

# Alaska Medicaid 2015 Annual Report



*Prepared By  
Division of Health Care Services  
January 2016*

Note to readers:

Data reporting sources for this document include the Division of Finance's, Alaska Data Enterprise Reporting (ALDER) data warehouse, and Cognos, the Alaska Medicaid Health Enterprise information system data repository. All data is reported based on the date of payment as opposed to date of service.

All versions distributed without a date present on this page or prior to this date should be discarded. January 28, 2016. Thank you.

Dear Reader,

It is my privilege to present to you the Alaska Medicaid Annual Report for state fiscal year 2015.

In the first of this two-part report you will find a brief overview of Medicaid's history, an outline of the program, the roles of each involved entity, and information about the complexities, challenges, and accomplishments of the program. The second part of this report provides you with a financial summary of the program, including expenditures and enrollment data.

This year has been both exciting and challenging for the program and its dedicated staff. While much has been accomplished, we are steadfast in our efforts to continue improving program efficacies and efficiencies, while remaining committed to our fundamental mission of providing quality and affordable health coverage to Alaskans in need.

I thank you for your continued support of this essential program and I welcome your questions and comments.

Sincerely,

A handwritten signature in blue ink, appearing to read "Margaret C. Brodie".

Margaret C. Brodie  
Director

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## History of Medicaid

Medicaid is a jointly funded (federal and state) health insurance program for low-income individuals. Medicaid provides coverage for pregnant women, children, families, adults with no children, and the elderly, blind, or disabled. Although primary oversight of the program is federal, each state may, within federal guidelines and approval establish its own eligibility standards, determine the type, amount, duration, and scope of services, and set payment rates.

### Medicaid Milestones: 1965 - 2014

1965: President Lyndon B. Johnson signs Medicaid into law as an amendment to the Social Security Act

1967: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program is established

1972: The Supplemental Security Income (SSI) program is created, providing income and Medicaid eligibility to very low income individuals who are age 65 or older, blind, or disabled

1972: Alaska joins the Medicaid program

1977: The Health Care Financing Administration (HCFA) is established to combine federal oversight of the Medicaid and Medicare programs

1981: Freedom of choice and home and community-based waivers (HCB) is federally mandated

States are federally mandated to make Disproportionate Share Hospital payments to hospitals that serve large numbers of Medicaid and uninsured individuals

1982: The Medicaid program becomes available in all 50 states as Arizona joins the program

Tax Equity and Fiscal Responsibility Act (TEFRA) Medicaid, known also as Deeming Waiver or Katie Beckett Medicaid, is established for children with physical and/or developmental disabilities who would otherwise be ineligible because of family income

1986: Medicaid coverage for pregnant women and infants is established as a state option for those whose incomes are below 100 percent of the federal poverty level (FPL)

1988: Medicaid income and resource provisions are enacted to prevent leaving an individual impoverished when his/her spouse enters long-term care

1990: The Medicaid prescription drug rebate program is enacted

1996: The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), also known as Welfare Reform, was signed into law. The act delinked Medicaid from cash assistance, eliminating the loss of health insurance as a barrier to employment.

The Health Insurance Portability and Accountability Act (HIPAA) establishes national standards to protect the confidentiality of medical records and other personal health information; protects health insurance coverage when an individual loses or changes employment; specifies electronic standards for the transmission of health information; and requires unique identifiers for providers.

1997: The State Children's Health Insurance Program (SCHIP), now known as the Children's Health Insurance Program (CHIP) is signed into law.

1999: Under the Ticket to Work and Work Incentives Improvements Act, Medicaid eligibility is expanded to certain disabled individuals who are not eligible for Medicaid because of earned income but who may qualify by paying a monthly premium.

Alaska implements SCHIP under the name Denali KidCare (DKC).

2001: HCFA is renamed Centers for Medicare and Medicaid Services (CMS).

2009: The American Recovery and Reinvestment Act requires all public and private health care providers and other eligible professionals to adopt the use of electronic medical records in order to maintain existing Medicare and Medicaid reimbursement levels.

Children's Health Insurance Program Reauthorization Act is enacted, providing states with significant new funding, program options and incentives.

2010: The Patient Protection and Affordable Care Act (ACA) is signed into law by President Barack Obama. The ACA, in part, allows states to expand Medicaid program to include low-income (below 133 percent of the FPL – 138 percent with a 5 percent disregard) adults ages 19-64.

2013: The Federal Facilitated Marketplace opens, enrolling individuals for coverage beginning 2014.

2014: Modified adjusted gross income (MAGI) replaces prior formulas for determining income eligibility and asset tests are eliminated for all categories of Medicaid except those for old age assistance and others based on disability.

## Medicaid: 2015

### Medicaid's 50th Anniversary

The first of two major milestones during 2015, the 50th anniversary of the establishment of the Medicaid program was celebrated on July 30th. President Obama marked the occasion by advocating for further expansion and improvements in health care. His remarks include:

*"For too many, quality, affordable health care is still out of reach -- and we must recommit to finishing this important task."*

*"Since the Affordable Care Act became law, health care prices have risen at the lowest rate since Medicare and Medicaid were established."*

*“...in America, health care is a right and not a privilege.”*

*“Five decades from now, when people look back on this time, let it be said that our generation put its shoulder to the wheel and carried forward the work of making affordable health care a reality for all Americans.”*

### **Alaska Expands Medicaid under the Affordable Care Act**

The second major milestone of 2015 occurred on September 1 when Alaska became the 30<sup>th</sup> state to expand its Medicaid program to include low-income (below 133 percent of the FPL – 138 percent with a 5 percent disregard) adults ages 19-64 who are not otherwise eligible for Medicaid or Medicare

# Legal Authority

## Federal

### Social Security Act

Title XIX of the Social Security Act established the Medicaid program to provide medical and health related services to low income individuals.

Title XXI of the Social Security Act established the State Children's Health Insurance Program (SCHIP), now known as CHIP.

[https://www.ssa.gov/OP\\_Home/ssact/ssact-toc.htm](https://www.ssa.gov/OP_Home/ssact/ssact-toc.htm)

### Code of Federal Regulations

Medicaid federal rules, published in the Federal Register, are codified in Title 42, Chapter 4, Parts 400 – 413 and 430 – 699 of the Code of Federal Regulations (CFR).

