ALASKA DEPARTMENT OF HEALTH

ANNUAL MEDICAID REFORM REPORT FY2024

Created in compliance with AS 47.05.270 on November 15, 2024

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

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I. EXECUTIVE SUMMARY

A. Key Accomplishments and Financial Impact

In the **2024 Annual Medicaid Reform Report,** the Department of Health (the Department) presents an analysis of the Alaska Medicaid Program's activities and outcomes, showcasing key reforms, cost savings, and programmatic changes. Building on the success and lessons from Fiscal Year 2023 (FY23), this report highlights Alaska's continued efforts to refine Medicaid program operations, reduce overall costs, and improve health outcomes for beneficiaries. A comprehensive comparison with the previous year's performance underscores the evolving nature of reforms and emerging trends.

1. Overall Program Cost Savings and Financial Improvements:

- **Cost Savings:** In FY24, Alaska Medicaid achieved an estimated $259M in state General Fund (GF) savings and cost avoidance, following an upward trend of cost savings over the past three years, which is detailed in the table "Alaska's Annual GF Cost Savings: FY22 - FY24".

2. Home and Community-Based Services:

- Expansion and Efficiency: Home and Community-Based Services (HCBS) waivers supported 5,448 recipients at a total cost of $388M, compared to $328M in FY23, representing an 18% increase. Without these waivers, the cost for institutional placements would have exceeded $1.16B. Increased utilization of HCBS means fewer individuals served in nursing home and other institutional care settings.
- Impact of Federal Funding Changes: The increased HCBS costs were primarily due to the reduced federal matching funds post-pandemic and a 7.9% rate increase for service providers—see Federal Medical Assistance Percentage (FMAP) details in the tables "FMAP Rates for the Medicaid Programs" and "Step Down of FMAP: Alaska's Annual FMAP Spend Compared to Stepping Down Rates". Despite these challenges, the shift to community-based services continued to yield significant cost savings compared to institutional care.

3. Telehealth Expansion and Utilization:

- Telehealth Cost Trends: Medicaid paid $71.8M in reimbursements to providers of medical and behavioral health services, down from just over $75M in FY23. This follows a similar decrease in reimbursements between FY23 and FY22, though marks a flattening of the substantial drop between FY22 and FY21, signaling stabilization in post pandemic service utilization.
- Telehealth Growth: The continued use of telehealth for behavioral and mental health services accounted for 44% of all telehealth services, indicating sustained demand for remote care options. Telehealth remains a key strategy for improving healthcare access, especially in rural areas. Further investment in telehealth infrastructure could reduce transportation costs and enhance healthcare delivery.

4. Pharmacy Program Initiatives:

- Pharmacy Cost Trends: The pharmacy program expenditures decreased by 4.7% from $249M in FY23 to $237.5M in FY24. This is primarily attributed to a decrease in per utilizer per month spend offsetting the rising cost of specialty drugs.
- Supplemental Rebates and Cost Containment: The Pharmacy and Therapeutics (P&T) Committee's management of the Preferred Drug List (PDL) resulted in $25M in supplemental rebates. Utilization management efforts, including opioid reduction strategies, led to $32M in cost avoidance.
- Opioid Reduction: The number of recipients receiving opioids decreased by 15.2% and over all opioid claim counts decreased 16.5% compared to FY23. This reduction reflects the end of flexibilities tied to the COVID-19 Public Health Emergency (PHE) which temporarily suspended prospective drug utilization edits on claims reflecting high opioid utilization. The return of these edits and the accompanying program oversight was directly tied to a decrease in high dose prescribing behaviors.

5. Behavioral Health Reforms and Waiver Extensions:

- 1115 Behavioral Health Reform Demonstration Waiver Extension: CMS approved Alaska's 1115 Behavioral Health Reform demonstration waiver through December 2028, providing continued flexibility to test new approaches to strengthen the behavioral health system. Subsequent discovery sessions prioritized Medicaid waivers that expand crisis services and improve youth access to behavioral health supports. In FY24, the waiver supported 6,695 recipients for Substance Use Disorder (SUD) services and 10,100 for behavioral health services, indicating an expanded reach and impact compared to FY23.
- Planning for Certified Community Behavioral Health Centers: Alaska has applied for a one-year planning grant to establish Certified Community Behavioral Health Centers (CCBHCs) as an eligible facility provider type within the Alaska Medicaid program. Grant activities would include establishing a state certification process and determining a Prospective Payment System (PPS) rate. These grant activities would support long-term program sustainability of existing SAMHSA grant-funded CCBHC providers and provide the Alaska Medicaid program with additional opportunities to expand comprehensive behavioral health service capacity .

6. Enhanced Payment Methodologies:

- Diagnosis-Related Group Payment Implementation: The transition to a Diagnosis-Related Group (DRG) based payment model for inpatient hospital services was completed on January 1, 2024, aligning reimbursement with patient acuity and promoting value-based care. This reform is expected to generate long-term cost savings and improve patient outcomes, replacing the previous per diem payment model.

7. Tribal Health System Partnerships:

- Alaska's partnerships with Tribal Health Organizations (THOs) resulted in almost $18M in GF savings during FY24 due to the continued expansion of services in rural areas that are mostly provided by THOs through their Community Health Aide Program, including dental health aides and behavioral health aides.

8. Reduction in Non-Emergency Transportation Costs:

- While overall transportation expenditures increased by 19.4% in FY24 compared to FY23, the adoption of telehealth services mitigated some of these costs by reducing the need for travel in certain cases. Future investments in local service options and telehealth are expected to stabilize or decrease transportation costs over time.

The **2024 Annual Medicaid Reform Report** illustrates Alaska's commitment to continuous improvement and innovation in Medicaid service delivery. By building on FY23 reforms, the state has successfully implemented cost-saving initiatives and strengthened access to care.

B. Fund Savings and Cost Avoidance Overview

This report identifies almost $260M in GF savings and cost avoidance that were achieved in FY24. 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 GF savings and avoided costs resulting from Medicaid reforms and cost-containment Initiatives identified throughout the report:

Alaska's Annual GF Cost Savings: FY22 – FY24

Program	FY22 GF Cost Savings	FY23 GF Cost Savings	FY24 GF Cost Savings	3-Year GF Costs Savings
Federal Tribal Reimbursement Policy	$57,500,000	$125,000,000	$139,000,000	$321,500,000
Medicaid Payment for Inpatient Care for Incarcerated Individuals (Out-of-Corrections Hospital Services)	$7,400,000	$8,500,000	$9,300,000	$25,200,000
Pharmacy Preferred Drug List	$11,200,000	$28,600,000	$26,900,000	$66,700,000
Pharmacy Prospective Drug Utilization Reviews	$9,400,000	$17,300,000	$32,000,000	$58,700,000
Home & Community-Based Services Utilization Control and Process Improvement	$5,000,000	$5,800,000	$11,700,000	$22,500,000
Surveillance & Utilization Review Subsystem (SURS) Overpayment Collections	$76,000	$40,000	$125,000	$241,000
Medicaid Program Integrity Overpayment Collected from Providers	$5,900,000	$2,800,000	$3,700,000	$12,400,000
Medicaid Program Integrity Cost Avoidance	$2,800,000	$194,000	$0	$2,994,000
Third-Party Liability Contract and Health Care Management Systems (HMS) Audit Recovery	$9,400,000	$17,200,000	$16,100,000	$42,700,000
Alaska Medicaid Coordinated Care Initiative (Primary Care Case Management)	$1,450,000	$1,700,000	$0	$3,150,000
Clinical Case Management	$1,450,000	$1,000,000	$136,000	$2,586,000
Care Management Program	$2,700,000	$3,400,000	$5,000,000	$11,100,000
Utilization Management Services	$42,000,000	$24,200,000	$15,300,000	$81,500,000
TOTAL	**$156,276,000**	**$235,734,000**	**$259,261,000**	**$651,271,000**

This table shows the traditional federal match for the Medicaid program over time and indicates a 0.01% formula increase for some programs in FY24.

FMAP Rates for the Medicaid Programs: FY19 – FY24

Direct Services	FY19	FY20	FY21-FY23	FY24
Regular Medicaid *	50.00%	50.00%	50.00%	50.01%
Indian Health Services (IHS)	100.00%	100.00%	100.00%	100.00%
Breast & Cervical Cancer (BCC)	65.00%	65.00%	65.00%	65.01%
Family Planning	90.00%	90.00%	90.00%	90.00%
1915(K) Community First Choice **	56.00%	56.00%	56.00%	56.01%
Medicaid Expansion ***	93.50%	91.50%	90.00%	90.00%
Expansion Indian Health Services	100.00%	100.00%	100.00%	100.00%
Children's Health Insurance Plan (CHIP) ****	88.00%	76.50%	65.00%	65.01%

* Medicaid FMAP is based on a formula for a federal FY 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 FY average.
**** The CHIP program applies Enhanced FMAP to both services and admin.

Resulting from the PHE, in calendar year 2020 (CY20) the federal government authorized a temporary increase of FMAP up to 6.2% to be applied toward a state's regular and enhanced FMAP rates on major categories of medical claims payments. This resulted in an increase of federal spending and a decrease in GF spending on associated claims. With the ending of the pandemic, the temporarily increased FMAP was stepped down incrementally across three quarters from 6.2% to 0%, which shifted the burden of associated cost back to GF. This decreased federal contribution will be a theme throughout the year-over-year comparisons throughout the report.

The below table shows the specific impacts of the step down in rates, with federal spending almost reaching $248M over the span of the PHE. These rates were applied to Medicaid and CHIP services as well as CHIP Admin costs. The $10M of FY24 FMAP demonstrates a partial federal contribution, as the step down to 0% became effective January 2024. FY25 will not post any temporary COVID spending.

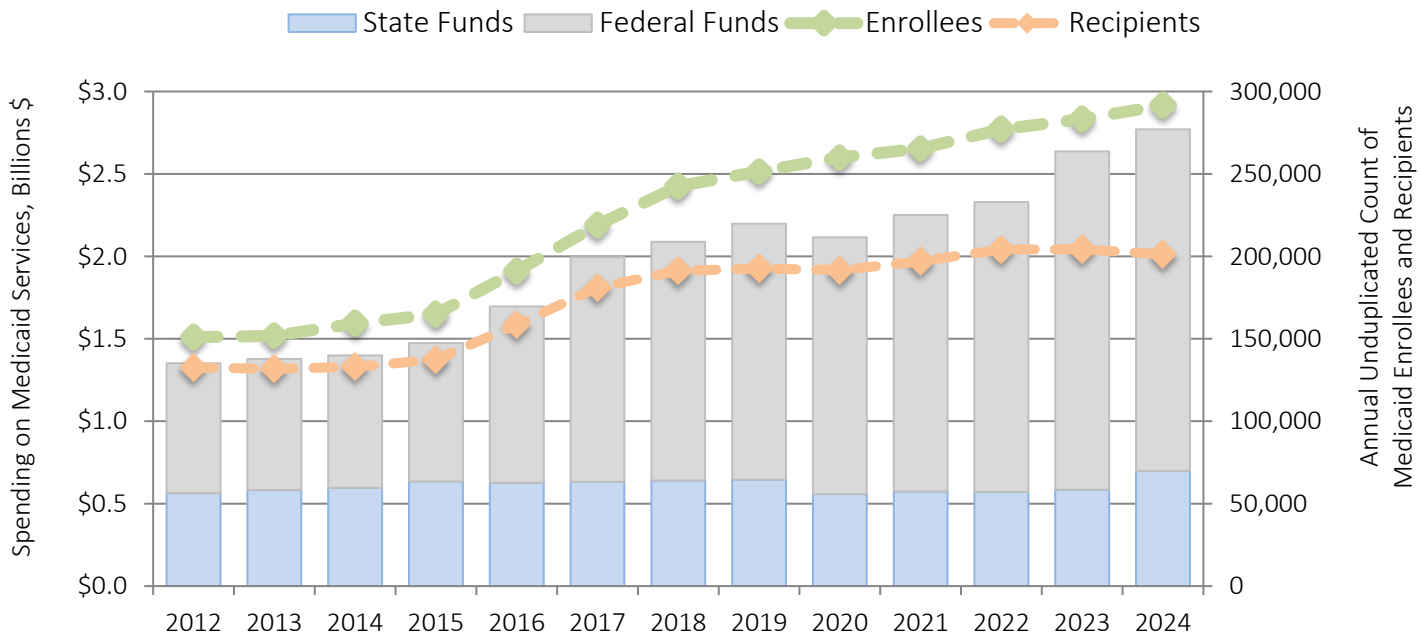
FMAP Step Down: Alaska's Annual FMAP Spend Compared to FMAP Rates Stepping Down Over Time

FY	TOTAL Temporary COVID FMAP Spend	Temporary COVID Regular FMAP Rate	Temporary COVID Enhanced FMAP Rate	Alaska's Regular FMAP Rate	Alaska's Enhanced FMAP Rate
FY20	$34M	6.2%	4.34%	50%	76.50%
FY21	$65M	6.2%	4.34%	50%	65%
FY22	$71M	6.2%	4.34%	50%	65%
FY23	$67M	6.2% → 5%	4.34% → 3.5%	50%	65%
FY24	$10M	2.5% → **0%**	1.75% → **0%**	50.01%	65.01%
	$248M				

The two following visualizations are preliminary figures that will undergo revision over the next few months before they are published in the next Medicaid Enrollment and Spending in Alaska (MESA Report) update (generally published in late January or early February).

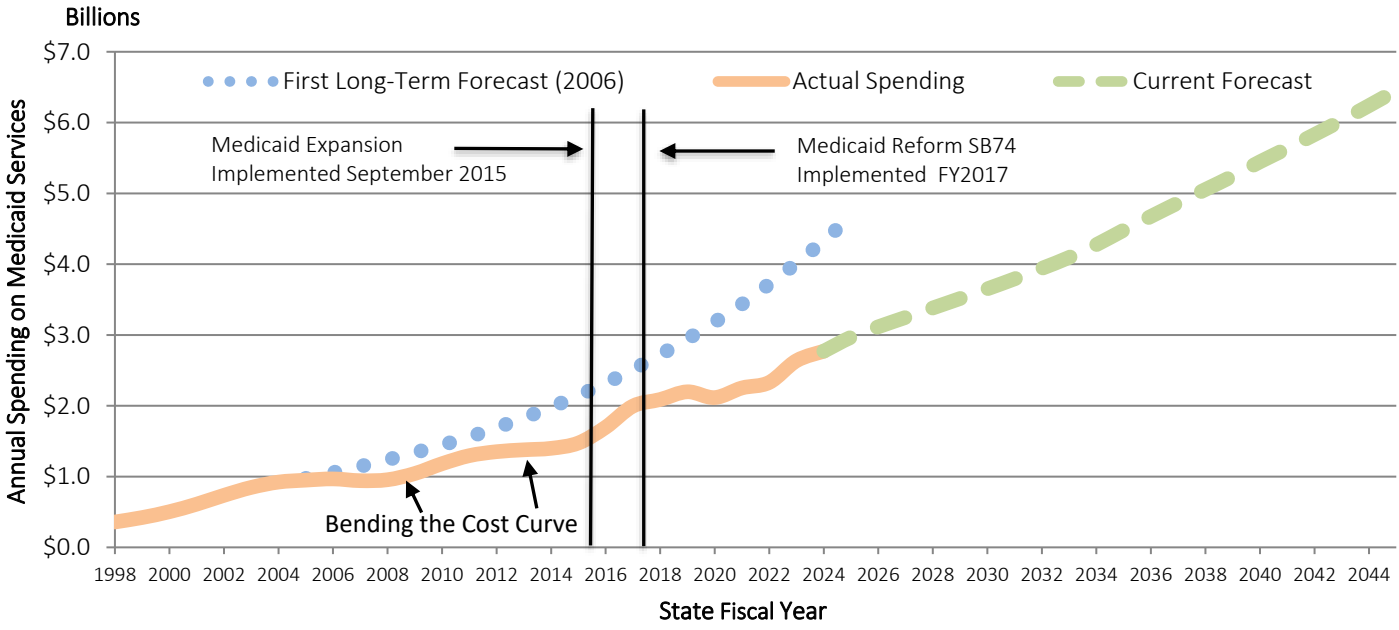
This first table stacks federal and state contributions totaling to the increased spend in 2024. When considering FMAP data shared above, the graph illustrates increased spending over the PHE, though decreased state contribution, until FY24 with partial year temporary COVID federal spending. Additionally, this visualization illustrates the difference between the growth in enrollees compared to the decrease in recipients of services.

