

AS 47.05.270(d)(6)

Waivers

DOH did not apply for any new Medicaid waivers in FY 2022. In late FY 2021, four of Alaska's five waivers were renewed for another five-year waiver cycle beginning July 1, 2021 (FY 2022).

State Plan Options

DOH did not apply for new state plan options in FY 2022.

Grants

DOH did not apply for new Medicaid grants in FY 2022.

COVID Flexibilities

In response to the COVID-19 public health emergency, DOH requested and received approval to waive or modify certain Medicaid requirements.

The department applied and received approval for COVID-19-related flexibilities via the following mechanisms:

- **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. These state-specific waivers are separate and distinct from the section 1135 blanket waivers issued by CMS. This waiver authority temporarily waives or modifies certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements. The waiver of these requirements is intended to support states in their efforts to ensure Medicaid recipients have access to necessary services during a public health emergency. Additionally, 1135 authority ensures reimbursement for services that are delivered in good faith and exempts providers from sanctions resulting from service delivery, absent determinations of fraud or abuse.

- **1915 (c) Appendix K**:
  This mechanism is used to request temporary amendments to 1915(c) waivers during public health emergencies and other disaster declarations. As with 1135 waiver authority, Appendix K amendments provide states with the flexibility necessary to ensure Medicaid recipients receive necessary services.

- **Disaster relief state plan amendment:**
  Disaster relief state plan amendments (dSPAs) are time limited submissions serving to waive or revise existing Medicaid state plan requirements. In response to a public health emergency or

disaster, states may wish to revise policies in their Medicaid state plan related to eligibility, enrollment, benefits, premiums and cost sharing, and/or payments via a dSPA.

In the FY 2021, Medicaid Reform Report the Department of Health provided a comprehensive chart containing the COVID-19 PHE flexibilities which remain in effect until the end of the PHE.

6) Demonstration Project Results

AS 47.05.270(d)(7)

DOH continues to implement two demonstration projects under SB 74:

1115 Waivers

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 of this report for information about this project.

The Coordinated Care Demonstration Project (CCDP)

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

7) Telehealth Improvements, Barriers, 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.
- 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.
- Federally Qualified Health Centers (FQHC) medical and behavioral health services provided via telehealth.
- Alternate methods of service delivery for behavioral health services such as text and audio only visits.
- Increased participation in substance use disorder treatment services in remote areas of the state.
- Improved ability to engage in preventive behavioral health services.

- Removing barriers to access to care such as finding childcare and transportation.
- Allowing members to participate in services with a level of community anonymity in rural settings that is not possible in a traditional 'waiting room' experience.

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. Telehealth flexibilities for outpatient dialysis, end-stage renal disease, direct entry midwife, and vision services expired November 1, 2021 but are being evaluated for potential incorporation in future telehealth program changes. CMS is considering making some of these new flexibilities permanent and the Department of Health and Human Services Office of Civil Rights has expanded HIPAA privacy and security rules to incorporate telehealth modalities. DOH 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 were typically completed in-person in an applicant's home. Due to increases in the number of applicants from rural Alaska and a reduction in the travel budget for assessors, the DSDS has been integrating telehealth assessments into the assessment workflow for the past few years.

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

A telehealth medical care advisory committee (MCAC) with a focus on 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. DOH anticipates a future MCAC for the adult population.

Additionally, the Department of Health is working to implement increased telehealth access through House Bill 265 which was passed during the 2022 legislative session, signed into law on July 13, 2022, and designed in-part to ensure regulatory support for continued, expanded telehealth modalities at the end of the current public health emergency. It is also important to note that the Medicaid Program can only authorize a service for telehealth that aligns with the statutory authority and regulatory oversight of the professional licensing boards within the Department of Commerce, Community, and Economic Development.

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)

The Alaska Medicaid transportation program saw a 17.5% increase in State General Fund (GF) from FY 2021 to FY 2022 largely due to an increase in emergent transportation events related to the COVID-19 public health emergency (PHE). In FY 2022, total emergent and non-emergent travel expenditures continue to be significantly lower than years prior to the PHE, with most expenditures being federal funds. Only 11.3%, or $7.7 million, of overall travel costs were State General Fund. Total travel expenditures increased by $14.2 million compared to 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 2022. 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 2021 and is a contributing factor to the reduced quantity of ER frequent utilizers. In January 2021 DOH adopted the Care Management Program regulation changes, with 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 DHCS continues to use these regulations to further reduce frequent emergency room utilizers.