<http://www.ecfr.gov>

### Medicaid State Plan

42 CFR 430.12 requires that each state maintain a Centers for Medicare and Medicaid Services (CMS) approved Medicaid State Plan. The Medicaid State Plan is an agreement between the State of Alaska and the Federal Government describing how the state will administer the program. The plan identifies groups of individuals to be covered, covered services, reimbursement methodologies, and other administrative activities of the state. State Plan amendments must be approved by CMS.

<http://dhss.alaska.gov/Commissioner/Pages/MedicaidStatePlan/default.aspx>

## State

### Alaska Statutes

State Medicaid rules are codified in Alaska Statute (AS) as follows:

Chapter AS 47.07 Medical Assistance for Needy Persons

Chapter AS 47.08 Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions

<http://www.legis.state.ak.us/basis/statutes.asp>

### Alaska Administrative Code

State Medicaid rules are adopted under the following chapters of the Alaska Administrative Code (AAC):

Medicaid Assistance Eligibility (7 AAC 100)

Medicaid Coverage and Payment (7 AAC 105 – 7 AAC 160)

<http://www.legis.state.ak.us/basis/aac.asp>

**Medicaid Provider Billing Manuals**

<http://manuals.medicaidalaska.com/>

**Medicaid Eligibility Policy Manuals**

<http://dhss.alaska.gov/dpa/Pages/features/org/manuals.aspx>

## Medicaid Federal Requirements and State Options

States receive federal matching dollars for allowable state Medicaid spending to establish and administer their own Medicaid programs within federal guidelines. CMS has determined what services each state must provide, and the ACA mandated a list of Essential Health Benefits (EHB).

To compare the state's Medicaid package coverage to the EHB, the state must verify the state plan against the state benchmark plan. Alaska's elected benchmark plan is Premera Blue Cross Blue Shield of Alaska. Using the benchmark plan as the mechanism for aligning Alaska's Medicaid state plan with EHBs, the state is required to demonstrate an actuarial equivalent in the aggregate within each EHB category.

States, including Alaska, offer certain benefits because they have been identified as cost saving measures. Further, while some benefits may be considered optional under federal Medicaid rules, the benefits are currently required by Alaska state statute. Mandatory and optional benefits are identified in AS 47.07.030.

Certain benefits are subject to (Early and Periodic Screening, Diagnostic and Treatment) EPSDT rules which state, "*Any Medicaid eligible child under 21 years of age, pursuant to 1905(r)(5) of the Social Security Act has access to necessary health care, diagnostic services, treatment and other measure described in 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not such services are covered under the state plan.*"

Some benefits are specific to eligibility categories. For example, chiropractic services are available only to children under the age of 21 as required by EPSDT rules, and environmental modifications such as bathroom modifications and stair lifts are available only to people with disabilities that qualify for those services by demonstrating that they meet level of care.

The following tables identify mandatory versus optional services, including the authority for the provision of each service, and the EHB and the Medicaid State Plan services used to meet the EHB requirements.

## Mandatory vs Optional Benefits

Medicaid State Plan Mandatory vs Optional Benefits		
Benefit	Category	Citations (Social Security Act and 42 CFR)
Inpatient Hospital Services	Mandatory	1905(a)(1), 440.10, 440.189(g)
Outpatient Hospital Services	Mandatory	1905(a)(2)(A), 440.20(a)
Rural Health Clinics	Mandatory	1905(a)(2)(B), 440.20(b) and (c), 1910(a)
Federally Qualified Health Centers	Mandatory	1905(a)(2)(C)
Other Laboratory and X-Ray Services	Mandatory	1905(a)(3), 440.30
Nursing Facility Services for Individuals Age 21 and Older	Mandatory	1905(a)(4)(A), 440.40(a)
Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	Mandatory	1905(a)(4)(B), 1902(a)(43), 1905(r)
Family Planning Services and Supports	Mandatory	1905(a)(4)(c ), 441 Subpart F
Cessation of Tobacco Use by Pregnant Women	Mandatory	1905(a)(4)(D)
Physicians' Services	Mandatory	1905(a)(5)(A), 440.50(a)
Medical and Surgical Services Furnished by a Dentist	Mandatory	1905(a)(5)(B), 440.50(b)
Nurse Midwife Services	Mandatory, if such services are permitted by state law	1905(a)(17), 440.165
Certified Pediatric or Family Nurse Practitioners' Services	Mandatory, if such services are permitted by state law	1905(a)(21), 440.166
Free Standing Birth Center Services	Mandatory	1905(a)(28)
Home Health Services - Intermittent and Part-time Nursing Services	Mandatory for individuals entitled to nursing facility services, Optional for others	1905(a)(7), 440.70(b)(1), 441.15
Home Health Services - Home Health Aide Services	Mandatory for individuals entitled to nursing facility services, Optional for others	1905(a)(7), 440.70(b)(2), 441.15
Home Health Services - Medical Supplies, Equipment and Appliances	Mandatory for individuals entitled to nursing facility services, Optional for others	1905(a)(7), 440.70(b)(3), 441.15
Other License Practitioners - Podiatrists' Services	Optional	1905(a)(6), 440.60
Other Licensed Practitioners - Optometrists' Services	Optional	1905(a)(6), 440.60
Other Licensed Practitioners - Chiropractors' Services	Optional	1905(a)(6), 440.60
Other Licensed Practitioners - Other Practitioners' Services	Optional	1905(a)(6), 440.60
Home Health Services - Physical Therapy	Optional	1905(a)(7), 440.70(b)(4), 441.15
Home Health Services - Occupational Therapy	Optional	1905(a)(7), 440.70(b)(4), 441.15
Home Health Services - Speech Pathology	Optional	1905(a)(7), 440.70(b)(4), 441.15
Home Health Services - Audiology	Optional	1905(a)(7), 440.70(b)(4), 441.15
Private Duty Nursing Services	Optional	1905(a)(8), 440.80
Clinic Services	Optional	1905(a)(9), 440.90
Dental Services	Optional	1905(a)(10), 440.100
Physical Therapy and Related Services- Physical Therapy	Optional	1905(a)(11), 440.110(a)
Physical Therapy and Related Services- Occupational Therapy	Optional	1905(a)(11), 440.110(b)
Physical Therapy and Related Services - Services for Individuals with Speech, Hearing and Language Disorders	Optional	1905(a)(11), 440.110(c )
Prescribed Drugs	Optional	1905(a)(12), 440.120(a)
Dentures	Optional	1905(a)(12), 440.120(b)
Prosthetic Devices	Optional	1905(a)(12), 440.120(c )
Eyeglasses	Optional	1905(a)(12), 440.120(d)
Diagnostic Services	Optional	1905(a)(13), 440.130(a)
Screening Services	Optional	1905(a)(13), 440.130(b)
Preventive Services	Optional	1905(a)(13), 440.130(c )
Rehabilitative Services - Substance Use	Optional	1905(a)(13), 440.130(d)
Rehabilitative Services - Mental Health	Optional	1905(a)(13), 440.130(d)