Spending on Medicaid Services, Enrollment in the Medicaid Program, and Recipients of Medicaid Services, Based on Date of Service, FY12 – FY24



As seen in the chart below, the impacts from Medicaid's expansion continues to fall below forecasted spending.

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



II. AS 47.05.270(D) REPORTING REQUIREMENTS

A. Accomplishments, 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 & Social Supports

AS 47.05.270(a)(1) Referrals to community and social support services, including career and education training services available through 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. DPA currently partners with more than 95 private and for-profit organizations to provide work supports to recipients of ATAP. The suppliers are spread across Alaska and use a voucher system to receive reimbursement for goods and services authorized by DPA's case management staff. These community vendors are a key part of job seekers to find and keep employment.

Services are available through the Supplemental Nutrition Assistance Program (SNAP) Employment and Training Program (E&T). DPA administers SNAP E&T through Provider Agreements with four non-profit agencies in Anchorage and Mat-Su and offers the following service components to participants:

- Case management
- Support services (participant reimbursements)
- Supervised job search
- Job search training, job retention
- Career/technical vocational training
- Basic foundational skills instruction
- Work based learning/internship
- Other work based learning and vocational training.

The SNAP E&T participant support services are paid up front by vendors who receive a 50% reimbursement through the Provider Agreement monthly billing process.

Expansion development is occurring in FY25 in Soldotna and a new service provider will expand services in Anchorage.

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 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 3,864 members using the new portal with an increase of 40% during FY24.

3. Telehealth

AS 47.05.270(a)(3) Expanding the use of telehealth[i] for primary care, behavioral health, and urgent care.

The PHE ended May 2023, and the Office of Civil Rights and Centers for Medicare & Medicaid Services (CMS) established permanent telehealth guidance that would meet Health Insurance Portability and Accountability Act (HIPAA) compliance rules. In accordance with House Bill 265 that was signed into law on July 3, 2023, the Department adopted revised telehealth regulations on September 1, 2023, expanding both telehealth modalities and service types.

Telehealth is a method of delivering medical services using telecommunication technologies to extend patient care in place of in-person appointments. Telehealth is a Medicaid-covered modality. Medicaid pays enrolled providers for medical and behavioral health services delivered through telehealth modalities if the service is:

- Identified as a covered service on the applicable fee schedule (see link below),
- covered under traditional, non-telehealth modalities,
- provided by a Medicaid-enrolled treating, consulting, presenting, or referring provider; and
- appropriate to be provided via telehealth per the provider's standards of practice.

Services indicated on the Telehealth Fee Schedule[ii] are services that meet all four of the abovementioned components of coverage. Enrolled providers may request coverage of additional codes using the Request for New Consideration (medical/dental service)[iii] form.

A service delivered via telehealth is reimbursed at the same rate as a service delivered in-person. Alaska Medicaid covers the following telehealth modalities:

- Synchronous (Live Interactive): Service delivery through a real-time, interactive two-way audio-video technology, or a two-way audio-only technology.
- Asynchronous (Store and Forward): The transfer of recorded digital images, video, or sounds from one location to another to allow a consulting provider to obtain information, analyze it, and report back.
- Patient-Initiated Online Digital Service (Synchronous or Asynchronous): Evaluation, assessment, and management services of an established patient through a secure platform such as an electronic record portal, secure electronic mail, or digital application.

While there may be increased utilization as access to services expands, telehealth services are reimbursed at the same rate as an in-person visit.

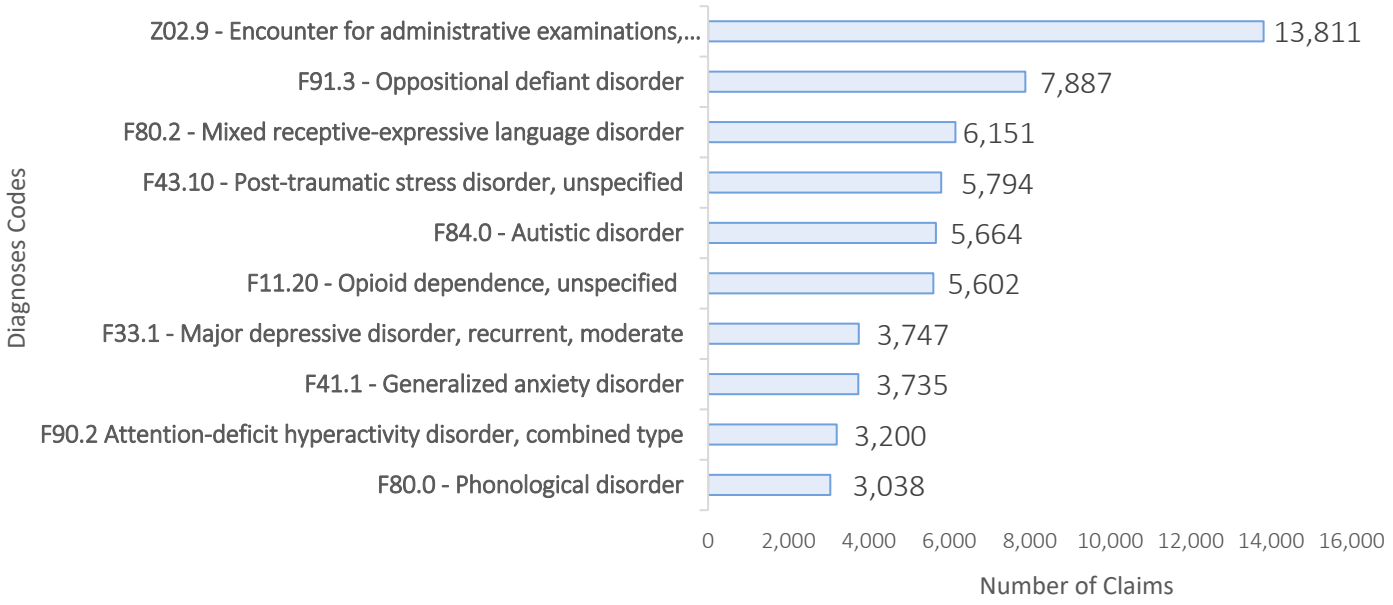
In FY24 the Medicaid program reimbursed:

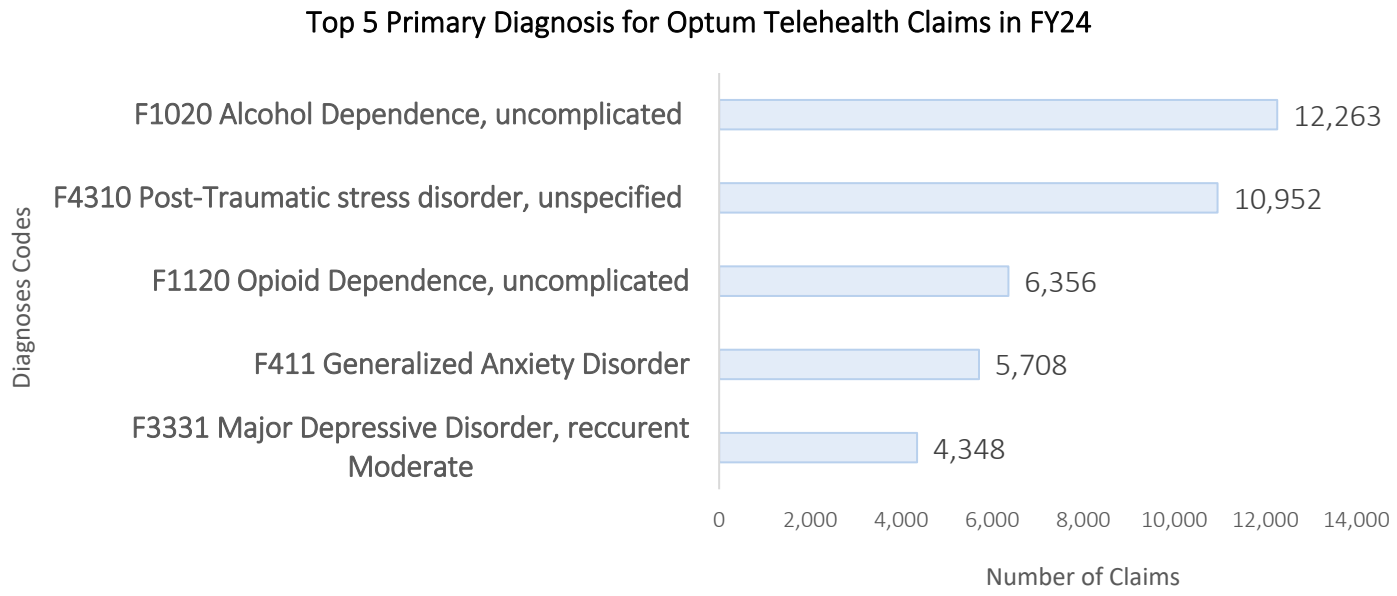
- $44.3M through Conduent for medical providers for services rendered via a telehealth modality (up 2.8% from FY23)
- $27.5M through Optum for behavioral health providers for services rendered via a telehealth modality (down 14% from FY23)

The following tables lists the top services and diagnoses for telehealth-delivered service claims rendered in FY24 separated by the entity adjudicating the claim. Most Medicaid claims are processed by Conduent, however certain behavioral health claims were processed by Optum. These charts illustrate that in FY24:

- The top two healthcare services provided via a telehealth modality in FY24 were:
  - Established patient office visits with moderate medical decision making
  - Monthly targeted case management service
- 44% of all telehealth was used for the treatment of a mental, behavioral, or neurodevelopmental disorder
- The top three conditions reported were:
  - Routine exams (encounter for administrative exam)
  - Oppositional defiant disorder
  - Mixed receptive-expressive language disorder

Conduent Top 10 Primary Diagnoses for Telehealth Claims FY24 Dates of Services





4. Fraud, Waste, and Abuse

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 (FMS) 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 has implemented the Medicaid Provider self-audit program as required by AS 47.05.235.

During FY24, MPI:

- Identified over $5.5M and recovered over $3.6M in overpayments paid to providers
- Issued 55 final audits in accordance with AS 47.05.200
- Processed 72 self-audits as required by AS 47.05.235
- Completed 54 records reviews for providers who were not compliant with the self-audit rules
- Completed 16 referral cases
- Worked 33 reviews of an independent contractor performing self-audits

The next round of self-audits are due no later than December 31, 2024.

MPI has established training guides and educational materials to assist with the Medicaid provider self-audit requirement. Medicaid providers who have not complied with the self-audit requirement may be referred for fiscal audit or be the subject of records request and review performed by MPI.

During FY24, MPI continued to work with 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. DSP has hired contractors known as Unified Program Integrity Contractors to perform data analysis and identify potential fraudulent activity based on their review of both Medicaid and Medicare claims data. Several projects were undertaken around high-level evaluation and management coding billed by providers. 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.

Additionally, MPI was subject to a comprehensive program integrity review performed by CPI. The comprehensive review included quality assurance functions conducted by quality sections in the Division of Health Care Services (HCS) and in the Division of Senior and Disabilities Services (SDS) Quality Assurance (QA) section. The comprehensive review report was issued in FY24 and did not contain any findings. The lack of findings in the CPI review report demonstrates Alaska's commitment to fighting fraud, waste, abuse, and preserving the assets of the Medicaid program.

MPI worked with CMS and their Payment Error Rate Measurement (PERM) contractors on the reporting year 2024 measurement for the medical records and data processing components which together make up the fee-for service measurement for PERM. The eligibility portion of the PERM measurement is managed by DPA. The results of the latest PERM review are expected to be released in mid-November 2024.

MPI employees and Medicaid division QA personnel attended training courses sponsored by the Medicaid Integrity Institute and the National Association for Medicaid Program Integrity to collaborate with other state personnel and identify best practices across the nation.

For FY24, MPI recovered over $3.6M, a 33% increase over last year, for a total return on investment of $3.20 per dollar spent.

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

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.

I) Programmatic Summary:

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 or intermediate care facility. HCBS includes Social Security Act Section 1905(a) personal care services, 1915(c) waiver services, and 1915(k) State Plan Community First Choice (CFC) services. 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.

Waiver services and CFC services are only available to individuals who require an institutional level of care. 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. Skilled nursing and intermediate care facility services are mandatory services under Medicaid, and 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.

II) Cost Savings:

State participation in HCBS services requires annual demonstration of cost neutrality. This means that the cost of providing services in the community through HCBS must be less than the cost of providing care in an institution, such as a nursing home or intermediate care facility. The following table illustrates the cost of waiver

services in FY24 compared to what the cost of nursing home and intermediate care facility services would have been if waiver services were not available.

The state avoided over $600M in FY24 by utilizing HCBS waiver services instead of institutional placements.

Cost of Institutional Care without HCBS Options

Services provided in FY24	# Served	Total Cost	What does this mean:
HCBS Recipients	5,448	$388,303,700	The state spent $388,303,718 for HCBS services in FY24, with an average cost of $71,275 per person.
Institutional placements	1,211	$174,026,300	The state spent $174,026,312 for services in FY24, with an average cost of $143,705 per person.
Total cost of HCBS and institutional care in FY24	6,514*	$562,330,000	The state spent $562,330,000 on HCBS and institutional placements in FY24.
Estimated total cost if no HCBS existed and services instead had to be provided in an institution	6,514*	$1,164,412,900	If all services were provided in an institution, the expected cost would have been approximately $1,164,412,900 in FY24.
Estimated additional funding needed if no HCBS existed and services instead had to be provided in an institution	6,514*	$602,082,800	HCBS allowed the state to avoid the cost of institutional care for waiver recipients, which would have been more than $600M in FY24.