Number of Medicaid Recipients Identified as Frequent Emergency Department Users

FY 2021	FY 2022	Percent Change
3,302	3,984	+17%

FY 2022 Top Diagnoses at ED Visit of Medicaid Recipients Identified as Frequent ED Users

Diagnosis	Number of Claims
Unclassified (e.g., fever, chest pain)	6,507
Behavioral Health Condition	5,501
Injury	3,815
Respiratory System Disease	2,679
Digestive Disease	1,796
Musculoskeletal System	1,606

10) Hospital Readmissions

AS 47.05.270(d)(11)

Readmission data was collected using J-SURS 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-day—to—thirty-day period following a hospital stay to omit hospital-to-hospital transfers that are captured as one-day readmissions.

Of the 1,397 recipients with readmission in FY 2022, which resulted in an increase of 52 had a hospitalization and subsequent readmission in FY 2021.

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

FY 2021	FY 2022	Percent Change
1,347	1,397	+4%

FY 2022 Top ICD-10 Diagnoses Classifications for Hospital Readmissions of all Medicaid Recipients

Diagnosis	Number of Claims
Behavioral Health Condition	384
Digestive System Diseases	205
Certain Infectious and Parasitic Diseases	198
Circulatory System Diseases	190
Injury	156
Respiratory Disease	148
Pregnancy, Childbirth, Puerperium and Perinatal	140

11) State General Fund Spending per Recipient

AS 47.05.270(d)(12)

State General Fund spending for the average medical assistance recipient increased by 5.07% in FY 2022 compared to FY 2021. In FY 2021 the State General Fund spending averaged $2,743 per recipient and in FY 2022 it averaged $2,882. In FY 2021 there were 201,419 recipients and State General Fund spending was $552.4 million, and in FY 2022 there were 211,286 recipients and State General Fund spending was $608.9 million.

Average State General Fund Spending per Medicaid Recipient

	FY 2021	FY 2022	Percent Change
Recipients	$201,419	$211,286	4.90%
General Fund Spend	$552,478,033	$608,925,407	10.22%
Spend Per Recipient	$2,743	$2,882	5.07%

12) Uncompensated Care Costs

AS 47.05.270(d)(13)

Alaska Hospital Uncompensated Care

The following are the 2012 – 2020 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: 2020 includes data from 7/1/2020- 6/30/21 for those on state fiscal year and 10/1/20 – 8/30/21 for those on federal fiscal year.

	Uncompensated Care	% Change from previous year
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	$52,493,032	0.9%
2020	$51,514,421	-1.9%

% Change since Medicaid expansion (2014 to 2020) -54.4%.

Health Insurance Premiums

The following information is provided by the Alaska Division of Insurance regarding the change in health insurance premiums from CY 2014 – CY 2021.

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%
Small Group Market	179,110	$154,819,740	$864.38	-1.00%
CY 2021				
Individual Market	238,522	$166,975,182	$700.04	-4.40%
Small Group Market	167,561	$146,665,904	$875.30	1.13%

13) Optional Services

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, most of the "optional" services are mandatory for 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% of State General Fund expenditures for optional services), (2) personal care services (~23% of State General Fund expenditures for optional services), and (3) behavioral health services (~22% 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 prevents the increased use of costly institutional placement (e.g., hospital, nursing homes, or correctional facilities), which 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 directly replace the need for more expensive mandatory services or reduce the need for additional mandatory services by improving health status. Eliminating these services would not significantly reduce the overall Medicaid budget.