Medicaid State Plan Mandatory vs Optional Benefits (cont.)		
Benefit	Category	Citations (Social Security Act and 42 CFR)
Services for Individuals Over Age 65 in IMDs - Inpatient Hospital Services	Optional	1905(a)(14), 440.140(a)
Services for Individuals Over Age 65 in IMDs - Nursing Facility Services	Optional	1905(a)(14), 440.140(b)
Intermediate Care Facility Services for Individuals with Mental Retardation or Persons with Related Conditions	Optional	1905(a)(15), 440.150
Inpatient Psychiatric Services for Individuals Under 22	Optional	1905(a)(16), 440.160
Hospice Care Services	Optional	1905(a)(18)
Case Management Services and TB-Related Services - Case Management Services	Optional	1905(a)(19), 440.169, 1915(g)
Case Management Services and TB-Related Services - Special TB Related Services	Optional	1905(a)(19)
Respiratory Care Services	Optional	1905(a)(20), 1902(e)(9)(A)-(C), 440.185
Personal care services in recipient's home	Optional	1905(a)(24), 440.167
Primary care case management services	Optional	1905(a)(25), 440.168
Special Sickle-Cell Anemia-Related Services	Optional	1905(a)(27)
Transportation	Mandatory	1905(a)(29), 440.170(a)
Services provided in religious non-medical health care facilities	Optional	1905(a)(29), 440.170(b) and (c)
Nursing facility services for patients under 21	Optional	1905(a)(29), 440.170(d)
Emergency hospital services	Optional	1905(a)(29), 440.170(e)
Medicare Cost-Sharing	Mandatory	1902(a)(10)(e), 1905(p), 1902(n), 1905(p)(3) and (4)
Medicare Premium Payments	Mandatory	1902(a)(1)(e), 1905(p), 1905(s), 1933, 431.62
Other Medical Insurance Premium Payments		1906, 1906A, 1902(a)(10)(F), 1902(u)(1)
Critical Access Hospitals	Optional	1905(a)(29), 440.170(g)
Community First Choice	Optional	1915(k)
Health Homes	Optional	1945
Alternative Benefit Plans (Benchmark Plans and Benchmark Equivalents)	Optional except for Adult Group	1937
Self Directed Personal Care	Optional	1915(j)
Emergency Services for Certain Legalized Aliens and Undocumented Aliens		1903(v), Section 401-403 of PRWORA, 440.25
Limited Coverage for Poverty Level Pregnant Women		1902(a)(10)(e)(5), 1902(a)(10)(end)(V)
Limited Coverage for Tuberculosis-related Outpatient Services		1902(z)(2)
Standards for Coverage of Transplant Services		1903(i)(1), 441.35
Benefits for Families Receiving Transitional Medical Assistance		1925, 1902(a)(52)
Methods and Standards to Assure High Quality Care		1902(a)(30)(A), 440.260
Medicaid Furnished Out-of-State		1902(a)(16), 431.52
Continued Coverage of Inpatient Services for Infants and Children		1902(e)(7)
Special Requirements Applicable to Sterilization Procedures		441 Subpart E, 441 Subpart F
Limitation on Benefits for Individuals Eligible Under the Breast and Cervical Cancer Eligibility Groups		1902(aa), 1902(a)(10)(end)(XIV)
Extended Services for Pregnant Women - Pregnancy-Related and Postpartum Services for a 60-day Period	Optional	1902(a)(10)(G)(V)
Extended Services for Pregnant Women - Additional Services for Any Other Medical Conditions That May Complicate Pregnancy	Optional	1902(e)(5)
Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period	Optional	1920
School-Based Services		
Special Requirements Applicable to Abortions		
Indian Health Services and Tribal Health Facilities		

## Affordable Care Act Essential Health Benefits

<b>Essential Health Benefits and Medicaid State Plan</b> 1937(b)(1)(A), (B),(C) and (D); 1937(b)(5) Section 1302(b) of the Affordable Care Act 42 CFR 440.330; 42 CFR 440.345; 42 CFR 440.347; 42 CFR 440.360 45 CFR Part 156	
<b>10 Essential Health Benefit Categories</b>	<b>Alaska State Plan Qualifying Services</b>
Ambulatory patient services	Outpatient hospital, physician services, other licensed practitioners, clinic services, family planning, dental, hospice, personal care services.
Emergency services	Outpatient hospital, ER transportation, physician services – urgent care.
Hospitalization	Hospitalization: inpatient
Maternity and newborn care	Physician services, inpatient.
Behavioral Health (and Mental Health Parity)	Outpatient Rehabilitative services, Inpatient mental health, outpatient chemical dependency, inpatient chemical dependency.
Prescription drugs	
Rehabilitative and habilitative services	Home health services, supplies equipment, and appliances, physical therapy and related services, nursing facilities.
Laboratory services	
Preventive and wellness services and chronic disease management	Preventive and wellness services and chronic disease management: tobacco cessation, preventive services.
Pediatric services – EPSDT as called out in 1905(r)(5) of Title XIX	Medicaid EPSDT

# Medicaid and Denali KidCare – A Multidivisional Effort

## Department of Health and Social Services: Single State Agency

Designated in accordance with 42 CFR 431.10 as Alaska Medicaid's single state agency, DHSS oversees all aspects of the Medicaid program. The following divisions within DHSS, as well as other departments, are involved in the day-to-day operations and/or support of the Alaska Medicaid program.