FY24 Costs by Funding Source and Average Cost per Person by Service Type (based on federal FY24 Final Auth Report and number of people for whom payments were made during FY24).
**The number of individuals varies from the count of HCBS recipients and institutional placements because some individuals switch waivers or enter institutional care mid-year.*

Comparing spending on the total HCBS between FY23 and FY24 shows that overall spending for services increased by 18% or $64M, with $52M of that coming from GF spending, a 46% increase. Three drivers explain the GF increase in spending:

- **Stepped down federal match:** Throughout the PHE, the state received an increase in the federal match. The increase of 6.2% was stepped down to 5% on April 1, 2023, and was eliminated in January 2024.
- **Increased waiver enrollment:** HCBS waivers reduce the utilization of institutional care, which is much more expensive per person than waiver services, so while the increased utilization resulted in increased spending, it is considerably less than it would cost the state otherwise to provide institutional care.
- **Rate increase:** A 7.9% rate increase implemented at the beginning of FY24, which reflects a combined 3.7% increase for inflation plus a 4.2% legislative adjustment.

Together, these factors contributed to the increase in FY24 shown in the tables below. The "Total HCBS" is the sum of the three component parts, each with their own sums: waivers, personal care services, and CFC services.

Expenditures Trends for Waiver and Personal Care Services FY21 - FY24:
Percent Change Compared Between FY24 to FY23

Total HCBS

Fund Source	FY21	FY22	FY23	FY24	$ Change	% Change
GF	$124,258,700	$119,285,600	$113,536,300	$165,914,500	$52,378,200	46%
Federal	$192,564,700	$203,087,800	$253,209,800	$265,171,100	$11,961,300	5%
Total	$316,823,400	$322,373,400	$366,746,100	$431,085,600	$64,339,500	18%

Waiver Services

Fund Source	FY21	FY22	FY23	FY24	$ Change	% Change
GF	$106,756,500	$103,795,000	$98,768,000	$147,772,100	$49,004,100	50%
Federal	$164,008,300	$177,770,500	$229,275,200	$240,531,600	$11,256,400	5%
Total	$270,764,800	$281,565,500	$328,043,200	$388,303,700	$60,260,500	18%

Personal Care Services

Fund Source	FY21	FY22	FY23	FY24	$ Change	% Change
GF	$10,690,400	$9,119,500	$8,375,300	$9,835,100	$1,459,800	17%
Federal	$14,670,100	$12,566,000	$11,246,800	$11,056,900	($189,900)	-2%
Total	$25,360,500	$21,685,500	$19,622,100	$20,892,000	$1,269,900	6%

CFC Services (Additional 6% FMAP)

Fund Source	FY21	FY22	FY23	FY24	$ Change	% Change
GF	$6,811,800	$6,371,000	$6,392,900	$8,307,200	$1,914,300	30%
Federal	$13,886,300	$12,751,400	$12,687,900	$13,582,700	$894,800	7%
Total	$20,698,100	$19,122,400	$19,080,800	$21,889,900	$2,809,100	15%

III) Reform Efforts

The PHE had multiple impacts on HCBS. The end of the PHE created an opportunity for the Department to permanently incorporate changes to service delivery introduced during the pandemic. Many of these changes brought efficiencies and were highly sought after by the public, who were eager to see them continue beyond the PHE. The Department worked with recipients, providers, and federal partners in multiple stakeholder engagement sessions to solicit input about what updates to service delivery brought about efficiencies, maintained a high level of service, and reduced fraud, waste, and abuse. Some of the changes to service delivery allowed under the PHE were permanently incorporated in FY23 and were thus able to continue after the PHE ended in FY24, including the ability to meet CPR and First Aid training requirements through virtual courses, the use of electronic signatures, and the option for distance delivery of select services. These permanent flexibilities

were celebrated by recipient and provider communities as they reflected the Department's responsiveness to overcome barriers to service delivery. Other changes, such as the ability for legally responsible individuals, SB57, to be paid providers of waiver services, including in-home supports and supported living services, were allowed under the PHE and were permanently added during FY24. After significant stakeholder engagement, the Department successfully pursued multiple Medicaid waiver amendments and regulations packages in FY24 to permanently adopt the changes.

The PHE brought with it a powerful tool for innovation: Appendix K of the Social Security Act Section 1915(c). The Department used Appendix K to receive permission from the federal government to enact specific flexibilities during the pandemic and pursued 10 Appendix K amendments between 2020- 2023. As noted above, the Department ultimately retained many of the flexibilities due to increased efficiencies. Appendix K also allowed for the Department to seek permission for new services and service flexibilities to tackle long-standing barriers to effective service delivery for individuals with complex needs. The final Appendix K amendments submitted in FY24 were aimed at creating additional staff support options, called acuity add-on, for individuals with medical and behavioral support needs that require additional staff. The changes to acuity add-on allowed for a greater array of staff support possibilities to ensure individuals are receiving the services they need to live in the community rather than an institution.

Additionally, Appendix K allowed the Department to request and receive approval for a new type of residential habilitation service for recipients who require more support than can be provided in existing residential habilitation services. The new services, called specialized group home habilitation and specialized family home habilitation, provide an additional option in the suite of HCBS for individuals who would otherwise have support needs requiring institutionalization. The Department is still developing these new services. In setting Alaska's FY23 operating budget, the Legislature requested the Department prepare a plan for eradicating the waitlist for the Intellectual and Developmental Disabilities (IDD) waiver, and to prevent waitlists for other HCBS waivers. Although the Legislature did not appropriate funding to eliminate the waitlist, the Department was appropriated funding to implement new assessment tools, called InterRAI. InterRAI will help modernize and improve the Department's ability to effectively manage eligibility for services and costs in collaboration with individuals on these waivers, ultimately enabling Alaska to have a clearer sense of the costs and benefits and potentially eliminate wait lists for services in the future.

During FY24, the Department worked with the State Procurement Office on executing a contract for intensive technical assistance on the implementation of the InterRAI. This contract allows for technical assistance on the software RFP for InterRAI, training for assessors and a detailed work plan for implementation. Work is expected to continue in FY25 with the plan to secure a federal match in funding to procure a software system that can house the InterRAI. InterRAI implementation is anticipated in early FY27 following robust stakeholder engagement, software readiness, regulation updates, and assessor training.

In the 2023 Legislative Session, SB57 passed, allowing individuals receiving personal care services through the CFC to be allowed to receive that care from a legally responsible family member or guardian. Such caregiving had been allowed under the PHE and will now continue indefinitely. This new allowance is not expected to significantly impact the budget.

In addition to this allowance, SB57 also created a new type of HCBS waiver service called adult host home care. This new service will be available to adults enrolled in Medicaid and eligible for an HCBS waiver that is approved for the host home care service. This new service will be provided in an adult host care home, a new setting to be licensed by HCS. An individual may receive habilitative care in addition to adult host home care services within the limits of Medicaid coverage. The new setting and service are expected to help address the shortage of services and settings for adults with disabilities, seniors, and other individuals who require help with the activities of daily living and other assistance to live more independently. This may create an option that enables some people to remain in a community setting when they might otherwise need to move into an institution, such as a nursing home. Waiver amendments successfully submitted to CMS took effect on July 1, 2024, and regulations are underway.

In FY23, the Department adopted electronic visit verification (EVV) for Medicaid state plan home health services. Working together, multiple divisions successfully met the federally mandated compliance date for home health services to use EVV by January 1, 2023. Home health services will now meet federal requirements that an EVV system be used to help reduce fraud, waste, and abuse by providers. Personal care services had been mandated to use EVV since January 1, 2021.

Additionally, in FY24 SDS successfully completed multiple projects that supported HCBS providers through the American Rescue Plan Act (ARPA) Section 9817 enhanced FMAP opportunity. Under this ARPA provision, states were allowed to receive an enhanced federal match for HCBS of 10% in exchange for the state's commitment to use the funding to enhance, expand, or strengthen HCBS. Alaska had a total of $18.5M available to use for expansion, enhancement, or strengthening efforts, and successfully completed two projects:

- **The Direct Support Incentive Fund** distributions project to assist providers in paying for recruitment and retention of key Direct Support staff. This project helped to alleviate HCBS staffing shortages and incentivize employment by providing immediate relief to providers that have taken efforts to project and retain their workforce. In FY24, this project continued auditing providers to ensure there were no overpayments. Any overpayments were rolled back into the ARPA program to use on other projects.
- **Training Pilot Project** establishing a new training and certification program for direct support professionals serving individuals with disabilities, with 50 individuals working at 13 agencies across the state completing certification in FY24. The initiative was conducted in partnership with the University of Alaska Anchorage Center for Human Development which already had significant infrastructure and experience in offering training to direct support professionals. While the ARPA portion of this project has concluded, this program will continue to operate in FY25 thanks to the work of the Alaska Training Cooperative and Mental Health Trust Authority.

By the end of FY24, with approximately $6M remaining, SDS received permission from CMS to develop new projects related to better serving children and adults with complex behavioral and developmental disabilities needs and technical assistance support for the new assessment tools (InterRAI). Work on both projects is expected to continue in FY25.

6. Pharmacy Initiatives

AS 47.05.270(a)(6) Pharmacy initiatives.

Negotiated pricing and utilization management within the pharmacy program has made an impact at bending the cost curve through additional supplemental and federal rebates, but the escalating cost of pharmaceuticals continues to risk strain to the system. HCS pharmacy staff coordinates the P&T Committee meetings comprised of practicing Alaska providers and pharmacists on a quarterly basis. During each meeting, a review is conducted of a group of drug classes to determine whether agents will be preferred or non-preferred on the Alaska Medicaid PDL. Placement on this PDL directly drives the supplemental rebates collected by the state, and through Alaska's relationship with other states to negotiate additional supplemental rebate opportunities for Alaska. There are also mandatory federal rebates controlled through manufacturer participation in the Medicaid Drug Rebate Program (MDRP). The Pharmacy Benefits Administrator, Magellan (contractor), collects the rebates, and the processing is conducted by the HCS Finance section in close collaboration with FMS.

Sole source brand name medications accounted for 87% of the overall pharmacy spend. The flexibility afforded by AS 47.07.065 to update the PDL 30 days after the publicly held P&T committee meetings has reinforced the Department's efforts to maximize value for the state, using an evidence-based approach to therapeutic outcomes while pursuing efficiency in pharmacy spending in the face of rapidly rising drug costs.

As the opioid epidemic continues to impact Alaskans, the Medicaid Pharmacy Program continues to employ strategies consistent with clinical appropriateness and the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (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 and antipsychotics.

I) Preferred Drug List and Prospective Drug Utilization Review

In the fall of 2019, the Alaska Medicaid pharmacy program gained authority through SB44, signed into law August 8, 2019, to begin updating its PDL following each P&T Committee meeting rather than adopting updates through the regulatory process. In FY24, the Supplemental Rebate Program yielded $25M in rebate collections, as a direct result of management of the PDL.

Systematic prospective drug utilization reviews resulted in an additional savings of over $32M in pharmacy cost avoidance by preventing dispensing of inappropriate medications. This represents a 13.6% impact in cost avoidance directly related to total spend. Approximately half of these savings and cost avoidance are GF.

II) 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 was 83.9% at the end of FY23. Generic drug utilization in the program is consistently at or above the national average. The Medicaid Pharmacy Medicaid Drug Utilization Review (DUR) Program continues to research opportunities for additional savings with the broader availability of biosimilar therapeutics during the FY24 review cycle.

III) Opioid Utilization Initiatives and Medication Assisted Therapy

The Alaska Medicaid drug utilization program continues to promote evidence-based opioid prescribing activities,

which has resulted in a decrease in overall opioid prescribing and doses within the Alaska Medicaid population as demonstrated by claims data. The Medicaid program further tightened previous quantity limits, established successively decreasing morphine milligram equivalent (MME) thresholds that would prompt prior authorization reviews, and enhanced cross-agency relationships through SUPPORT Act activities. Prescribers must provide treatment plans to demonstrate the need for doses more than the daily MME threshold.

In the six-month period from January- June 2024, less than 113 unique Medicaid members received opioid prescriptions with a combined daily MME more than 120. This reflects a 15% reduction in high-dose utilizers as compared to the period in 2023. 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[iv], available to all Alaskan clinicians at no charge [1-844-520-PAIN (7246)]. This multidisciplinary team assists Alaska Medicaid in conducting second level reviews and makes recommendations for complex opioid utilization cases. The greatest impact is the clinical and personal benefit of decreasing medically unnecessary opioid utilization and providing opportunities to move individuals into recovery.

In addition to monitoring the prescribing of opioids, the program monitors medications supporting substance use recovery within its member population. Access to treatment continues to grow with elimination of the X-Waiver though the Consolidated Appropriations Act of 2023. This removed the federal requirement for practitioners to submit a waiver to prescribe medications for the treatment of opioid use disorder (OUD).

Total pharmacy reimbursement costs for buprenorphine-based products were $10.66M during FY24, up from $9.86M during FY23. The corresponding trend in decreased opioid utilization has helped to blunt the financial impact in the short-term by off-setting part of the increased costs for opioid dependence treatment.

The DUR meetings are held quarterly and as part of the agenda strategies are evaluated related to opioid retrospective and prospective reviews to determine if further policy changes are necessary. The strategies that have been evaluated are formalized in the Alaska Statewide Opioid Action Plan[4].

DUR Program Activities and Strategies Addressing the Opioid Epidemic

Efforts of the Alaska Medicaid Drug Utilization Review Program	Alaska Opioid Action Plan[v]
The Alaska Medicaid DUR Program continues to utilize quantity limits, daily MME limits, early refill, concurrent opioid-benzodiazepine, opioid naive day supply edit, 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 (MAT) Standards of Care program promotes evidence-based prescribing of buprenorphine-based products.	Strategy 2.4 3.2 5.2 5.5

Efforts of the Alaska Medicaid Drug Utilization Review Program	Alaska Opioid Action Plan[v]
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 prompted 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 can independently dispense naloxone to Medicaid members. A prompt was deployed for the pharmacist to assess for naloxone need at 90 MME.	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 Bamboo Health on specific SUPPORT Act initiatives including identifying critical data analytics and reporting platforms. The PDMP vendor was able to integrate control substance data into the Medicaid Management Information System (MMIS) system and provide necessary information to complete the mandated Annual DUR report.

IV) Pharmacy Professional Service Reimbursement

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. The adoption of preventive service regulations, 7 AAC 120.110(c)(d), now allows enrolled pharmacists to bill for services located on the Pharmacist Fee Schedule, to include independent prescribing of opioid reversal agents, epinephrine, and vaccines. System changes allowing the enrollment of pharmacists were completed in the middle of FY24. Non-dispensing pharmacist professional service reimbursement continues into FY25 and will evolve with further refinement of scope of practice under the Board of Pharmacy authority, through the Department of Commerce, Community, and Economic Development (DCCED).

7. Enhanced Care Management

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

The EOMB portal continues to be a resource for Medicaid beneficiaries to review claims activity paid on their behalf. There are currently 3,864 members using the new portal with an increase of 40% during FY24. HCS' QA team reviews all EOMB portal results to determine if services were appropriately rendered by conducting investigations. These investigations help to identify if the issue identified is a singular instance of concern or

represents an ongoing pattern requiring additional review. Issues identified through the EOMB process may be referred for overpayment, recovery, education, or other administrative remedies.

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 continue to be analyzed and developed. The following table recaps GF cost savings and cost avoidance resulting from these programs.

