THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health

FINANCE AND MANAGEMENT SERVICES
Juneau Office

P.O. Box 110650
Juneau, Alaska 99811-0650
Main: 907.465.3082
Fax: 907.465.2499

February 20, 2025

The Honorable Andy Josephson
House HSS Finance Subcommittee Chair
Alaska State Capitol, Room 505
Juneau, AK 99801

Dear Representative Josephson:

The Department of Health received the following questions during the Medicaid budget presentation to the House Health and Social Services Finance Subcommittee on February 11, 2025:

What are public assistance programs that have work requirements?

The Alaska Temporary Assistance Program (ATAP) and Alaska's Supplemental Nutrition Assistance Program (SNAP) are subject to federal work requirements established in federal regulations at 45 CFR 261 and in federal statute by the Food and Nutrition Act of 2008, respectively.

What is the best way for a provider to learn about Medicaid rates and participate in public comment and learn about the timelines for rate increases?

Medicaid reimbursement rates vary by provider type and are set and updated through different processes. Providers can access Medicaid rates on the Department of Health website, receive updates through remittance advice notices, and participate in public comment during the regulatory process, which includes designated timeframes for feedback on rate changes.

Rate Types
Providers are reimbursed through different payment models depending on the service type:

- Per Diem/Per Day Rate: A fixed daily payment per provider, per person, to cover care services (e.g., certain Home and Community Based Waiver services, for select inpatient hospitals, long-term care services).

- Encounter Rate: A single payment made per patient visit, regardless of the number of services provided (e.g., Tribal All-Inclusive Rate, Federally Qualified Health Centers).
- Fee-for-Service Rate: A payment made for each individual service rendered to a Medicaid recipient.
- Percent of Charges: Reimbursement based on a percentage of a facility's charges for specific service types and occurrences (e.g., hospital outpatient).
- Diagnosis-Related Group Rates: A fixed rate based on a patient's diagnosis and severity of their condition (e.g., select inpatient hospitals).

Rate Adjustments

Medicaid rates are reviewed and adjusted through the following mechanisms:

- Inflation: Some rates are adjusted annually for inflation, using national sources and in compliance with state regulations and the relevant Medicaid State Plan Amendment (SPA). Inflationary adjustments are made either based the provider's specific fiscal year (calendar fiscal year, state fiscal, or federal fiscal year) or the rate fiscal period.
- Rebasing: Some rates are periodically recalculated using updated cost data to ensure they reflect current costs. This process and timeline are guided by state regulations and SPA, can vary by provider type, and is managed by different divisions.
    - Hospitals, nursing facilities, and Federally Qualified Health Centers (Office of Rate Review)
    - Home and Community-Based Wavier Services and Personal Care Services (Division of Senior and Disabilities Services)
    - 1115 Medicaid Waiver Services and Behavioral Health Services (Division of Behavioral Health)
- Legislative Adjustments: Rate changes can be set or adjusted during the legislative process, either by a fixed dollar amount or percentage (e.g., recent increases for Home and Community Based Services and Autism rates). Legislative rate adjustments are required to go through the regulatory process.
- Federal: Some rates are set or adjusted by federal requirements, including:
    - Tribal All-Inclusive Rates for Indian Health Service (IHS) services are updated annually, established by the Centers for Medicare and Medicaid based on cost data submitted by IHS and Tribal health programs, and published in the Federal Register.
    - Physician Services (Resource Based Relative Value Scale – RBRVS) are updated annually on a state fiscal year basis, calculated by states according to federal and state guidelines.

Finding Published Rates

Medicaid rates are published and updated regularly by different divisions. Providers can access fee schedules online:

- Division of Health Care Services rates are published here:
  - https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Sites/FeeSchedule.html
- Division of Senior and Disabilities Services rates are published here:
  - https://health.alaska.gov/dsds/Documents/pdfs/CPC-Services-CFC-Services.pdf
  - https://health.alaska.gov/dsds/Documents/pdfs/Chart-of-Waiver-Services-Rates.pdf
  - https://health.alaska.gov/dsds/Documents/pdfs/CLS-STCM-Rates.pdf
  - https://health.alaska.gov/dsds/Documents/pdfs/FY23--RateChartSME.pdf
- Division of Behavioral Health rates are published here:
  - https://health.alaska.gov/dbh/Documents/Medicaid%20Related/Chart-1115-MedicaidWaiverServices_3.26.23.pdf
- Office of Rate Review rates are published here:
  - https://health.alaska.gov/Commissioner/Pages/RateReview/Rate-Setting.aspx

Commenting on Rates:

- Any changes to rate methodologies are subject to the regulatory process, including public notice, in accordance with the Administrative Procedure Act, AS 44.62, which allows for specific timeframes for the public to make verbal and written comments.
- Updated fee schedules are published in remittance advice notices to providers and posted on the websites for each division.
- Providers with cost-based rates receive direct communication at the conclusion of the rebasing process, outlining timelines for feedback and appeals.

Could we get information about the increase for state match for Medicaid for FY2015-FY2024? It is hard to see in the chart.