### Division of Public Assistance

Division of Public Assistance (DPA) staff determines eligibility for Medicaid and other programs including Supplemental Nutrition Assistance Program (SNAP), Adult Public Assistance, child care assistance, heating assistance, and Senior Benefits. DPA is responsible for establishing eligibility regulations and policy in accordance with federal regulations and state statute. Additionally, DPA is responsible for issuance of Medicaid eligibility cards, oversight of the DHSS contract with Deloitte Consulting, which operates and maintains the Alaska Resource for Integrated Eligibility Services (ARIES), an online eligibility determination system.

### Division of Health Care Services

The Division of Health Care Services (DHCS) is the state entity primarily responsible for oversight of the fiscal agent contractual activities including enrollment of all Medicaid providers, payment of all provider claims, provider publications and training, surveillance and utilization review, third-party liability and recoveries, service authorization, provider relations, and recipient relations. DHCS oversees the fiscal agent operation and maintenance of Alaska's Medicaid Management Information System (MMIS), also known as Alaska Medicaid Health Enterprise.

DHCS program managers are responsible for the day-to-day support of most enrolled tribal and non-tribal providers and services. Program managers oversee claims and service authorization activities; ensure compliance with federal regulations, state regulations/statute, and national coding standards; and provide other technical expertise to ensure that providers are correctly reimbursed for services they render to Alaska Medicaid recipients. Some of the provider types for which DHCS program managers are responsible include physician, advanced nurse practitioner (ANP), physician assistant (PA), direct entry midwife (DEM), chiropractor, podiatrist, dentist, orthodontist, transportation, physical/occupational therapist, audiologist, speech/language therapist, nutrition, family planning, hospice, laboratory, radiology, pharmacy, durable medical equipment, inpatient and outpatient hospital, long-term acute care hospital, federally qualified health center, rural health clinic, home health, ambulatory surgery center, and dialysis clinic.

Other DHCS responsibilities include federal reporting, finance and budget, residential licensing and background check, health care facility licensing and certification, and certificate of need.

## **Division of Behavioral Health**

The Division of Behavioral Health (DBH) is responsible for Alaska's public behavioral health system, including community mental health and substance disorder programs. DBH oversees the statewide delivery of residential and community-based treatment and recovery services; manages Alaska Psychiatric Institute, the State's only public psychiatric hospital; administers grants to the State's network of local community mental health and substance abuse programs; and coordinates with other government, tribal and private providers of behavioral health services to ensure the provision of comprehensive behavioral health services to Alaska residents. DBH works closely with the Alaska Mental Health Board, mental health and substance abuse planning councils, and provider organizations such as Alaska Behavioral Health Association and Alaska's Substance Abuse Directors on system planning and evaluation.

## **Division of Senior and Disabilities Services**

The Division of Senior and Disabilities Services (DSDS) oversees services for the elderly and disabled including long-term care, administrative wait/swing bed, personal care attendant (PCA), residential supportive living, and Alaska's Home and Community Based (HCB) services programs. DSDS also oversees Senior Services and Community Developmental Disabilities grants programs. Adult protective services, care coordinator training, nursing home level of care, and other grant services also fall under DSDS oversight.

## **Finance and Management Services**

Finance and Management Services (FMS) is responsible for all administrative service and management functions of DHSS. These responsibilities range from managing Department policy to insuring that all DHSS external and internal customer needs are met in an effective and efficient manner. FMS plays a key role in federal reporting to CMS for federal match funding of the Medicaid program.

## **Division of Public Health**

Although Division of Public Health (DPH) programs generally cover those who are not eligible for Medicaid and services not covered by Medicaid, DPH plays a key role in several Medicaid-related programs. Some of these programs include managing the EPSDT tracking system; providing breast and cervical cancer and other preventive and screening services; administration of family planning and other grant programs; and oversight of the state's immunization program.

DPH operates other population-based programs that focus on protecting and promoting the health of entire communities and of all Alaskans. DPH conducts disease surveillance and investigation and provides treatment consultation and laboratory testing services to prevent epidemics and control outbreaks of communicable diseases.

## **Office of Rate Review**

The Office of Rate Review (ORR) establishes Medicaid payment rates for hospitals, nursing facilities, home health agencies, ambulatory surgical centers, rural health clinics, and federally qualified health centers. ORR also works with tribal providers and various divisions and units throughout the Alaska Department of Health and Social Services on rate setting and accounting issues.

## **Office of Administrative Hearings**

Under the Department of Administration, the Office of Administrative Hearings (OAH) is responsible for recipient case hearings and provider rate appeals. OAH schedules hearings and coordinates pre-hearing arrangements, holds pre-hearing conferences, presides over formal hearings, analyzes and evaluates facts and pertinent laws, prepares reports and findings, and recommends orders and decisions for consideration by the Commissioner.

## Medical Care Advisory Committee

The Medical Care Advisory Committee (MCAC) is a public advisory group charged with advising the State's Medicaid agency, the Alaska Department of Health and Social Services, on Medicaid policy and program changes.

Section 1902(a)(4) of the federal Social Security Act (Title XIX) requires that each state establish a Medical Care Advisory Committee to advise the Medicaid agency in order to obtain federal matching funds for the Medicaid program. The MCAC members meet quarterly via teleconference or face-to-face. The face-to-face meetings are held in communities so members may gain insight into community specific issues.

<http://dhss.alaska.gov/dhcs/pages/mcac>

## Medicaid Contractors

The Alaska Medicaid program contracts with several entities to perform various program functions.

### Xerox State Healthcare

States are permitted to utilize contractual services of a fiscal agent for the design, development, operation, and maintenance of Alaska's MMIS, also known as Alaska Medicaid Health Enterprise, and associated functions.