GF Cost Savings and Cost Avoidance Due to Current Care Management Programs

Program	FY24
Primary Care Case Management	$0
Clinical Case Management	$135,800
Care Management Program	$5,000,500

I) Primary Care Case Management, Alaska Medicaid Coordinated Care Initiative

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 18 Alaska Medicaid recipients per month during FY24. The Alaska Medicaid Coordinated Care Initiative (AMCCI) is a voluntary program.

II) 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 who have experienced catastrophic injuries and illnesses. Most referrals to clinical case management originated from physicians and other medical providers, HCS staff, and Comagine utilization management staff. Through the 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.

III) Care Management Program

Established during the mid-1990s, the Department'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. The Department 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 $16.6M during FY24, approximately 30% of which, approximately $5M, was GF. Savings were achieved through cost avoidance due to improved continuity of care that reduced the use of inappropriate services (e.g., use of hospital emergency departments for non-emergent care), visits to multiple providers for the same issue, and duplicative prescriptions. FY25 CMP enrollment is expected to achieve a monthly average of 950 recipients, a 19% increase over FY24. It is expected that cost-savings/cost avoidance will also increase 19%.

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 a recipient or for care related to specific diagnosis.

I) Diagnosis Related Groups

The Office of Rate Review (ORR) led an initiative to implement Diagnosis Related Groups (DRGs) as a value-based payment methodology for inpatient stays at general acute care hospitals. ORR was assisted by contractor Myers and Stauffer LLC. Together they met regularly over the last several years with members of the Alaska Hospital & Healthcare Association (AHHA), formerly the Alaska State Hospital and Nursing Home Association (ASHNHA) and achieved consensus on key decision points regarding the DRG Project. The DRG Project was implemented on January 1, 2024.

The DRG payment methodology for inpatient hospital services supports implementation of policies and practices that promote quality and are patient centered, fair to providers and fiscally responsible. The previous per diem methodology reimbursed 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 currently from the DRG payment methodology. Psychiatric, rehabilitation, and long-term acute care hospitals were excluded in the DRG payment methodology; however, psychiatric, rehabilitation, SUD, and neonate services provided by general acute care hospitals are included.

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 the Department’s ability to implement performance review and cost-saving measures, including potentially preventable readmissions and hospital acquired conditions.

II) Medicaid Payment Methodology Evaluation

The Department initiated the Medicaid Payment Methodology Evaluation project in FY24. The goal of this multiyear capital project is to establish transparent Medicaid rate-setting methodologies that:

- Promote access to healthcare for all Alaskans from a rate setting perspective, and support budget sustainability through advancing efficient and effective care
- Account for the unique challenges associated with delivering services to diverse populations with complex needs (e.g., youth, elderly, etc.)
- Consider Alaska's unique geographical and regional complexities
- Consider Alaska's substantial THOs and intersection with Alaska Medicaid
- Result in rates sufficient to meet workforce recruitment and retention needs and provider resources
- Ease administrative burden for the state and the provider community
- Allow for regular review, maintenance, and updates to reflect changing costs and resources in the Alaska health care market

The project will be carried out in two phases of Medicaid services. Phase 1 service categories include behavioral health, long-term services and supports, federally qualified health centers (FQHCs), and non-emergency medical transportation. Phase 2 services include facility services, professional services, emergency medical transportation, dental services, and other Medicaid rate methodologies (e.g. durable medical equipment, pharmacy, school-based services).

In March 2024, the Department issued an RFP for the Medicaid Payment Methodology Evaluation project, a comprehensive evaluation of Alaska Medicaid payment methodologies. The contract was awarded to Guidehouse LLC, a national consulting firm with extensive Medicaid rate setting experience. Adoption and implementation of any rate recommendations from Guidehouse will be subject to the normal Medicaid rate setting and legislative budgetary processes. The Department has committed resources from multiple divisions to support this project, including the Division for Behavioral Health (DBH), HCS, SDS, ORR, and the Commissioner's Office.

III) Coordinated Care Demonstration Projects

Enacted in 2016 as part of the Medicaid Redesign initiatives under SB74, AS 47.07.039 authorizes the Department to implement one or more coordinated care demonstration projects to test the efficacy of alternate health care delivery models with respect to cost, access, and quality of care for medical assistance recipients. The Department issued a Request for Information (RFI) in June 2024 seeking public input and gauging interest from qualified vendors interested in pursuing demonstration projects under the scope articulated in statute. The Department received multiple responses and will be evaluating the responses in FY25 for further action.

9. Quality and Cost Effectiveness Targets Stakeholder Involvement

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

With this report, the Department is transitioning from the previously used set of performance measures to an evolving set of measures in preparation for a 2026 federally mandated report. Specifically, the measures established in FY17 (and reported on from FY18-FY23) are being changed to the quality measure sets introduced and required by CMS.

Most of the measures previously identified by the Quality and Cost Effectiveness (QCE) workgroup are also in the CMS quality measure sets. Sometimes the changes are as slight as changing the age range of what is being measured.

For example:

- Percentage with at least one Well-Care Visit with a Primary Care Practitioner or Obstetrician/Gynecologist
  - *Original* - Ages 12 to 21
  - *Updated* - Ages 12 to 17 **and** ages 18 to 21

While some measures which closely align with the current measures are being merged, others are new. For example, there is a new domain, "Experience of Care", with six new quality measures, including "getting needed care composite." Lastly, 12 measures will no longer be included. In general, over half of the 62 total measures across six domains are new this year.

It is important to migrate the measures at this time to meet the CMS mandate, though it will come at the cost of losing some longitudinal data. That said, in coming years, the aligned data will afford a better overview of trends in Alaska compared to the national median.

Federal law requires states to have a Medical Care Advisory Committee (MCAC) to advise the Medicaid agency about health and medical care services, help develop Medicaid policies, and give ideas about how the program should be run. Alaska's MCAC tentatively has these new quality measures slated to be on the agenda in Fall 2024.

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.

I) All Transportation

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.

Below are the Alaska Medicaid transportation program expenditures since FY21.

Health Care Medicaid Services Travel Expenditures Chart: FY 21 - FY24

Travel Fund Sources	FY21	FY22	FY23	FY24
State (Unrestricted Designated, Other)	$6,553,600	$7,702,500	$7,519,300	$9,745,900
Federal	$47,627,400	$60,631,600	$135,570,500	$85,376,800
All Transportation	**$54,181,000**	**$68,334,100**	**$143,089,800**	**$95,122,700**

With travel returning to pre-pandemic levels, the program saw a 26% increase in GF from FY23 to FY24. In FY24, the Supplemental Emergency Medical Transportation (SEMT) program was still in full operations, which is federally funded and contributed greatly to the total increase in transportation.

The Department is taking several steps to contain costs, including the following:

- Contracting with Guidehouse to update the Medicaid rate methodology for non-emergency medical transportation (NEMT) services, recommendations are expected around May 2025
- Adopting expanded telehealth regulations to support care in a recipient's community as much as possible and reduce travel as appropriate

II) Non-Emergent Medical Transportation

All NEMT 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 beneficiary is a Tribal member, to the nearest Tribal 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. 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 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, and ensuring that medical necessity exists for all travel referrals.

In FY24, total Medicaid transportation expenditures increased 19.4% from FY23. While there was an $11M increase from FY23, when taking into consideration pre-pandemic travel costs (FY19, $82.9M) that threshold has not yet been met.

Medicaid Non-Emergent Transportation Expenditures Comparison: FY24 to FY23

Service Type	FY23	FY24
Commercial/Chartered Flight	$36,117,200	$45,620,300
Lodging	$15,982,000	$16,542,600
Ground/Water Transportation	$3,951,200	$4,427,200
Meals	$2,955,900	$2,838,200
Other Fees	$1,388,900	$1,685,900
TOTAL	$60,062,408	$71,114,200

During FY23, the Department overhauled the non-emergent transportation program to reduce administrative burdens and expedite travel determinations. Changes include:

- Implementing *Presumptive Travel Eligibility* where providers may request transportation up to 12 months in advance so long as the recipient is eligible on the date of the request. This allows providers more flexibility in appointment scheduling and significantly increased recipients' abilities to make needed reservations to better meet travel needs.
- Developing an *Arranging Patient Travel* website as a one-stop shop for all Medicaid travel needs including manuals, forms, requirements, contact information, and reminders.
- Streamlining the request process to reduce call hold times.

11. Disease Prevention and Wellness

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

The Department 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. In FY24, the Department made progress in disease prevention and wellness in three ways:

- **Regulations for the Adult Preventive** package for Medicaid became effective March 3, 2023. These regulations cover more extensively the Affordable Care Act (ACA) mandates including the U.S. 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.
- **Utilizing the MCAC** to engage with community partners and providers, to develop solid, evidence-based, policy recommendations which make sense to Alaskans in terms of value. There currently are three workgroups related to telehealth specifically Remote Patient Monitoring (RPM), solutioning barriers to post-acute care, and pediatric nurse triage.
- **Participating in national projects to prevent and manage chronic diseases** that will result in healthier Alaskans in the future. The Division of Public Health (DPH) and HCS continue to jointly participate in a *Case for Coverage* project, hosted by the National Association of Chronic Disease Directors in collaboration with the Centers for Disease Control and Prevention (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 Department 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 the Department 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.

In January 2018 the Department applied for an 1115 Behavioral Health waiver as part of SB74. The intent was to create a data-driven, integrated behavioral health system of care for Alaskans experiencing serious mental illness, severe emotional disturbance, SUD, co-occurring substance use and mental illness, and at-risk families and children. At the guidance of CMS, the SUD component was broken out separately from the rest of the behavioral health services to move it forward more quickly in response to the growing opioid epidemic. It was approved in November 2018, with the implementation plan receiving approval in March 2019. The behavioral health component later received approval in September 2019.

The extension approval was finalized on March 26, 2024, and provided for continued utilization of the demonstration waiver through December 31, 2028. The extension authorized the state to change the title of the demonstration from "Substance Use Disorder Treatment and Behavioral Health Program (SUD-BHP) to

"Behavioral Health Reform." The title change aligns mental health and SUD under a broader behavioral health definition to reflect the state's commitment to program reform and system transformation. Beyond the title change, the state did not request changes with this extension but rather sought to continue operations of the current demonstration.

I) 1115 Behavioral Health Reform Demonstration Waiver Amendment Opportunity

With the CMS approval and extension of the 1115 Behavioral Health Reform demonstration waiver, Alaska now has opportunity to apply to expand services through an amendment. The services identified for an amendment include:

- Increasing flexibilities for and expanding community-based crisis services
- Strengthening in-home and community-based health services to support youth remaining close to home and family to receive services

These prioritized services are a direct result of engagement with communities and stakeholders through the Behavioral Health Roadmap Project for Youth.

II) Behavioral Health Roadmap Project for Youth: Engagement and Recommendations

Department leadership and representation from every division participated in each of the five regional events, the virtual statewide session, and each of the six community listening sessions in addition to all of the Steering Committee meetings. These events served as forums for stakeholders, providers, partners, and families with lived experience to collaboratively identify challenges, opportunities, and solutions to improve the youth behavioral health system of care in Alaska. Focus areas within these meetings consisted of the following:

- Prevention, Early Intervention, and Health Related Needs (HRN)
- Community Based Services and Supports
- Mental Health in Schools
- Residential Services
- Crisis Services
- Acute Care

The final report for this project was completed in June 2024 and is posted on the Department's website at https://health.alaska.gov/Commissioner/Pages/bhroadmap/default.aspx.

The report identifies 47 Action Items, several of which are currently underway within the division such as:

- Reviewing Medicaid rates and methodology
- Developing regional provider capacity and support
- Conducting a crisis continuum assessment
- Strengthening 1115 Behavioral Health Reform demonstration waiver services
- Removing administrative barriers
- Developing a Behavioral Health Provider Support Organization
- Making strides toward Medicaid behavioral health claims payment and accuracy

III) Assessment of Alaska's Behavioral Health Crisis Services Continuum of Care

By the third Behavioral Health Roadmap Project for Youth meeting, a theme emerged that existing crisis services within the 1115 Behavioral Health Reform demonstration waiver did not provide enough flexibility for rural communities to implement services within their communities, taking into consideration remoteness and staff shortages. As a result, DBH began engagement with Milliman, Inc. to analyze Alaska's behavioral health crisis continuum of care. The report provides an overview of the current state of behavioral health crisis care in all communities across the state and focuses on mobile crisis response and crisis stabilization facilities, as crisis call centers were outside the project scope.

Five areas of opportunity emerged as options for Alaska to consider:

- Enhancing the crisis services array
- Streamlining documentation
- Providing additional support for providers and community partners
- Improving sustainable financing
- Facilitating collaboration

Implementation of these key activities include planning and design, stakeholder engagement, regulatory authority, payment review and rate development, and updates to internal operations and documentation. This work contributes to the future 1115 Behavioral Health Reform demonstration waiver amendment and will be ongoing in the next fiscal year.

IV) Certified Community Behavioral Health Centers

DBH applied for a one-year planning grant in September 2024. While Alaska previously had received a planning grant in 2016 and developed much of the necessary requirements to move forward with an application for a demonstration grant, the application was not submitted. Since the behavioral health landscape in Alaska has changed considerably since 2016, DBH chose to pursue another planning grant. If awarded the grant, DBH will engage with existing Certified Community Behavioral Health Clinics (CCBHC) who are grantees of the Substance Abuse and Mental Health Service Administration (SAMHSA) in addition to other stakeholders to develop policy for state certification of CCBHCs as well as identify a PPS to enhance reimbursement to CCBHC providers. CCBHCs will be reimbursed under this PPS, similar to the system used by FQHCs.

A CCBHC model is designed to ensure access to coordinated comprehensive behavioral health care. Organizations that meet the CCBHC criteria are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age – including developmentally appropriate care for children and youth. CCBHCs must provide 24/7 crisis services and meet standards for the range of services they offer. CCBHCs also provide care coordination to help individuals navigate behavioral health care, physical health care, social services, and other systems.