The information below is from the Alaska Budget System, based on spending from the Medicaid Services appropriation. Medicaid spending from all fund sources has increased from $1.6 billion in FY2015 to $2.8 billion in FY2024. Non-federal spending is primarily unrestricted general funds, but also typically includes a few million dollars from other fund sources such as statutory designated program receipts, interagency receipts, Mental Health Trust Authority Authorized Receipts (MHTAAR), and tobacco use education and cessation funds.

Medicaid Services Spending FY2015-FY2024 In thousands			
	Federal	Non-Federal	Total
FY2015	900,704.4	681,064.0	1,581,768.4
FY2016	1,089,381.9	644,289.8	1,733,671.7
FY2017	1,418,917.9	658,038.3	2,076,956.2
FY2018	1,440,492.9	646,310.9	2,086,803.8
FY2019	1,640,345.6	679,840.0	2,320,185.6
FY2020	1,652,705.8	596,432.7	2,249,138.5
FY2021	1,617,446.4	559,565.6	2,177,012.0
FY2022	1,870,817.9	612,253.7	2,483,071.6
FY2023	2,084,517.1	614,227.9	2,698,745.0
FY2024	2,058,648.1	716,721.7	2,775,369.8

What is the timeframe for paying Medicaid claims?

The Alaska Medicaid Management Information System (MMIS) processes over 8.5 million claims annually. Most (94 percent) clean claims submitted to the MMIS are adjudicated (i.e., paid or denied) automatically, without the need for manual intervention.

The Code of Federal Regulations (42 CFR 447.45(d)) requires states to process claims within the following timeframes:

- 90 percent of all clean claims must be paid within 30 days of the date of receipt.
- 99 percent of all clean claims must be paid within 90 days of the date of receipt.
- 100 percent of all clean claims must be paid within 12 months of the date of receipt.

The Division of Health Care Services has established additional, more stringent requirements for vendor processing of clean claims that suspend for review.

- Claims that are pended for a manual review because they have attachments forthcoming or require handling are processed within 15 days.
- Claims that require review of medical records prior to adjudication are processed within 90 days.

Paper claims are entered into the system by a state vendor and are processed when all required documentation is received. Incomplete claims are returned to the provider for additional information.

Adjudicated claims are paid weekly.

Suspended or denied claims are noticed to the provider within their Remittance Advice that accompanies every check write or through a transaction called an "835" for their awareness and potential follow-up actions. Billers are encouraged to closely monitor those notices, as the provider is responsible for responding to notices of suspense or denial.

There are many published trainings on the Alaska Medicaid Health Enterprise website available to assist providers (https://www.medicaidalaska.com/).

The Division of Health Care Services monitors and tracks issues daily and continuously meets or exceeds the federal timelines and meets the more stringent requirements established with its vendors 95.6 percent of the time (as of January 28, 2025).

Please provide information about claims where Medicaid is the primary payer versus the secondary payer.

Medicaid is the payer of last resort, i.e., when a Medicaid recipient has other insurance in addition to Medicaid, the Medicaid claim cannot be paid until the other insurance has paid (with limited exceptions).

The recipient's provider must first bill the recipient's other insurance, and then may submit a Medicaid claim, along with the Explanation of Benefits (EOB) from the other insurance. Some exceptions are made, such as when Medicare is the other insurance, the Medicare claim is automatically transmitted to Medicaid, once Medicare has paid.

Provider instructions are found in the Alaska Medicaid Provider Billing Manuals, e.g., Institutional Claims Management, page 10, Third Party Liability. https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Manuals/Professional_Claims_Management.pdf

Medicaid recipients are made aware of the requirement to report other insurance, both by the Division of Public Assistance at the time of enrollment/reenrollment and via the Medicaid Recipient Handbook, page 3, Other Medical Insurance/Health Coverage. https://health.alaska.gov/dhcs/Documents/PDF/Recipient-Handbook.pdf

The Division of Health Care Services is working on updates that would allow providers to enter the EOB directly into the claim and remove the need for an EOB indicator with attached supportive documentation, which seems to be the issue for some clearinghouses and electronic health record vendors. Health Care Services has a target date of April 30, 2025, to make these changes and issue guidance.

If you have additional questions, please contact me at (907) 465-1630.

Sincerely,

Pam Halloran
Assistant Commissioner

cc: Valerie Rose, Fiscal Analyst, Legislative Finance
Jordan Shilling, Director, Governor's Legislative Office
Tim Hess, Office of Management and Budget
Heidi Hedberg, Commissioner
Robert Lawrence, Chief Medical Officer
Emily Ricci, Deputy Commissioner
Tracy Dompeling, Director of Division of Behavioral Health
Lynne Keilman-Cruz, Acting Director of Division of Health Care Services
Deb Etheridge, Director of Division of Public Assistance
Tony Newman, Director of Division of Senior and Disabilities Services
Raquel Solomon-Gross, Deputy Director of Finance and Management Services
Dustin Scown, Budget Manager
Courtney Enright, Legislative Liaison

Log 13085/2025