Alaska's MMIS developer and current fiscal agent is Xerox State Healthcare. As such, Xerox is responsible for the following:

- Provider enrollment
- Processing and payment of claims
- Service authorization for transportation, dental and other specified services
- First level appeals
- Provider inquiry and problem resolution
- Provider education
- Provider communication and outreach
- Care Management Program
- Surveillance and Utilization Review

### Qualis Health

Qualis Health, a private nonprofit Quality Improvement Organization, has provided services to Alaska Medicaid, its providers and its recipients since 1984. Internationally recognized InterQual criteria are followed as Qualis' Utilization Review Accreditation Commission (URAC) accredited clinicians provide:

- Utilization management (UM), also known as utilization review or service authorization for
  - Select inpatient and outpatient diagnoses and procedures
  - All acute care inpatient stays exceeding three days
  - Psychiatric inpatient admissions
  - Quality of care reviews
  - TEFRA application and renewal review
- Case management (CM) services
- Quality of care reviews
- Provider education

## **Magellan Medicaid Administration**

Magellan Medicaid Administration provides pharmacy benefits administration for Alaska Medicaid. Magellan processes electronic point of sale pharmacy claims and provides recipient eligibility verification and allowable amounts, and Prospective Drug Utilization Review (ProDUR) updates.

Through the National Medicaid Pooling Initiative, Alaska Medicaid realizes millions in annual savings through multi-state pharmaceutical rebate agreements and the Preferred Drug List. Magellan operates a clinical call center and service authorization help desk.

## **Rochester Optical**

Rochester Optical is the Alaska Medicaid contractor for lenses, glasses frames, and contact lenses. All vision service providers are required to order from this contractor when prescribing eyewear for Alaska Medicaid recipients.

## **MedExpert International, Inc.**

Alaska Medicaid contracts with MedExpert International Inc. to provide case management services to high utilizing recipients under the Alaska Medicaid Coordinated Care Initiative (AMCCI).

# Medicaid Eligibility

## Medicaid Categories

### Children, Adults, and Families

Individuals may meet the eligibility criteria for more than one category, but will be appropriately placed depending on their age, condition and situation. The following Medicaid categories for children, adults, and families are presented in the order that is followed when determining eligibility.

#### *Pregnant Woman*

A pregnant woman whose household income does not exceed 200% of the FPL for her household size and who meets the Family Medicaid non-financial criteria is eligible for Denali KidCare (DKC). There is no resource requirement or insurance restriction for this coverage.

Pregnant Woman eligibility may extend three months retroactively if the applicant was pregnant during that period and meets all other DKC eligibility requirements. Even if a woman is not eligible in the application month or month following the application month, but is eligible in Alaska in one of the three retroactive months before the application month, she is considered eligible for DKC from that month throughout her pregnancy, regardless of changes in her household income.

#### *Postpartum*

A pregnant woman who applied for and was receiving Medicaid or DKC coverage on or before the date of the end of the pregnancy is automatically eligible to receive 60 days of postpartum coverage. Postpartum coverage begins on the day the pregnancy ends and ends on the last day of the month in which the 60 days ends.

#### *Newborn*

A child born to a woman who is eligible for and receiving Alaska Medicaid in the month of delivery is automatically eligible for Newborn Medicaid, without the need to apply. This includes a child born to a woman who is receiving coverage under the Emergency Treatment of Aliens category.

Newborn eligibility is not dependent on the continuation of the mother's eligibility. Eligibility for the newborn automatically continues until the end of the month in which the child turns one year old.

### *Denali KidCare (Children Under Age 19)*

Eligibility for DKC is based on two income limits, depending upon whether the child is covered under a qualified health insurance plan. If all other nonfinancial eligibility criteria are met, a child under the age of 19

- with insurance is eligible for DKC if the household's income does not exceed 177% of the FPL for Alaska
- without insurance is eligible for DKC if the household's income does not exceed 203% of the FPL for Alaska

A child who is in the custody of the State may also be determined eligible for DKC.

### *Family Medicaid*

Family Medicaid is available to adults and their dependent children, essentially the same population that would have received Medicaid in conjunction with Aid to Families with Dependent Children (AFDC). When AFDC was replaced by the Temporary Assistance to Needy Families (TANF) in 1997, Medicaid was delinked, eliminating the loss of health insurance as a barrier to employment.

Eligibility for Family Medicaid requires that a dependent child and a parent or other specified caretaker relative be present in the home. The dependent child is defined as child who is under age 18 years, or age 18 and enrolled full-time in a high school, GED program, or a vocational or technical training program; and is deprived of parental support and care.

### *Hospital Presumptive Eligibility*

Qualified hospitals may elect to make Hospital Presumptive Eligibility (HPE) determinations for Medicaid. HPE may be approved only for the following Medicaid categories:

- Children under age 19
- Parents and caretaker relatives
- Pregnant women
- People under age 26 who were in foster care in Alaska at age 18
- Women in treatment for breast and/or cervical cancer
- Expansion Group

The approved hospital will make the eligibility determination for the presumptive eligibility period. DPA is authorizing the Medicaid benefits based on the hospitals determination. The presumptive eligibility period begins the date that the hospital determines the applicant presumptively eligibility for Medicaid and ends the earlier of:

- The date the eligibility determination for regular Medicaid is made, if a full application for Medicaid is filed by the end of the month after the month that HPE is determined
- Or the last day of the month after the month of the HPE determination, if a full application for Medicaid is not filed

The hospital may make only one presumptive eligibility determination per individual within a 12-month period, starting with the effective date of the initial presumptive eligibility period, except that a pregnant woman can be found presumptively eligible once per pregnancy when multiple pregnancies occur within the same 12 month period.

### *Medicaid Expansion - Adults Age 19-64*

Effective September 1, 2015, Alaska Governor Bill Walker expanded Medicaid eligibility under provisions of the ACA to include individuals who are financially unable to purchase health insurance, but who did not meet categorical eligibility requirements for Medicaid under pre-ACA rules. The Medicaid expansion group covers adults who

- are between ages 19 and 64
- earn less than 133% of the FPL for Alaska (138% less 5% disregard) and
- are not eligible for another type of Medicaid or Medicare

Financial eligibility for the Medicaid expansion category is based on the same household composition and income rules as other Children, Family and Adult Medicaid categories.

Expansion group individuals must also meet all non-financial eligibility requirements including citizenship or qualified alien status, residency, Social Security enumeration, and Assignment of Rights.

### *Individuals Under the Age of 21*

This eligibility category was established primarily for 19 and 20 year old individuals, as eligibility for those under age 19 would be determined under DKC. This category is also available to children who are in the custody of the Division of Juvenile Justice, and to those who are eligible for Title IV-E and State-only subsidized adoption coverage and non-Title IV-E state-only foster care.