FY 2022 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 2022	STATE SPENDING	FEDERAL SPENDING	TOTAL SPENDING
WAIVER			
1115 WAIVER MH	$28,594,861	$63,424,489	$92,019,350
1115 WAIVER SUD	$8,543,745	$56,578,428	$65,122,173
ADULT DAY CARE	$1,349,919	$3,709,739	$5,059,658
CARE COORDINATION	$5,717,689	$9,213,758	$14,931,446
CHORE SERVICES	$331,260	$556,055	$887,314
DAY HABILITATION	$12,345,905	$18,785,783	$31,131,687
ENVIRONMENTAL MODIFICATIONS	$62,407	$84,055	$146,463
INTENSIVE ACTIVE TREATMENT/THERAPY	$264,264	$403,147	$667,411
MEALS	$940,137	$1,426,808	$2,366,945
RESIDENTIAL HABILITATION	$57,293,417	$91,922,971	$149,216,388
RESIDENTIAL SUPPORTED LIVING	$23,227,327	$36,340,726	$59,568,053
RESPITE CARE	$4,923,777	$7,425,135	$12,348,913
SPECIALIZED EQUIPMENT AND SUPPLIES	$46,480	$85,510	$131,990
SPECIALIZED PRIVATE DUTY NURSING	$301,051	$457,678	$758,728
SUPPORTED EMPLOYMENT	$2,531,892	$3,747,009	$6,278,901
TRANSPORTATION	$525,720	$946,522	$1,472,243
TOTAL WAIVER SERVICES	**$146,999,850**	**$295,107,814**	**$442,107,664**
OPTIONAL			
CASE MANAGEMENT SERVICES	$0	$79,044	$79,044
CHIROPRACTIC SERVICES	$21,755	$30,512	$52,267
DENTAL SERVICES.	$7,567,730	$29,979,845	$37,547,575
DRUG ABUSE CENTER	$1,321,739	$10,879,466	$12,201,205
DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES	$2,282,832	$4,975,569	$7,258,402
END STAGE RENAL DISEASE SERVICES	$1,178,250	$1,627,222	$2,805,472
HEARING SERVICES	$1,092,140	$2,407,317	$3,499,457
HOSPICE CARE	$766,162	$1,333,653	$2,099,815
INPATIENT PSYCH SERVICE	$106,173	$203,844	$310,017
INTENSIVE CARE FACILITY/INTELLECTUALLY DISABLED SERVICE	$570,340	$780,258	$1,350,598
MEDICAL SUPPLIES SERVICE	$3,026,273	$5,618,914	$8,645,187
MENTAL HEALTH SERVICE	$6,444,822	$43,180,106	$49,624,928
NUTRITION SERVICES	$2,276	$3,226	$5,502
OCCUPATIONAL THERAPY	$197,725	$539,990	$737,714
PERSONAL CARE SERVICES	$14,308,406	$22,981,414	$37,289,820
PODIATRY	$45,786	$71,749	$117,535
PRESCRIBED DRUGS	$35,899,825	$146,962,251	$182,862,077
PROSTHETICS & ORTHOTICS	$446,288	$1,162,869	$1,609,158
PSYCHOLOGY SERVICES	$219,749	$604,798	$824,547
REHABILITATIVE SERVICES	$2,148,440	$6,220,409	$8,368,850
VISION SERVICES	$1,899,758	$4,609,186	$6,508,944
TOTAL OPTIONAL SERVICES	**$79,546,469**	**$284,251,644**	**$363,798,112**
GRAND TOTAL	**$226,546,319**	**$579,359,457**	**$805,905,776**

Source: Data is for claims with a paid date within the SFY 2022 (07/01/2021 - 06/30/2022). The source for claims processed by Behavioral Health's ASO are the Optum Alaska Reconciliation Detail Reports. All other claims were extracted from MMIS/COGNOS. Medicaid providers are allowed to submit claims up to one year after the date of service.

Note: Waiver Services are the Adult Waiver Services and the Child Waiver Services combined. Optional Services are only Adults Optional services.

14) Tribal Medicaid Reimbursement Policy Savings

AS 47.05.270(d)(15)

On February 26, 2016, Centers for Medicare/Medicaid Services (CMS) released State Health Official (SHO) letter #16-002 updating its policy regarding circumstances in which 100% 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 7,029 CCAs in place between 18 THOs and 537 non-tribal providers. Note that some, but not all, of the THOs have signed an agreement with each of the 537 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% federal funding. DHCS has requested and verified 168,659 referrals since the new policy was implemented; 34,238 or 20% were sufficiently documented. DOH continues to partner with the THOs to identify ways to increase the percentage of verified referrals. In FY 2022, the number of verified referrals showed an increase of 35% compared to the previous fiscal year.

Fiscal Year	Total # of Referrals Requested	Total # of Verified Referrals	Total # of Unverified Referrals	Average Percentage of Verified Referrals	Average Percentage of Unverified
FY 2017	4,142	1,090	3,052	26%	74%
FY 2018	16,337	3,475	12,872	21%	79%
FY 2019	26,652	5,896	20,773	22%	78%
FY 2020	37,372	6,317	31,055	17%	83%
FY 2021	38,698	7,425	31,273	19%	81%
FY 2022	45,458	10,035	35,423	22%	78%
Totals	**168,659**	**34,238**	**134,448**	**20%**	**80%**

Based on the efforts described above, DOH has been able to save approximately $375.9 million in State General Funds from the February 2016 date of the SHO letter through the end of FY 2022. 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.

Fiscal Year	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
FY 2022	$16,302,909.95	$58,109,421.89	$74,412,331.84
Totals	**$121,249,118.74**	**$258,365,353.52**	**$379,614,472.26**