13. Behavioral Health System Capacity

I) FY24 Overall Data

In 2019, DBH contracted an Administrative Services Organization (ASO), Optum, to support the implementation and ongoing activities related to 1115 Behavioral Health Reform demonstration waiver. As a component of this contract, the ASO absorbed claims processing responsibility from the State's Health Enterprise MMIS for all

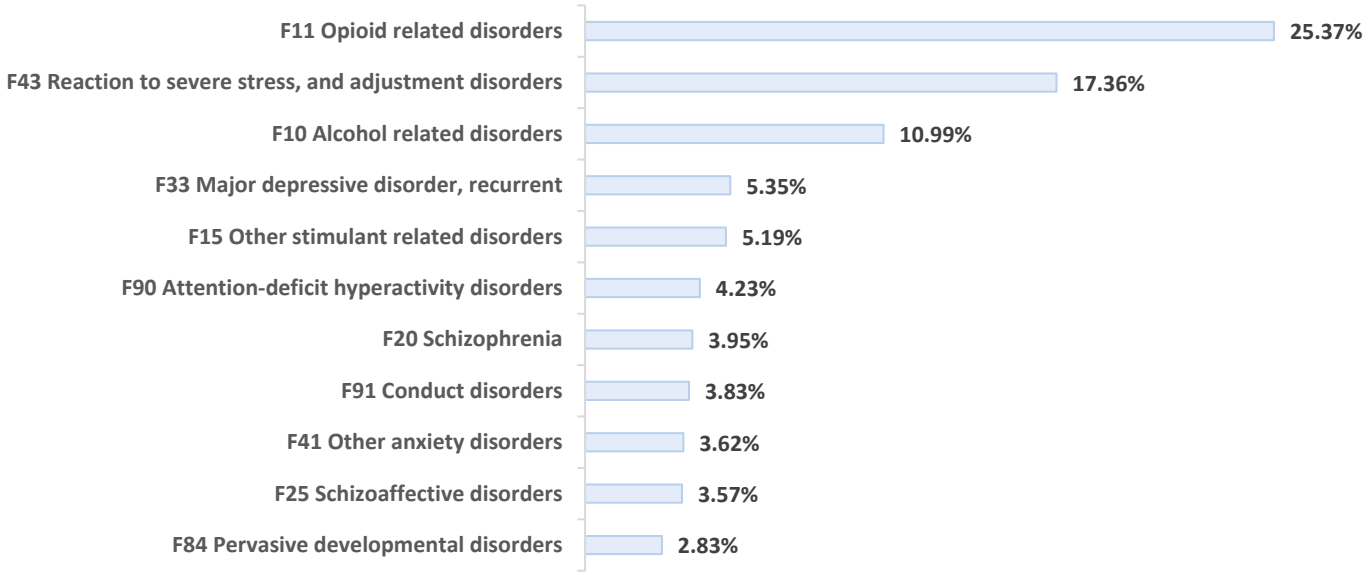
behavioral health and SUD services in February 2020, and staggered integration of State Plan service claims processing for all behavioral health provider types, to include CCBHCs, mental health physicians clinics, independent practitioners, and Autism providers beginning in July 2020. Claims processing for 1115 Behavioral Health Reform demonstration waiver services returned back to the MMIS from Optum in November 2024.

In FY24, the ASO processed a combined 837,026 behavioral health Medicaid claims, totaling $337M in reimbursement to providers for rendered services. Of note, in FY24:

- 1115 Behavioral Health Reform demonstration waiver expansion of the State Plan service array benefited 15,099 unique recipients
    - 5,788 recipients received SUD services
    - 9,311 recipients received behavioral health services

The figure below highlights the top 10 primary diagnosis groups billed on ASO claims served by the 1115 Behavioral Health Reform demonstration waiver and State Plan Behavioral Health continuum services during FY24. Consistent with historical trends, alcohol and opioid related disorders remain among the leading diagnosed concerns, with reactions to severe stress and adjustment disorders increasing in frequency since the onset of the pandemic.

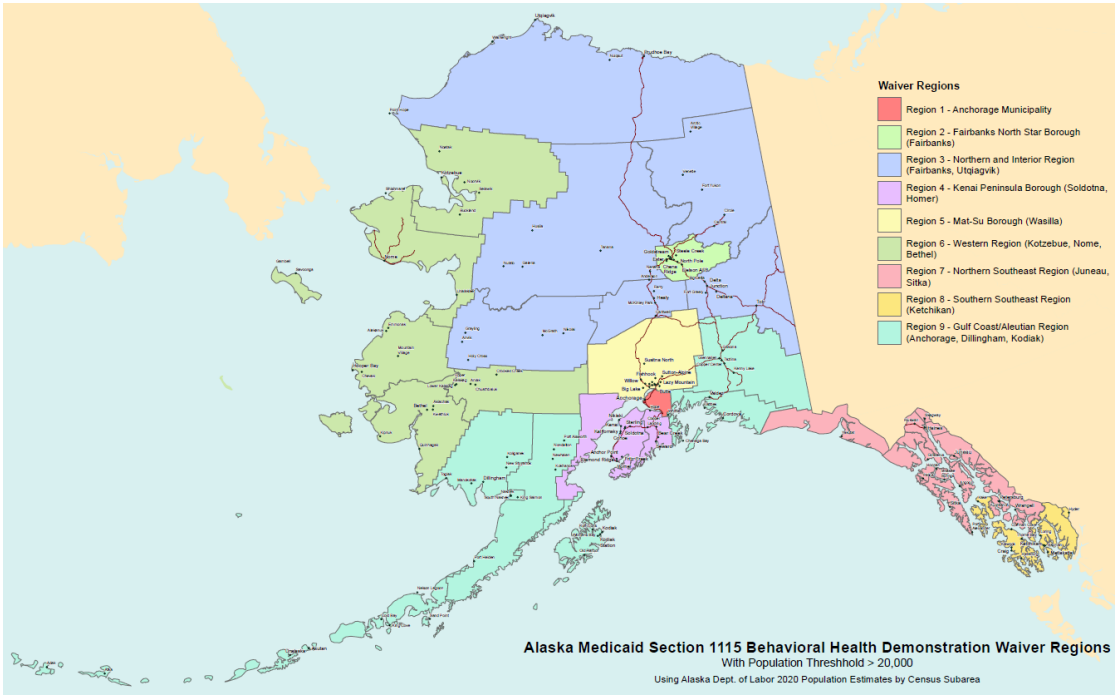
Top 10 Primary Diagnosis Groups as % Total Optum Claims in FY24



II) Provider Enrollment

Several components of the 1115 Behavioral Health Reform demonstration wavier program seek to improve the behavioral health service continuum through enhanced regional infrastructure that supports the expansion of existing Medicaid behavioral health agency operations as well as the establishment of new providers. To support this regional focus, DBH consulted with Milliman's actuarial team to develop the 1115 Behavioral Health Reform demonstration waiver Alaska Regional map below. Regions were created to align 1115 Behavioral Health Reform demonstration waiver reporting of behavioral health service activity throughout the State, with specific focus on ensuring safe harbor thresholds were met for communities with low census.

Alaska Medicaid Section 1115 Behavioral Health Demonstration Waiver Regions



Of note in FY24, DBH saw two significant increases:

- 41.6% in independent practitioner enrollments over those in FY23, comprised of:
    - 37 new independent practitioner agencies enrolled to provide services in the following regions:
        - 16 in the Anchorage Municipality (Region 1)
        - 3 in the Fairbanks North Star Borough (Region 2)
        - 7 in the Kenai Peninsula Borough (Region 4)
        - 2 in the Mat-Su Borough (Region 5)
        - 3 each in the Northern and Interior (Region 3) and Northern Southeast (Region 7)
        - 1 each in the Southern Southeast (Region 8), Western (Region 6), and Gulf Coast/Aleutian (Region 9)
- 8.3% in Community Behavioral Health state plan provider enrollments over those in FY23 comprised of:
    - 7 new enrollments
        - 3 Community Behavioral Health facility expansions
        - 4 with an Autism services specialty

14. Emergency Care Improvement

The Emergency Department Coordination Project (EDCP) continues to facilitate the exchange of health information between the Emergency Department Information Exchange (EDIE) and healthEconnect's Health Information Exchange (HIE). In FY24, oversight of EDIE platform transitioned and is currently overseen by PointClickCare. The volume of providers connected to EDIE and HIE continues to grow as awareness of the functionality increases among both clinics and hospitals.

The HIE continues to add features and functionality to better serve emergency department stakeholders. Integrated single sign-on, enhanced care alerts, and greater visibility into a patients care team have improved services within emergency departments. New features to simplify referrals, incorporate HRNs, and expanded partnerships with community-based organizations are further expected to improve care.

15. Health Information Infrastructure Plan

Section 56 of SB74 requires Department 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.

Established under AS 18.23.3000, the HIE system continues to be one of the two primary health information utilities that connect Alaskans to their health information. During FY24 the HIE continued to deliver reliable data exchange between healthcare stakeholders for the purposes of payment, treatment, and care coordination. The addition of new hospitals, clinics, doctors, care coordinators, and other providers, helped grow participation in the HIE in FY24. Functionality to provide ongoing Medicaid redetermination status to stakeholders was successfully implemented for many providers.

The Department worked with CMS to draw down 8% more federal funds for allowable services in FY24 (30% to 38%). These funds for the HIE offset what has historically been funded via GF. The Department continues to identify functionality and business processes that are eligible for federal funding and is engaging CMS on additional opportunities. In FY25 the Department will be working with CMS to capture additional federal funds to further increase the 38% cost allocation for the HIE.

The second health information utility is Alaska's federally required Interoperability solution. The Department has completed Phase 1 of the required interoperability framework to ensure compliance with Application Programming Interface (API) standards for secure data transmission of certain Medicaid data. Phase 1 included an API for patient facing data and a separate requirement for an API for use as an Enrolled Provider Directory. Interoperability Phase 2 was announced federally in January 2024 and requires new functionality to be built and delivered during FY25-FY27. Phase 2 requires implementation of an advanced provider directory and new provider and patient facing service authorization status requirements.

The Department is also working on a multi-year Medicaid Modernization Strategy that improves the technical infrastructure of Alaska's Medicaid Enterprise. This includes updates to the Eligibility Systems to provide an improved user experience for applicants of public assistance programs. These improvements will also improve efficiency for state staff working with the applications. The modernization plan also includes providing digital proof of eligibility for Medicaid patients via smartphone app. The patient application will also include access to a comprehensive provider directory and the ability to communicate with Department staff for some beneficiary functions.

The Medicaid Modernization Plan will also include significant upgrades to the provider enrollment process, service authorization request process, and other functionalities to reduce administrative burden among current

and prospective Medicaid providers. Overall, the Department is working closely with CMS on the timing and financing of the Modernization Plan to ensure minimal disruptions with current functionality, ensure compliance with upcoming federal rules, and to maximize federal funding opportunities.

B. Additional Reporting Requirements

1. Realized Cost Savings

AS 47.05.270(d)(1) Realized cost savings related to reform efforts under this section.

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

2. Realized Cost Savings Related to Other Reform Efforts

AS 47.05.270(d)(2) Realized cost savings related to medical assistance reform efforts undertaken by the Department other than the reform efforts described in this section.

The following table reports FY24's GF costs savings and cost avoidance across defined reform efforts and then compares it to FY23, concluding that there was over an $8.7M cost savings and cost avoidance over last year.

GF Cost Savings and Cost Avoidance Due to Other Reform & Cost Containment Efforts

Program	FY23	FY24	Increase/Decrease
Utilization Management	$24,219,000	$15,277,300	-$8,941,700
HMS Third-Party Liability & Audit Recovery	$17,132,800	$16,118,400	-$1,014,400
Tribal Health System Partnerships	$595,661,500	$613,571,000	$17,909,500
Department of Corrections (DOC) Inpatient Care Cost Avoidance	$8,458,400	$9,246,000	$787,600
Total	**$645,471,700**	**$654,212,700**	**$8,741,000**

I) Utilization Management

The Department 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 FY24, these utilization management services yielded gross Medicaid program savings of $15.2M, approximately 30% of which, or $4.6M, was GF and a return on investment of $15.55 for every $1.00 spent through the avoidance of unnecessary or untimely medical care.

II) Healthcare Management Systems Third-Party Liability and Audit Recovery

The Department contracts with 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 FY24, third party liability (TPL) realized $53.7M in recoveries and savings, and approximately 30% of which $16.1M was in GF.

HMS Third-Party Liability & Audit Recovery Comparison: FY24 to FY23

Types of Savings	FY23	FY24
Recoveries	$27,717,000	$26,260,400
Health Insurance Premium Payments (HIPP) Cost Savings	$2,426,300	$2,075,000
TPL Cost Savings	$26,966,100	$25,392,500
Total Savings	**$57,109,400**	**$53,727,900**
GF Savings	**$17,132,820**	**$16,118,370**

III) Tribal Health System Partnerships

In FY24, the Department continued to support expansion of services in the Tribal Health System, including:

- Expanded service provision and payment to over 430 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
- Additional residential capacity in Anchorage to accommodate recipients on the Alaska Native Medical Center campus

Medicaid Tribal Health Partnership Expenditures Comparison: FY24 to FY3

Program Expenditures	FY23	FY24	Increase/Decrease
Tribal Health System Partnership	$595,661,500	$613,571,000	$17,909,500

3. Achievement of Quality & Cost Effectiveness Targets

AS 47.05.270(d)(3) A statement of whether the Department has met annual targets for quality and cost-effectiveness.

Below are the results of 2023 Core Measures across the following six domains: Behavioral Health Care; Care of Acute and Chronic Conditions; Dental and Oral Health Services; Experience of Care; Maternal and Perinatal Health; and Primary Care Access and Preventive Care.

This year, in addition to the updated quality measures in preparation for the 2026 CMS mandated change to reporting requirements, the two data charts have been merged this year. As a result, it is clear which measures have met the U.S. national median targets over time, and for the most recent year's comparison (FY23), it is clear by how much. Across all six domains, there are now 62 measures. Of those, only 19 (or 31%) were achieved. While a majority of measures were not met when compared to the national median, it is important to consider the following:

- 32 were new measures (more than half of the overall measures)
- 43% of the measures with three or more years of comparison data show an improvement this year

In that sense, Alaska both is moving in the right direction and has clear targets for improvement.

NOTES:

- Based on the national reporting cadence, FY23 data is the most recent data
- Typically, the target is met with the Alaska rate exceeds the U.S. National Median rate listed in the last column for FY23
    - In three instances, the question phrasing is flipped. To avoid confusion, a reminder note is in the Measure Name column, reading, *"The target is achieved when the U.S. median exceeds the Alaskan rate"*
- Resulting from the changed quality measures previously described, 14 data points have no FY23 U.S. National Median rate and have therefore been removed, as no future comparisons will be possible

Child and Health Care Quality Measures FY19 - FY23
FY23 Alaska Rates in Six Domains Compared to U.S. National Median

I) Behavioral Health Care

11 of 24 measures were achieved. 19 measures are new this year and of the measures with three or more years to compare, all demonstrated improved rates (3 of 3). 1 measure only had two years of comparison data.