### *Former Foster Children up to Age 26*

The ACA created a new mandatory Medicaid coverage group for former foster care children. To be eligible for this category, an individual must be at least age 18 and under the age of 26, and have been in state or tribal foster care in Alaska and enrolled in Medicaid upon reaching age 18 or any higher range at which the state or tribal foster care ended.

The eligibility determination for the Former Foster Care category is not automatic. When individuals age out of foster care, they must reapply for Medicaid if continued eligibility is desired.

### **Aged, Blind, and Disabled**

Recipients of Supplemental Security Income (SSI) and Adult Public Assistance (APA), and individuals who are eligible for either program but choose not to receive cash are automatically eligible for Medicaid.

### ***SSI Recipient***

An individual verified as receiving case assistance payment is eligible for Medicaid coverage. This includes an individual who is:

- Receiving SSI pending a final determination of blindness or disability, including a low-birth weight infant who is receiving presumptive disability payments
- Not receiving an SSI payment solely because of recoupment of a previous overpayment
- Receiving SSI cash assistance under a conditional agreement with the Social Security Administration (SSA) to dispose of resources that exceed the SSI resource limit
- A disabled child under age 18 who is receiving SSI

### ***APA Recipient***

An individual eligible for and receiving APA cash payment is eligible for Medicaid coverage.

### ***SSI or APA Eligible, Not Receiving Cash Payments***

Individuals who are eligible for SSI or APA case assistance payment are eligible for Medicaid, even if they choose to not receive cash payments. All financial and non-financial requirements of the SSI or APA cash grant program must be met. This eligibility category does not include individuals who are pending a final determination of SSI eligibility, or who would have entered into an agreement with SSA or to the State to dispose of resources that exceed the SSI dollar limits on resources.

### ***SSI Disabled Adult Children***

SSI Disabled Adult Children are those who are age 18 or older, received SSI or APA benefits that began prior to age 22, and who lost eligibility on or after July 1, 1987 because the individual became newly eligible for Social Security benefits as a disabled adult child or because of an increase in Social Security Title II benefits.

### ***Section 1619(B) Eligible***

This category of eligibility provides Medicaid for a blind or disabled individual who, because of work at substantial gainful activities, is SSI-ineligible but whose SSI eligibility status is maintained for Medicaid purposes.

### ***Disabled Widow(er) Who Has Lost SSI or APA Due to Receipt of Title II Benefits***

A widow(er) between the ages of 60 and 64 who has lost SSI benefits as a result of becoming entitled to, or receiving Title II SSA early widow(er) benefits is eligible to continue receiving Medicaid until s/he becomes eligible for Medicare Part A. The individual is deemed to be an SSI recipient as long as he or she would be eligible for SSI or APA in the absence of their SSA widow(er) benefits.

### *Deemed an SSI/APA Recipient Under the Pickle Amendment*

Named for U.S. Representative James J. Pickle (Texas), the sponsor of the bill that was enacted in 1976, the Pickle Amendment established a separate category of Medicaid eligibility. This amendment requires that an individual be deemed an SSI or APA recipient (and so eligible for Medicaid) if the individual meets certain eligibility factors. This category applies to an individual who is ineligible for SSI or APA because of cost-of-living adjustments in that individual's Title II Old Age, Survivors, and Disability benefits (OASDI).

An individual who is no longer eligible for SSI or APA eligibility may qualify for Medicaid if s/he:

- Was entitled to receive both OASDI and SSI or APA cash benefits in at least one month after April 1977;
- Is currently eligible for and receiving OASDI benefits;
- Receives income that, after deducting OASDI cost-of-living adjustments received since the last month in which the individual was eligible for both OASDI and SSI, meets SSI or APA limits, and
- Meets all other Medicaid eligibility requirements

### *SSI or APA Ineligible for Reasons that do not Apply to Medicaid*

Medicaid is available to individuals who would otherwise be eligible for SSI/APA except that they do not meet a SSI/APA rule that is specifically prohibited in the Medicaid program.

### *Disabled Children at Home (TEFRA Medicaid)*

A disabled child who is under 19 years of age and who does not qualify for SSI cash assistance due to parental income or resources may be eligible for TEFRA Medicaid based on the child's own income and resources.

To be eligible for this category, the child must:

- Meet the disability criteria for SSI eligibility;
- Be eligible for Medicaid if institutionalized, under the Special Long Term Care (LTC) Income Standard and using the \$2,000 APA-Related Medicaid resource limit;
- Reside at home and not in a residential care setting;
- Meet one of the level of care standards designated by the program;
- Be deemed appropriate to receive necessary medical care outside an institution as indicated on the plan of care approved by DHCS; and
- Have an estimated cost of care for services rendered in the home that is less than the cost of institutionalization as determined by DHCS

### *Working Disabled Medicaid Buy-In*

A disabled individual who is ineligible for APA and Medicaid because of the individual's or spouse's earned income may be eligible for Medicaid under the Working Disabled Medicaid

Buy-in category, even if he or she has not previously received Medicaid or disability benefits. A disability determination is required. Individuals who qualify under this category may be required to pay a premium to DHCS to continue to receive coverage.

### *Nursing Home*

An individual who resides in an intermediate care or skilled nursing facility for at least 30 consecutive days may be Medicaid- eligible if the individual meets all SSI or APA program requirements except for income and the financial eligibility rules as set by the program and has gross income equal to or below the LTC income standard.

### *Home and Community-Based Services*

An individual who has been approved by the DSDS to receive HCB services is eligible if the individual meets all SSI or APA requirements except for income, age and the financial eligibility rules as set by the program and has gross income equal to or below the LTC income standard.

## **Other Medical Assistance**

### *Breast and Cervical Cancer Program*

The Breast and Cervical Cancer Program (BCCP) is available to women who have been screened by a Breast and Cervical Health Check (BCHC) provider and found to have either a precancerous condition or cancer of the breast or cervix. The program provides breast and cervical screening services to women who meet certain income guidelines and who do not have insurance or who cannot meet their insurance deductible.