Antidepressant Medication Management: Ages 18 and Older

Rate Definition	FY19	FY20	FY21	FY22	FY23	2023 U.S Median
Percentage with a diagnosis of major depression who were treated with and remained on an antidepressant medication for 12 weeks	.	.	.	.	60.9	58.7
Percentage with a diagnosis of major depression who were treated with and remained on an antidepressant medication for the continuation phase (6 months)	.	.	.	.	44.7	40.6

Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of Emergency Department (ED) visits for mental illness or intentional self-harm with a follow-up visit within 30 days of the ED visit	.	.	.	44.5	62.6	69.6
Percentage of ED visits for mental illness or intentional self-harm with a follow-up visit within 7 days of the ED visit	.	.	.	26.8	45.1	51.5

Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of ED visits for SUD or drug overdose with a follow-up visit within 30 days of the ED visit	.	.	.	.	30.9	33.7
Percentage of ED visits for SUD or drug overdose with a follow-up visit within 7 days of the ED visit	.	.	.	.	25.5	22.8

Follow-Up After Hospitalization for Mental Illness: Ages 18 and Older

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of discharges for adults hospitalized for treatment of mental illness or intentional self-harm with a follow-up visit within 30 days after discharge	.	.	.	.	62.8	53.9
Percentage of discharges for adults hospitalized for treatment of mental illness or intentional self-harm with a follow-up visit within 7 days after discharge	.	.	.	.	39.2	32.3

Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of discharges for children hospitalized for treatment of mental illness or intentional self-harm with a follow-up visit within 30 days after discharge: ages 6 – 17	34.8	43	32.5	16.8	44	72.1
Percentage of discharges for children hospitalized for treatment of mental illness or intentional self-harm with a follow-up visit within 7 days after discharge: ages 6 – 17	13.9	12.6	19.9	8	25.9	47.3
Percentage newly prescribed ADHD medication with at least one follow-up visit during the 30-day initiation phase: ages 6 – 12	.	.	.	.	50.1	46
Percentage newly prescribed ADHD medication with at least two follow-up visits in the 9-month continuation and maintenance phase: ages 6 – 12	.	.	.	.	49	54.1

Initiation and Engagement of Substance Use Disorder Treatment: Age 18 and Older

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of new episodes of alcohol use disorder (AUD) with engagement of SUD treatment within 34 days of initiation: ages 18 – 64	.	.	.	.	16.1	13.2
Percentage of new episodes of AUD with initiation of SUD treatment within 14 days: ages 18 – 64	.	.	.	.	61.3	41.3
Percentage of new episodes of OUD with engagement of SUD treatment within 34 days of initiation: ages 18 – 64	.	.	.	.	15.6	32.9
Percentage of new episodes of OUD with initiation of SUD treatment within 14 days: ages 18 – 64	.	.	.	.	56.5	60.9
Percentage of new episodes of other SUD with engagement of SUD treatment within 34 days of initiation: ages 18 – 64	.	.	.	.	12.1	12.1
Percentage of new episodes of other SUD with initiation of SUD treatment within 14 days: ages 18 – 64	.	.	.	.	50.2	41.6
Percentage of new episodes of total SUD with engagement of SUD treatment within 34 days of initiation: ages 18 – 64	.	.	.	.	14.8	15.5
Percentage of new episodes of total SUD with initiation of SUD treatment within 14 days: ages 18 – 64	.	.	.	.	57.1	57.1
Percentage with two or more antipsychotic prescriptions that had metabolic testing for blood glucose and cholesterol: ages 1 – 17	.	.	.	.	24.6	32.2
Percentage with two or more antipsychotic prescriptions that had metabolic testing for blood glucose: ages 1 – 17	.	.	.	.	44.4	53.1
Percentage with two or more antipsychotic prescriptions that had metabolic testing for cholesterol: ages 1 – 17	.	.	.	.	26.4	34.2

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 17

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment	.	54.4	52.5	52	54.8	60.5

II) Care of Acute and Chronic Conditions

2 of 5 measures were achieved. 1 measure is new this year and of the measures with three or more years to compare, only 25% demonstrated improved rates (1 of 4).

Ambulatory Care: Emergency Department Visits: Ages 0 to 19

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
ED visits per 1,000 beneficiary months*	34.1	34.5	17.6	20.5	26	36.5

**The target is achieved when the U.S. median exceeds the Alaskan rate.*

Asthma Medication Ratio: Ages 5 to 18

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater: ages 12 – 18	55	51.2	82.2	74.5	66.7	68.7
Percentage with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater: ages 5 – 11	60.4	60.4	44.6	82.1	74.7	75.9
Percentage with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater: ages 5 – 18	57.7	56	62.6	78	70.5	71.6

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of episodes for beneficiaries with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event	.	.	.	.	83.6	71.4

III) Dental and Oral Health Services

1 of 4 measures were achieved. There were no new measures this year and of the measures with three or more years to compare, none demonstrated improved rates (0 of 2). 2 measures only had two years of comparison data.

Oral Evaluation, Dental Services: Ages <1 to 20

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation	.	.	.	42.6	42.1	42.8

Sealant Receipt on Permanent First Molars: Age 10

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage who received sealants on all four permanent first molars by their 10th birthday	.	.	36.4	34.7	34	35.4
Percentage who received a sealant on at least one permanent first molar tooth by their 10th birthday	.	.	57.3	54.3	52.3	48.3

Topical Fluoride for Children: Ages 1 to 20

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of enrolled children who received at least two topical fluoride applications as dental or oral health services	.	.	.	15.3	18.7	19

IV) Experience of Care

All 6 measures were new this year and none were achieved.

CAHPS Health Plan Survey 5.1H- Child Version Including Medicaid and Children with Chronic Conditions Supplement *

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Getting Care Quickly Composite	.	.	.	.	64.1	70.9
Getting Needed Care Composite	.	.	.	.	50.1	60.5
How Well Doctors Communicate Composite	.	.	.	.	73.3	78.8
Rating of Health Care	.	.	.	.	59.6	68.2
Rating of Health Plan	.	.	.	.	61.6	71.8
Rating of Personal Doctor	.	.	.	.	74.9	75.2

**These measures are not based on claims; instead, the rate reports telephonic survey results about patient experience using 3-5 composite questions with varying weighted scores. This method has not been certified as evidence-based data. This only reports on the Medicaid data, and not the CHIP data as the measure name indicates.*

V) Maternal and Perinatal Health

5 of 9 measures were achieved. 4 measures were new this year and of the measures with three or more years to compare, only 25% demonstrated improved rates (1 of 4). 1 measure only had two years of comparison data.

Contraceptive Care- All Women Ages 15 to 20

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of all women at risk of unintended pregnancy provided a long-acting reversible method of contraception	4.8	5.2	3.8	5.1	4.2	3
Percentage of all women at risk of unintended pregnancy provided a most effective or moderately effective method of contraception	20.5	20.6	18.1	19.6	17.8	23.8

Contraceptive Care- Postpartum Women Ages 15 to 20

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of postpartum women with a live birth provided a long-acting reversible method of contraception within 3 days of delivery	.	.	.	.	5.3	2.8
Percentage of postpartum women with a live birth provided a long-acting reversible method of contraception within 90 days of delivery	.	.	.	.	17.8	18.1
Percentage of postpartum women with a live birth provided a most effective or moderately effective method of contraception within 3 days of delivery	.	.	.	.	12.5	5.9
Percentage of postpartum women with a live birth provided a most effective or moderately effective method of contraception within 90 days of delivery	.	.	.	.	41.8	45.3

Live Births Weighing Less Than 2,500 Grams

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of live births weighing less than 2,500 grams*	7	7.8	7.6	7.9	8.5	10.4

**The target is achieved when the U.S. median exceeds the Alaskan rate.*

Low-Risk Cesarean Delivery

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of nulliparous, term, singleton, in a cephalic presentation births delivered by cesarean*	.	.	16.5	18.6	15.1	24.2

**The target is achieved when the U.S. median exceeds the Alaskan rate.*

Prenatal and Postpartum Care: Timeliness of Prenatal Care

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of women delivering a live birth with a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in Medicaid or CHIP	.	.	.	32.7	71.7	80

VI) Primary Care Access and Preventive Care: None of the 14 measures were achieved though just over half of the measures with three or more years to compare demonstrated improved rates (6 of 11). There were 2 new measures this year.

Child and Adolescent Well-Care Visits: Ages 3 to 21

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage with at least 1 well-care visit with a primary care practitioner or obstetrician/gynecologist: ages 12 to 17	.	.	19.1	30	28.8	48.5
Percentage with at least 1 well-care visit with a primary care practitioner or obstetrician/gynecologist: ages 18 to 21	.	.	6.5	9.1	7.7	22.4
Percentage with at least 1 well-care visit with a primary care practitioner or obstetrician/gynecologist: ages 3 to 11	.	.	24	31.1	30.9	53.3
Percentage with at least 1 well-care visit with a primary care practitioner or obstetrician/gynecologist: ages 3 to 21	.	.	20	27.1	26.2	45.3

Chlamydia Screening in Women Ages 16 to 20

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of sexually active women screened for chlamydia	49.9	48.5	44.4	43.2	43.8	46.8

Developmental Screening in the First Three Years of Life: Ages 0 to 3

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage screened for risk of developmental, behavioral, and social delays using a standardized screening tool	3.8	5.3	4.8	3.5	4	35.7

Immunizations for Adolescents: Age 13

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage who completed the human papillomavirus (HPV) vaccine series by their 13th birthday	0.9	4	4.7	3.7	3.6	33.7
Percentage up to date on recommended immunizations (Combination 1) by their 13th birthday	.	.	.	.	11.2	76.5

Lead Screening in Children: Age 2

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage who had one or more capillary or venous lead blood test for lead poisoning by their second birthday	.	.	.	.	16.9	57
Percentage with an outpatient visit and body mass index percentile documented in the medical record: ages 3 to 17	.	18.7	19.6	5.3	6	73.5
Percentage with an outpatient visit and counseling for nutrition documented in the medical record: ages 3 to 17	.	7.2	7.3	3	3.1	63.5
Percentage with an outpatient visit and counseling for physical activity documented in the medical record: ages 3 to 17	.	14	7.2	7.7	8.2	59.9

Well-Child Visits in the First 15 Months of Life

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of children who had 6 or more well-child visits with a primary care practitioner during the first 15 months of life	69.2	65.3	68.4	30.1	29.9	59.2

Well-Child Visits in the First 30 Months of Life

Rate Definition	FY19	FY20	FY21	FY22	FY23	FY23 U.S Median
Percentage of children who had 2 or more well-child visits with a primary care practitioner during the 15th to 30th months of life	.	.	54.2	36.5	38.3	64.8

4. Recommendations for Legislative or Budgetary Changes

AS 47.05.270(d)(4) Recommendations for legislative or budgetary changes related to medical assistance reforms during the next fiscal year.

No recommended changes at this time. Potential recommendations are under evaluation.

5. Changes in Federal Laws that Impact the Budget

AS 47.05.270(d)(5) Changes in federal laws that the Department expects will result in a cost or savings to the state of more than $1,000,000.

In April 2024, CMS finalized multiple rules focusing on access to Medicaid services and care. These rules cover a wide array of topics and have compliance requirements spanning from 2024 to 2030. Final Rule changes include topics such as ensuring access to Medicaid services; streamlining enrollment and renewal processes in Medicaid and CHIP; eligibility and enrollment; minimum staffing standards for long-term care facilities and Medicaid institutional payment transparency and reporting; and interoperability and prior authorization.

Additional federal changes that may impact Medicaid budgets include:

- Consolidated Appropriations Act of 2023 requiring:
  - Provider directory changes by July 1, 2025
  - Incarcerated youth to receive additional services prior to and/or post release by January 1, 2025
- Section 504 Final Rule requiring:
  - Web accessibility standards by 2027
- Section 1557 of the Affordable Care Act requiring:
  - States/Marketplaces to reduce disparities in health care, which the Department is still assessing

Depending on the requirement and within each rule, there are multiple implementation timelines. A majority of requirements fall within the next 1-3 years. While many updates required by these federal Final Rule updates are already in place, the Department anticipates a significant amount of work necessary to come into compliance with all the rules on target will require significant staff efforts.

Anticipated costs associated with the abovementioned requirements have yet to be identified but are expected to impact the Medicaid budget.

6. Applications for Medicaid Grants, Options or Waivers

AS 47.05.270(d)(6) A description of any medical assistance grants, options, or waivers the Department applied for in the previous fiscal year.

I) Medicaid State Plan Amendments

The Department submitted eleven Medicaid State Plan Amendments (SPA) during FY24, as follows:

- 23-0009 Update effective dates of fee schedules
- 23-0010 Addition of diagnosis-related groups and a new disproportionate share hospital (DSH) category; language, grammar, and organization structure revisions

- 23-0011 Annual Aged, Disabled, and Blind Medicaid eligibility category income standards update
- 23-0012 Addition of coverage and payment for recommended non-routine vaccines by the Advisory Committee on Immunization Practices (ACIP) and their administration for adults, without cost sharing
- 23-0013 Alternative Benefit Plan: Addition of coverage and payment for recommended non-routine vaccines by the ACIP and their administration for adults, without cost sharing
- 24-0001 Extension of postpartum coverage from 60 days to 12 months and addition of an optional Medicaid eligibility category for pregnant women with income between 201-225% of the Federal Poverty Level (FPL)
- 24-0002 Addition of advanced practice dental hygienists as a Medicaid provider
- 24-0003 Alternative Benefit Plan: Addition of advanced practice dental hygienists as a Medicaid provider
- 24-0004 Add clarifying language for both the implementation process of the IHS all-inclusive rates published Federal Register and community health practitioners and community health aid levels
- 24-0004 Biannual review of the Medicaid Recovery Audit Contractor program

II) SPAs Extending PHE Flexibilities

- 24-0006 Continuation of SPA 23-0007 through June 30, 2025, to suspend Medicaid state plan behavioral health service authorizations
- 24-0007 Continuation of SPA 23-0008 through June 30, 2025, of reimbursement of temporary, interim pharmacy dispensing fee rates, with modifications

III) Additional Flexibilities

- SDS maintained Appendix K flexibilities throughout FY24 to allow for flexibility in service delivery, including the ability for legally responsible individuals to serve as paid providers under certain conditions, during the federal PHE. Many flexibilities were adopted permanently and with additional guardrails to maximize efficiencies and maintain high quality service delivery post-PHE.
- DBH waived service authorizations during the PHE using federal 1135 waiver flexibilities. The Division requested a disaster state plan amendment to suspend service authorizations for state plan services for an additional year beyond the end of the public health emergency, to May 11, 2024. This request is intended to allow the Division time to review existing service authorization regulations and consider alternative methods for ensuring proper utilization and fiscal management while reducing administrative burden to providers, ensuring Alaskans have access to the services they need.

7. Demonstration Project Results

AS 47.05.270(d)(7) The results of demonstration projects the Department has implemented.

The Department continues to implement the 1115 Behavioral Health Reform demonstration waiver required under AS 47.05.270(b) and AS 47.07.036(f). On March 26, 2023, CMS approved this waiver for an additional 5-year period, through to December 31, 2028. The extension authorizes the State to change the title of the demonstration from “Substance Use Disorder Treatment and Behavioral health Program (SUD-BHP)” to “Behavioral Health Reform.” The title change aligns mental health and SUD under a broader behavioral health definition to reflect the State’s commitment to program reform and system transformation.

Activities that occurred within DBH between July 1, 2023, and June 30, 2024, to support implementation of the 1115 Behavioral Health Reform demonstration wavier and expand behavioral health capacity include:

- Beginning in February 2024, DBH has been focused on the Behavioral Health Medicaid Claims transition from its current ASO Optum, back into MMIS within HCS. DBH and HCS have been continuously meeting to develop and implement transition activities with all vendors/parties.
- On February 2, 2024, the State finalized the regulation package for changes to 1115 Behavioral Health Reform demonstration waiver services, including the elimination of service authorization requirements for outpatient services. However, the State suspended some service authorization requirements to match the CMS approved extension of the Alaska Disaster State Plan through May 12, 2024. On July 16, 2024, CMS approved the temporary suspension of behavioral health services prior/service authorizations effective May 13, 2024 - June 30, 2025.
- Initiated a regulations package to revise the Medicaid coverage and payment for 1115 Behavioral Health Reform demonstration waiver services through a proposed 4.5% increase to existing service reimbursement.
- Published an RFP for a Behavioral Health Provider Support Organization (BHPSO) that is intended to result in a contract for an organization with demonstrated specialized expertise in the behavioral health Medicaid system to partner in fully implementing and realizing the services available under the 1115 Behavioral Health Reform demonstration waiver.
- Provided trainings, technical assistance teleconferences, and email notices with information related to provider enrollment and billing for services under the 1115 Behavioral Health Reform demonstration waiver.
- Provided on-site technical assistance in conjunction with HCS to providers interested in expanding services within existing facilities and designing future crisis-specific facilities.

For the 1115 Behavioral Health Reform demonstration waiver, the Department submits annual and quarterly monitoring reports containing 25 required monitoring metrics that track progress towards the six domain milestones identified by CMS that indicate program success. Included in the waiver evaluation design, DBH identified a desired direction for each metric to increase or decrease and an overall demonstration target percentage of change to indicate that the waiver has measurable success.

In partial fulfillment of the 1115 Behavioral Health Reform demonstration waiver requirements, DBH contracted with the Health Services Advisory Group (HSAG) to perform an independent evaluation[vi] of the implementation and ongoing activities of the waiver. According to the Interim Evaluation analysis provided by HSAG, metrics observed during the first three years of the demonstration waiver, the reporting period January 2019-December 2021, generated mixed results in terms of success, as described below. A summative evaluation report by HSAG will include an analysis of the full five-year demonstration period and is currently underway and due to CMS in September 2025.

The 1115 Behavioral Health Reform demonstration waiver was designed to support the following goals:

- Rebalance the current behavioral health system of care to reduce Alaska's over-reliance on acute, institutional care and shift to more community- or regionally based care
- Intervene as early as possible in the lives of Alaskans to address behavioral health symptoms before

symptoms cascade into functional impairments

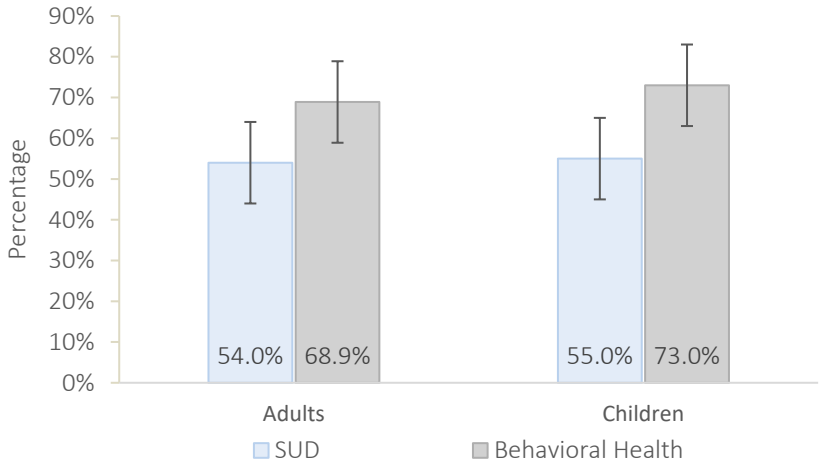
- Improve the overall behavioral health system accountability by reforming the existing system of care

Some notable successes identified during the Interim Evaluation report include a doubling of reported SUD and behavioral health Medicaid provider enrollments, reductions in emergency department visits specifically for OUD and timelier initiation of treatment for SUD. This last success is still largely attributed to the to the authority granted to Alaska under the 1115 Behavioral Health Reform demonstration waiver that removed the 16-bed federal restriction for SUD residential facilities billing Medicaid, thereby increasing beneficiary access to critical SUD treatment services and providing a measure of sustainability to provider operations by cost-shifting away from grant funding to a Medicaid reimbursement strategy.

Challenges identified include notable reductions in the percentage of beneficiaries screened for SUD and behavioral health disorders and related comorbidities, lower rates of follow-up after discharge from an emergency department visit for SUD or behavioral health disorder, and higher rates of statewide (including non-Medicaid) overdose deaths, including those from opioids. The observed increase in Alaska's overdose mortality was a trend observed nation-wide during the COVID-19 pandemic, where studies have suggested a correlation with suppressed service availability resulting from pandemic transmission mitigation efforts and workforce shortages, as well as the emergence of lethal fentanyl substance misuse, with a disproportionate impact for those living in rural areas. In Alaska, although emergency regulations were created to expand telehealth service availability across the behavioral health continuum, many providers experienced initial difficulty transitioning to a distance delivery model of care. In addition to the Medicaid program, DBH continues to support prevention and early intervention efforts through a series of federal and state grant funded awards in collaboration with our DPH to integrate efforts to address the statewide need for mental health and substance abuse supports.

HSAG also conducted beneficiary surveys as part of the Interim Evaluation. Key findings are presented below, with a focus on measuring the percentage of Medicaid beneficiaries who demonstrate knowledge of available SUD and behavioral health treatment services through a custom-designed survey instrument. The first component of this measure assesses the percentage of beneficiaries who responded that they knew where to find SUD or behavioral health treatment services. The table below shows that over half of adults (54%) reported that they knew where to find treatment for substance abuse if needed, while over two-thirds (68.9%) reported that they knew where to find treatment for behavioral health disorders if needed. This relationship was similar among children, where 55% of respondents indicated that they knew where to find treatment for SUD while 73% knew where to find treatment for a behavioral health disorder for their child.

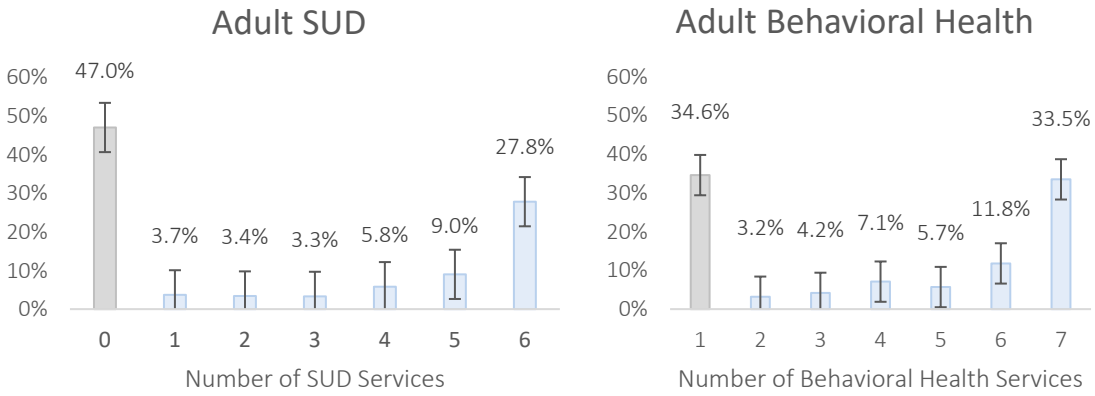
Percentage of Beneficiaries Who Know Where to find SUD/Behavioral Health Treatment If Needed



Note: Error bars show 95% confidence intervals.

The next table below shows that 42.6% of adult respondents indicated they knew where to receive four or more different types of treatment for SUD, with just over a quarter (27.8%) indicating they knew where to receive all six different types of treatment mentioned in the survey. Over half of adult respondents (51%) indicated they knew where to receive four or more different types of behavioral health treatment, with one-third indicating they knew where to receive all six types of behavioral health treatment mentioned.

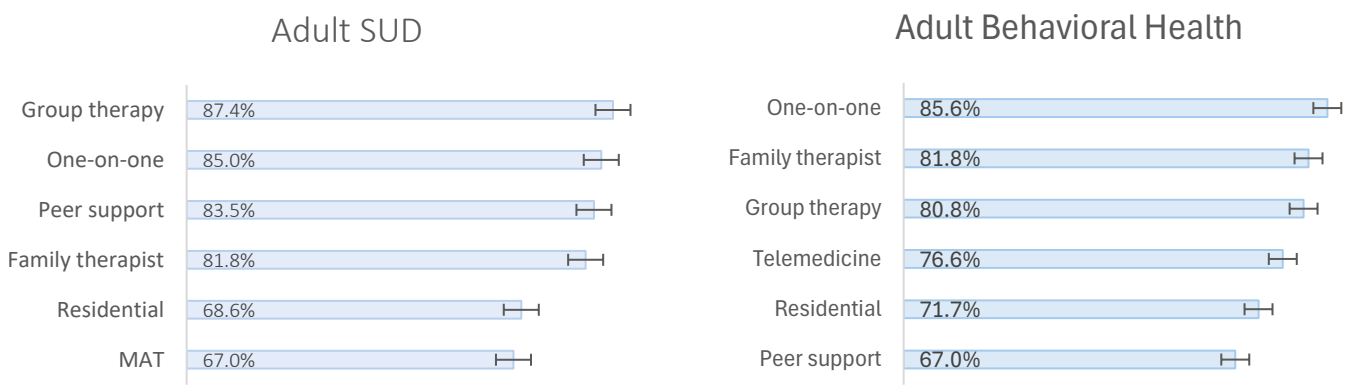
Percentage of Beneficiaries Who Are Knowledgeable of the Number of SUD and Behavioral Health Services Available for Adults



Note: Error bars show 95% confidence intervals.

The following table shows that among those who indicated they knew where to find treatment, group therapy, and one-on-one treatment were the most commonly identified settings for both SUD and behavioral health treatment. The fewest adult respondents knew where to find treatment through MAT and peer support settings for SUD and behavioral health, respectively.

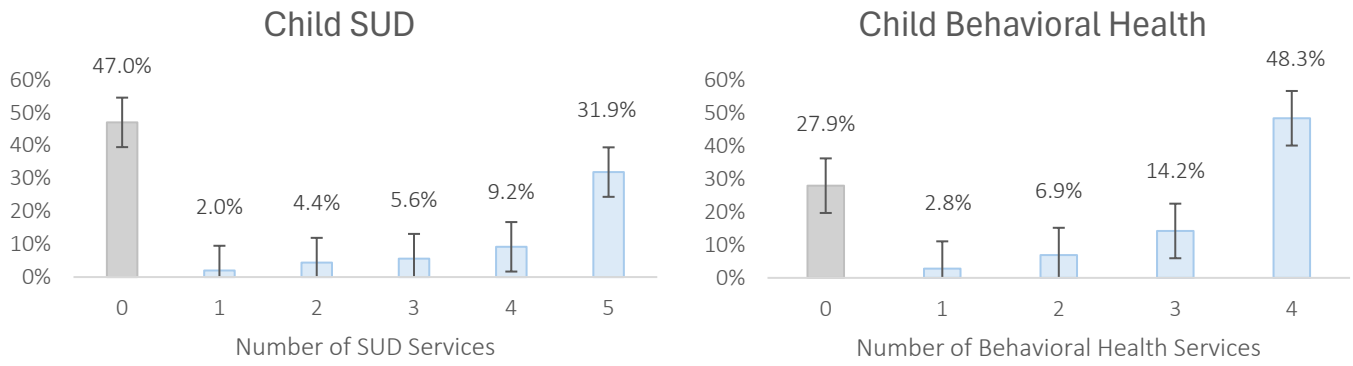
Beneficiary of Knowledge of Setting Type-Adults



Note: Error bars show 95% confidence intervals.

The next table shows that among services for children, nearly one-third (31.9%) of beneficiaries indicated they knew where to receive all five different types of SUD treatment, and nearly half (48.3%) indicated they knew where to receive all four types of treatment for behavioral health mentioned in the survey.

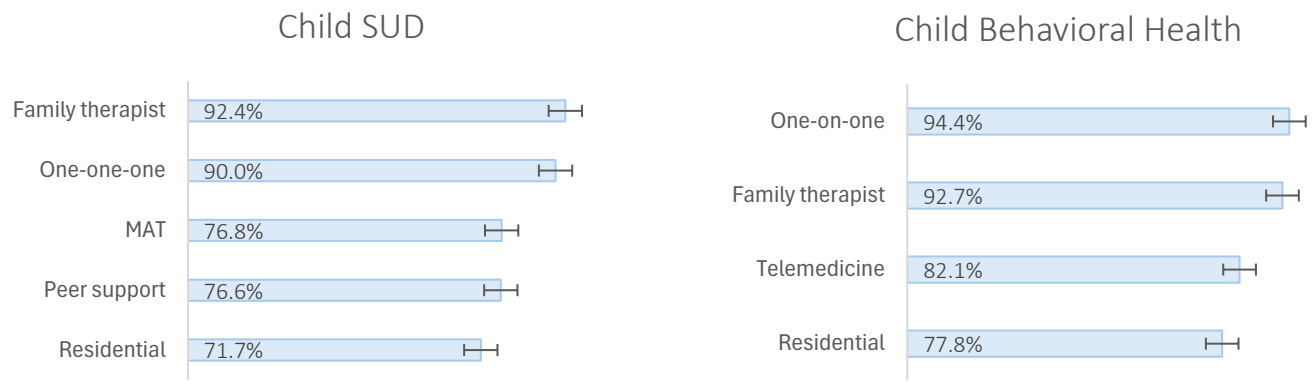
Percentage of Beneficiaries Who Are Knowledgeable of the Number of SUD and Behavioral Health Services Available for Children



Note: Error bars show 95% confidence intervals.

This next table shows that, among those who knew where to receive SUD or behavioral health treatment, over 9 in 10 respondents knew where to receive family therapy or one-on-one treatment, while more than 7 in 10 knew where to receive residential treatment.

Beneficiary Knowledge of Setting Type-Children



Note: Error bars show 95% confidence intervals.

These results indicate that beneficiaries demonstrated a high level of knowledge of treatment for SUD and behavioral health disorders, although there is still room to improve beneficiary knowledge of treatment, particularly for SUD. Just over half of beneficiaries indicated they knew where to receive SUD treatment (for both adults and children), while over two-thirds knew where to receive behavioral health treatment. Among those who did know where to receive treatment, over two-thirds of beneficiaries had knowledge of every treatment setting, and over 70% of beneficiaries has knowledge of every child treatment setting.

8. Telehealth Barriers, Improvements, and Recommendations

AS 47.05.270(d)(8) Legal and technological barriers to the expanded use of telehealth, improvements in the use of telehealth in the state, and recommendations for changes or investments that would allow cost-effective expansion of telehealth.

In September 2023, Medicaid permanently expanded telehealth services to provide safe treatment options for members and providers. Changes include:

- Not restricting patient and provider location
- Expanding coverage to include telephone and online digital check-ins
- Removing the requirement for an in-person initial visit
- Covering physician visits in skilled nursing facilities via telehealth
- Hospital initial, subsequent, observation, and discharge evaluations provided via telehealth
- Allowing Physical Therapy, Occupational Therapy, and Speech Language Pathology services via live interactive modalities
- Adding Direct Entry Midwives, Vision, and End-Stage Renal Disease services to telehealth
- Expanding telehealth options for FQHCs
- Alternate modalities of service delivery such audio only visits and patient-initiated digital services

The goals of this expansion are to:

- Improve access to care for disabled or homebound recipients
- Ensure medical providers can maintain a safe distance while still providing patients with needed care

- Increased participation in SUD treatment services in remote areas
- 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
- Allow for patients with contagious illnesses to remain in isolation and prevent the spread of the disease while still receiving care

SDS conducts assessments to determine eligibility for HCBS, CFC services, and personal care services. Prior to the pandemic, 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, SDS updated regulations and has been integrating telehealth assessments into the assessment workflow for the past few years.