### *Chronic and Acute Medical Assistance (CAMA)*

Chronic and Acute Medical Assistance (CAMA), a state-funded program designed to help Alaskans with specific illnesses, is a restricted benefit program for individuals age 21 through 64 who do not qualify for Medicaid benefits, have very little income, and have inadequate or no health insurance. Eligibility for CAMA requires one or more of the following diagnoses:

- Terminal illness
- Cancer requiring chemotherapy
- Diabetes or Diabetes insipidus
- Chronic hypertension
- Chronic mental illness
- Chronic seizure disorder

## Medicaid Application Process

### How to Apply

There are various ways to obtain an application for the Medicaid program. Applicants can apply for coverage online, by mail, in-person, fax, or by utilizing a DPA fee agent if the applicant lives in a rural area.

#### *Apply Online*

To apply online, applicants can go to [www.healthcare.gov](http://www.healthcare.gov), or to myAlaska, <https://my.alaska.gov/> and utilize the ARIES Self-Service Portal.

#### *Download and Submit a Paper Application*

Applicants can download and print an application form, and return it by mail or facsimile it to a DPA office. The form is available under this link: <http://dpaweb.hss.state.ak.us/e-forms/pdf/Gen50c.pdf>.

#### *Submit a Paper Application Obtained from DPA*

DPA offices are available in several cities and towns throughout Alaska. A listing of local DPA offices is available under this link: <http://dhss.alaska.gov/dpa/Pages/features/org/dpado.aspx>.

#### *Apply with a Fee Agent*

DPA contracts with fee agents to assist applicants who live in communities without a DPA office. Fee agents guide the applicant through Medicaid and other DPA programs application processes. Applicants can call a DPA office to get a listing of fee agents in their community.

### Medicaid Applicant/Recipient Responsibilities

In order for DPA to determine an individual's eligibility for Medicaid, the individual must:

- Submit an identifiable application;
- Complete and sign an approved application form;
- Attend an interview with a DPA caseworker or fee agent (required only for aged, blind and disabled Medicaid categories; and
- Provide documentation and verification, including required forms, needed to determine program eligibility (e.g., citizenship and identity, income, other assets, health/disability status).

Applicants and recipients are also required to report changes that could affect their eligibility and benefit amount, such as income, resources (if required by the Medicaid category), address, household composition, and health insurance coverage.

## Application Processing Deadlines

To meet federal requirements, DPA is required to process the application within 30 days of the application filing date, and an adequate notice must be sent to the household following a determination of eligibility. Adequate notice means that the individual is informed of the action taken, the reasons for the action, and the federal or statutory citations that support the action.

## Medicaid Application Interview Requirements

In-person interviews are required for some categories of Medicaid, and not for others.

Interview Required	Interview NOT Required
<ul style="list-style-type: none"> <li>• Supplemental Security Income (SSI) Recipient</li> <li>• Adult Public Assistance (APA) Recipient</li> <li>• SSI Eligible – Not Receiving Cash Payments</li> <li>• APA Eligible – Not Receiving Cash Payments</li> <li>• SSI or APA Ineligibles for Reasons Prohibited by Medicaid</li> <li>• Working Disabled Medicaid Buy-in</li> <li>• Special Long Term Care</li> <li>• Disabled Children at Home (TEFRA)</li> <li>• Pickle Amendment</li> <li>• Section 1619(b) Eligible</li> <li>• SSI Disabled Children</li> <li>• Disabled Widow(er)</li> <li>• Qualified Medicare Beneficiary (QMB)</li> <li>• Qualified Disabled and Working Individuals</li> <li>• Specified Low Income Medicare Beneficiary</li> <li>• Specified Low Income Medicare Beneficiary</li> </ul>	<ul style="list-style-type: none"> <li>• Parents and Other Caretakers</li> <li>• Pregnant Women</li> <li>• Infants and Children Under Age 19</li> <li>• Former Foster Care Children up to Age 26</li> <li>• Under 21 Medicaid</li> <li>• Expansion Group</li> </ul>

## Verification Requirements

Verification through the use of documentation or third party information is required to confirm certain points of Medicaid eligibility. Verification can be obtained through documents, online system information or electronic data, contacts with third parties, and other sources.

When an individual submits an application or reports a change, citizenship and alien status must be verified through electronic data. However, most eligibility requirements can be verified through client statement or electronic interfaces. If eligibility cannot be verified electronically,

the household may be required to provide documentary proof (original, photocopy, faxed or scanned document), that they meet eligibility requirements.

Verification requirements for individuals applying for aged, blind, disabled, and LTC Medicaid are more extensive; however, DPA caseworkers can assist with obtaining verification, particularly when it can be obtained faster through Social Security Administration and other interface exchanges.

## **Non-Financial Eligibility Criteria**

Depending on the category of Medicaid, the following non-financial factors of eligibility may apply to individuals applying for coverage:

- US Citizenship and Identity, or Qualified Alien Status
- Alaska Residency
- Age
- Social Security Enumeration
- Assignment of Rights
- Cooperation with Child Support
- Development of Income
- Blindness and/or Disability

## **Financial Eligibility Criteria**

Financial eligibility for MAGI-based Medicaid categories is based on household composition and income standards according to FPL guidelines. Countable income for MAGI-based Medicaid is determined following the rules of Internal Revenue Service for countable income and deductions with some exceptions.

For the Aged, Blind, and Disabled and (Long Term Care) LTC Medicaid categories, financial eligibility is based on income and resource standards as set forth by program rules. Resources are any assets, including cash or any other real or personal property, that an individual (or the individual's spouse or alien sponsor, if any) owns and can convert to cash to be used for support and maintenance.