The PHE accelerated the use of telehealth assessments at the SDS. Under the authority of Appendix K and Section 1135 allowances, flexibilities were adopted that allow for telehealth assessments and distance delivery of some services. SDS operated under the Appendix K authority throughout FY24 and adopted changes to allow the use of telehealth and distance delivery to continue after Appendix K ended on June 30, 2024. While most initial assessments will return to an in-person assessment post-PHE, the ability to utilize telehealth to conduct assessments will continue beyond FY24. This is particularly advantageous for applicants and recipients in rural communities where travel may present a barrier. The ability to conduct assessments using secure platforms allows for assessments to be completed timely where in the past weather delays may have impeded the ability to get to a community for an assessment.

An RPM medical care advisory committee work group was formed to evaluate various uses of RPM to address certain healthcare conditions. 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.

Recommendations from the committee and the Medicaid Task Force Telehealth Workgroup, a state and Tribal collaborative, will continue to 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.

9. Medicaid Travel Costs

AS 47.05.270(d)(9) The percentage decrease in costs of travel for medical assistance recipients compared to the previous fiscal year.

The Alaska Medicaid transportation program saw a 32% decrease in GF spending from FY23 to FY24. The significant increase in FY23 was largely due to expenditures returning to pre-pandemic levels and FY24 expenditure is within the average annual spending. Also, in FY23, the SEMT program was fully implemented, which is federally funded and contributed greatly to the total increase in transportation for the time period.

10. Emergency Department Frequent Utilizers

AS 47.05.270(d)(10) The percentage decrease in the number of medical assistance recipients identified as frequent users of emergency departments compared to the previous fiscal year.

The following table depicts the number of frequent users of emergency departments in FY24. 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 FY22 and continued this effort through FY24.

Number of Medicaid Recipients Identified as Frequent Emergency Department Users Comparison: FY24 to FY23

FY23	FY24	Percent Change
7,750	7,365	-4.96%

11. Hospital Readmissions

AS 47.05.270(d)(11) The percentage increase or decrease in the number of hospital readmissions within 30 days after a hospital stay for medical assistance recipients compared to the previous fiscal year.

Readmission data was collected using Java Surveillance and Utilization Review Subsystem (JSURS). JSURS is a healthcare data profiling application that is the basis for Alaska's Fraud, Waste, and Abuse effort. State Medicaid Agencies (SMA) are required by 42 CFR § 456 to have an analytics tool to profile provider and patient populations to perform statistical analysis and peer group comparison against distinct populations. The following table depicts the number of hospitalized Medicaid recipients who were readmitted to the hospital within 30 days of discharge. Readmissions are counted for the 2-30-day period following a hospital stay to omit hospital-to-hospital transfers that are captured as one-day readmissions.

In FY24, there was an increase of those who had hospitalization and subsequent readmission in comparison to FY23.

Number of Hospital Readmissions (2 - 30 Days Following Discharge) Comparison: FY24 to FY23

FY23	FY24	Percent Change
1,165	1,256	+7.81%

FY24 Top ICD-10 Diagnoses Classifications for Hospital Readmissions of all Medicaid Recipients

Diagnosis	Number of Claims
Behavioral Health Condition	993
Digestive System Diseases	336
Pregnancy, Childbirth, Puerperium and Perinatal	218
Respiratory Disease	794
Circulatory System Diseases	1010
Metabolic and Renal Diseases	1193
Certain Infectious and Parasitic Diseases	1945

12. State General Fund Spending per Recipient

AS 47.05.270(d)(12) The percentage increase or decrease in GF spending for the average medical assistance recipient compared to the previous fiscal year.

The table below shows how the GF spending for the average medical assistance recipient increased by 16% in FY24 compared to FY23.

Medicaid Average Medical Assistance Expendature Comparison: FY24 to FY23

Type of Expendature	FY23	FY24	Percent Change
Recipients	213,900	210,100	-1.8%
GF Spend	$617,926,700	$703,755,200	14%
Spend Per Recipient	$2,889	$3,350	16%

Two major changes in FY24 drove this increase per receipt spend.

- **FMAP Step Down:** As is mentioned elsewhere in this report, the temporary COVID enhanced FMAP step down from 6.2% to 0% (56.2% to 50%) between FY23 and FY24, significantly impacted major GF spending categories.
- **Rate increases for Medical Claims:** Several new and recurring rate increases, largely reflecting the effects of inflation, occurred in FY24 affecting the GF as required by state and federal regulations for waivers and medical services.

13. Uncompensated Care Costs

AS 47.05.270(d)(13) The percentage increase or decrease in uncompensated care costs incurred by medical assistance providers compared to the percentage change in private health insurance premiums for individual and small group health insurance.

I) Alaska Hospital Uncompensated Care Costs, FY12-FY22

The following are the FY12 – FY22 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 2022) provided to the Department by AHHA.

Due to differences in hospital fiscal years, the data may represent different periods. For example, 2022 includes data from 7/1/2022- 6/30/23 for those on state fiscal year whereas data from 10/1/22 – 9/30/23 capture federal fiscal year data.

Nevertheless, including this year's growth, the percent of change since Medicaid Expansion (from 2014-2022) is -50%, down from last year's percent change of-58%.

Year-Over-Year Uncompensated Care Costs Comparison: FY12 - FY22

Year	Uncompensated Care Costs	% Change from previous year
FY12	$90,813,400	NA
FY13	$95,402,100	5%
FY14	$112,930,300	18%
FY15	$95,261,100	-16%
FY16	$73,066,400	-23%
FY17	$60,091,400	-18%
FY18	$52,038,000	-13%
FY19	$52,493,000	1%
FY20	$51,514,400	-2%
FY21	$47,048,200	-9%
FY22	$56,825,600	21%

Source: AHHA, October 2024. S-10 worksheet line 30 (cost of non-Medicare bad debt + charity care to uninsured patients), includes cost report data submitted through facility FY22.

II) Health Insurance Premiums

The following information is provided by DCCED, Division of Insurance (obtained from the annual health survey summary pages).

Change in Alaska Health Insurance Premiums Comparisons: CY14 - CY23

Calendar Year/Market	Member Months	Total Direct Premiums Paid	Premium Per Member Per Month (PMPM)	PMPM Increase From Previous Year
CY14				
Individual Market	266,002	$117,103,500	$440	
Small Group Market	205,017	$123,538,400	$603	
CY15				
Individual Market	326,711	$200,892,200	$615	40%
Small Group Market	208,435	$133,752,600	$642	6%
CY16				
Individual Market	256,629	$215,793,800	$841	37%
Small Group Market	202,711	$134,307,200	$663	3%
CY17				
Individual Market	221,398	$208,007,000	$940	12%
Small Group Market	195,703	$138,549,000	$708	7%
CY18				
Individual Market	228,360	$177,027,000	$775	-17%
Small Group Market	177,154	$139,226,100	$786	11%

Calendar Year/Market	Member Months	Total Direct Premiums Paid	Premium Per Member Per Month (PMPM)	PMPM Increase From Previous Year
CY19				
Individual Market	217,716	$155,611,700	$715	-8%
Small Group Market	170,315	$148,505,400	$872	11%
CY20				
Individual Market	218,182	$159,716,100	$732	2%
Small Group Market	179,110	$154,819,800	$864	-1%
CY21				
Individual Market	238,522	$166,975,200	$700	-4%
Small Group Market	167,561	$146,666,000	$875	1%
CY22				
Individual Market	274,497	$209,872,400	$765	9%
Small Group Market	165,319	$142,948,500	$865	-1%
CY23				
Individual Market	282,492	$245,136,400	$868	14%
Small Group Market	147,366	$134,554,000	$913	6%

14. Optional Services

AS 47.05.270(d)(14) The cost, in state and federal funds, for providing optional services under AS 47.07.030(b).

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 MAT for OUD, became mandatory. Today, most of the "optional" services are mandatory for all populations under the ACA. In Alaska, some optional services are included in the 1115 Behavioral Health Reform demonstration 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 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 Medicaid state plan. 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. While it is technically possible to create and administer separate benefit plans, it would be administratively cumbersome, costly, and might not provide savings.

The top three cost drivers within the Medicaid optional services, are as listed, followed in parentheses by the approximate percentage of GF spending this optional service accounts for:

1) Prescription drugs (43%)
2) Personal care services (19%)
3) Behavioral health services (9%)

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 20% of GF 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.

FY24 Optional Services Expenditures by Service Category and by Funding Source

Waiver or Optional Service FY24	State Spending	Federal Spending	Total Spending
Waiver Services			
1115 Behavioral Health Waiver (Mental Health)	$30,147,000	$74,206,300	$104,353,300
1115 Behavioral Health Waiver (SUD)	$11,471,500	$81,546,300	$93,017,800
Adult Day Care	$2,618,100	$7,543,400	$10,161,500
Care Coordination	$9,544,800	$14,568,400	$24,113,200
Chore Services	$319,900	$455,300	$775,200
Day Habilitation	$17,819,800	$26,978,900	$44,798,700
Environmental Modifications	$115,800	$120,200	$236,000
Intensive Active Treatment/Therapy	$387,400	$736,200	$1,123,600
Meals	$2,232,100	$3,639,200	$5,871,300
Residential Habilitation	$73,175,100	$122,743,400	$195,918,500
Residential Supported Living	$30,106,700	$52,241,700	$82,348,400
Respite Care	$6,853,700	$8,894,800	$15,748,500
Specialized Equipment and Supplies	$58,300	$85,000	$143,300
Specialized Private Duty Nursing	$801,400	$842,200	$1,643,600
Supported Employment	$3,451,700	$4,489,500	$7,941,200
Transportation	$1,142,700	$2,336,000	$3,478,700
Total Waiver Services	**$190,246,000**	**$401,426,800**	**$591,672,800**

Waiver or Optional Service FY24	State Spending	Federal Spending	Total Spending
Optional Services			
Case Management Services	$0	$0	$0
Chiropractic Services	$24,500	$27,600	$52,100
Dental Services	$7,973,900	$30,971,300	$38,945,200
Drug Abuse Center	$3,380,400	$35,868,900	$39,249,300
Durable Medical Equipment/Medical Supplies	$2,435,900	$4,762,800	$7,198,700
End Stage Renal Disease Services	$1,726,600	$2,758,000	$4,484,600
Hearing Services	$1,073,200	$1,932,200	$3,005,400
Hospice Care	$1,632,300	$2,071,500	$3,703,800
Inpatient Psych Service	$48,780	$594,900	$643,680
Intensive Care Facility/Intellectually Disabled Service	$682,100	$712,500	$1,394,600
Medical Supplies Service	$3,060,000	$5,622,600	$8,682,600
Mental Health Service	$8,624,400	$54,326,900	$62,951,300
Nutrition Services	$600	$900	$1,500
Occupational Therapy	$224,500	$508,500	$733,000
Personal Care Services	$17,519,000	$23,629,300	$41,148,300
Podiatry	$43,500	$63,400	$106,900
Prescribed Drugs	$40,336,800	$151,552,400	$191,889,200
Prosthetics & Orthotics	$418,100	$955,200	$1,373,300
Psychology Services	$204,200	$521,200	$725,400
Rehabilitative Services	$2,387,010	$5,768,100	$8,155,110
Vision Services	$1,867,800	$4,012,200	$5,880,000
Total Optional Services	**$93,663,590**	**$326,660,400**	**$420,323,990**
Grand Total	**$283,909,590**	**$728,087,200**	**$1,011,996,790**

Source: Data is for claims with a paid date within the FY24. The source for claims processed by DBH'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.

15. Tribal Medicaid Reimbursement Policy Savings

AS 47.05.270(d)(15) The amount of state funds saved as a result of implementing changes in federal policy authorizing 100% federal funding for services provided to American Indian and Alaska Native individuals eligible for Medicaid, and the estimated savings in state funds that could have been achieved if the Department had fully implemented the changes in policy.

On February 26, 2016, 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 IHS, including THOs.

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. HCS continues to work with 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 8,159 CCAs in place between 18 THOs and 623 non-Tribal providers. Note that some, but not all, of the THOs have signed an agreement with each of the 623 non-Tribal providers. The Department was able to save $138.4M in GF in FY24 and a total of $638.3M in GFs from the start of the SHO letter through the end of FY24. 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.

GF Savings from Implementation of the Tribal Medicaid Reimbursement Policy: FY17 - FY24

Year	GF Savings (Transportation)	GF Savings (Other Services)	GF Savings TOTAL
FY17	$10,589,500	$24,192,300	$34,781,800
FY18	$15,902,000	$29,285,000	$45,187,000
FY19	$26,922,900	$42,423,300	$69,346,200
FY20	$35,999,000	$58,112,300	$94,111,300
FY21	$15,533,000	$41,935,000	$57,468,000
FY22	$16,303,000	$58,109,400	$74,412,400
FY23	$27,617,000	$96,934,800	$124,551,800
FY24	$40,436,700	$98,031,600	$138,468,300
TOTAL	**$189,303,100**	**$449,023,700**	**$638,326,800**

As part of the reclaiming process, the Tribal Health Section within HCS tracks the care coordination agreements and partners with THOs to verify referrals and exchange of health records to ensure the state can claim 100% federal funding. HCS has verified 266,201 referrals since the new policy was implemented; 55,946 or 21% were sufficiently documented. The Department continues to partner with THOs to identify ways to increase the percentage of verified referrals.

Verified/Unverified Referrals by Fiscal Year Comparison: FY17 – FY23

Year	Total # Referrals Requested	Total # Verified Referrals	Total # Unverified Referrals	Average % Verified Referrals	Average % Unverified Referrals
FY17	4,142	1,090	3,052	26%	74%
FY18	16,337	3,475	12,872	21%	79%
FY19	26,652	5,896	20,773	22%	78%
FY20	37,372	6,317	31,055	17%	83%
FY21	38,698	7,425	31,273	19%	81%
FY22	45,458	10,035	35,423	22%	78%

Year	Total # Referrals Requested	Total # Verified Referrals	Total # Unverified Referrals	Average % Verified Referrals	Average % Unverified Referrals
FY23	48,571	11,006	37,565	23%	77%
FY24	48,971	10,702	38,269	22%	78%
TOTAL	266,201	55,946	210,282	21%	79%

[i] As defined in *AS 47.05.270*(e) "In this section, 'telehealth' means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other or between a provider and a recipient who are physically separated from each other."

[ii] https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Fee_Schedules/Fees_Telehealth_FY2411.pdf

[iii] https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Provider_Forms/Request_for_New_Consideration_of_Medical_and_Dental_Services_Coverage.pdf

[iv] https://waportal.org/resources/uw-medicine-pain-and-opioid-consult-hotline-clinicians

[v] DBH Research and Systems synopsis of the Interim Evaluation report by DBH's 1115 Independent Evaluator, Health Services Advisory Group (HSAG); Accepted by CMS 9/27/2023; Available online: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ak-behavioral-health-sud-interim-evaluton-rpt-09272023.pdf

[vi] DBH Research and Systems synopsis of the Interim Evaluation report by DBH's 1115 Independent Evaluator, Health Services Advisory Group (HSAG); Accepted by CMS 9/27/2023; Available online: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ak-behavioral-health-sud-interim-evaluton-rpt-09272023.pdf.