<b>MAGI MEDICAID INCOME ELIGIBILITY STANDARDS – FPL BASED</b>				
<b>Effective 3/01/2015</b>				
<b>Household Size</b>	<b>Pregnant Women</b>	<b>Children-Under age 19 With Insurance</b>	<b>Children-Under age 19 Without Insurance</b>	<b>Expansion Group added 9/01/15</b>
	<b>200% of FPL</b>	<b>177% of FPL</b>	<b>203% of FPL</b>	<b>133% of FPL</b>
1	\$2,454	\$2,172	\$2,491	\$1,632
2	\$3,320	\$2,939	\$3,370	\$2,208
3	\$4,187	\$3,706	\$4,250	\$2,785
4	\$5,054	\$4,473	\$5,130	\$3,361
5	\$5,920	\$5,240	\$6,009	\$3,937
6	\$6,787	\$6,007	\$6,889	\$4,514
7	\$7,654	\$6,774	\$7,769	\$5,090
8	\$8,520	\$7,541	\$8,648	\$5,666
<b>Each Additional</b>	<b>\$867</b>	<b>\$767</b>	<b>\$880</b>	<b>\$577</b>

<b>MAGI MEDICAID INCOME ELIGIBILITY STANDARDS – COLA BASED</b>			
<b>Parents / Caretaker Relatives and Under 21</b>			
<b>Household Size</b>	<b>Income Standard Effective 1/01/14</b>	<b>Income Standard Effective 1/01/15</b>	<b>Income Standard Effective 1/01/16</b>
1	\$1,352	\$1,487	\$1,487
2	\$2,110	\$2,370	\$2,370
3	\$2,525	\$2,904	\$2,904
4	\$2,939	\$3,437	\$3,437
5	\$3,354	\$3,972	\$3,972
6	\$3,768	\$4,505	\$4,505
7	\$4,182	\$5,038	\$5,038
8	\$4,596	\$5,571	\$5,571
9	\$5,011	\$6,105	\$6,105
10	\$5,425	\$6,638	\$6,638
<b>Each Additional</b>	<b>\$390</b>	<b>\$534</b>	<b>\$534</b>

<b>MAGI MEDICAID INCOME DISREGARD</b>	
<b>5% of FPL</b>	
<b>Household Size</b>	<b>Monthly Income Limit Effective 3/1/2015</b>
1	\$62
2	\$83
3	\$105
4	\$127
5	\$148
6	\$170
7	\$192
8	\$213
9	\$235
10	\$257
<b>Each Additional</b>	<b>\$22</b>



OLD AGE AND DISABLED INCOME ELIGIBILITY STANDARDS					
Effective 3/01/2015					
HOUSEHOLD SIZE	WORKING DISABLED	QMB	SLMB Base	SLMB Plus	QDWI
	250% of FPL	100% of FPL	120% of FPL	135% of FPL	200% of FPL
1	\$3,067	\$1,227	\$1,472	\$1,656	\$2,454
2	\$4,150	\$1,660	\$1,992	\$2,241	\$3,320
3	\$5,234				
4	\$6,317				
5	\$7,400				
6	\$8,484				
7	\$9,567				
8	\$10,650				
Each Additional	\$1,084				

2013 - 2015 SELF-EMPLOYMENT INCOME ANNUALIZATION STANDARDS (185% of FPL)			
Household Size	Income Standard Effective 3/01/2013	Income Standard Effective 3/01/2014	Income Standard Effective 3/01/2015
1	\$26,548	\$26,973	\$27,232
2	\$35,853	\$36,371	\$36,852
3	\$45,159	\$45,769	\$46,472
4	\$54,464	\$55,167	\$56,092
5	\$63,770	\$64,565	\$65,712
6	\$73,075	\$73,963	\$75,332
7	\$82,381	\$83,361	\$84,952
8	\$91,686	\$92,759	\$94,572
Each Additional	\$9,306	\$9,398	\$9,620

2014 – 2016 SSI PAYMENT STANDARDS			
SSI COLA INCREASE	1.5%	1.7%	0.0%
HOUSEHOLD TYPE	1/01/2014	1/01/2015	1/01/2016
A Individual	\$721	\$733	\$733
B Individual	\$480.67	\$488.67	\$488.67
A Couple, Both Eligible	\$1,082	\$1,100	\$1,100
B Couple, Both Eligible	\$721	\$733	\$733
NH Personal Needs Allowance	\$30	\$30	\$30

2014 – 2016 LONG TERM CARE STANDARDS			
	1/01/2014	1/01/2015	1/01/2016
NH, HCB Waiver, TEFRA Income Standard	\$2,163	\$2,199	\$2,199
Alaska NH Personal Needs Allowance	\$200	\$200	\$200
Alaska HCB Personal Needs Allowance	\$1,656	\$1,656	\$1,656
Alaska ALH Personal Needs Allowance	\$1,396	\$1,396	\$1,396
Maximum Community Spouse Resource Allowance	\$117,240	\$119,220	\$119,220
Community Spouse Monthly Income Maintenance Standard	\$2,931	\$2,980.50	\$2,980.50
Monthly Income Standard for Additional Household Members	\$977	\$993.50	\$993.50

## Medicaid Financing

Medicaid is jointly (federal/state) funded. The Federal Medical Assistance Percentage (FMAP) is the federal share of Medicaid expenditures and is calculated based on each state's per capita income.

- State FMAP rates range from 50% to 88%; the average state FMAP for non-expansion Medicaid services is 57%.
- State FMAP rate for Medicaid expansion services is currently 100%; this rate will be gradually decreased (95% in 2017, 94% in 2018, 93% in 2019) and will become permanent at 90% beginning in 2020.
- Family planning and other services, and Medicaid information systems expenditures receive higher FMAP rates.
- The Medicaid FMAP for tribal claims expenditures is 100%.
- All states receive a 50% FMAP for Medicaid administrative costs.

Alaska FMAP rates:

Alaska FMAP		
FFY	Medicaid	CHIP
2016	50.00%	88.00%
2015	50.00%	65.00%
2014	50.00%	65.00%
2013	50.00%	65.00%
2012	50.00%	65.00%
2011	50.00%	65.00%
2010	51.43%	66.00%
2009	50.53%	65.37%
2008	52.48%	66.74%
2007	51.07%	65.75%
2006	50.16%	65.11%
2005	57.58%	70.31%
2004	58.39%	70.87%

# Medicaid Administration

## Provider Enrollment

Enrollment as an Alaska Medicaid provider is required for a provider to receive reimbursement for services rendered to a Medicaid recipient. Alaska Medicaid, through its fiscal agent, enrolls providers that provide a broad range of services including physicians, dentists, podiatrists, and other medical professionals; ANP, PA, registered nurse anesthetists, and other mid-level professionals; physical, occupational, speech/language, and other therapists; federally qualified and rural health clinics; pharmacies and durable medical equipment providers; hospitals, long-term care facilities, ambulatory surgery centers, and other medical facilities; emergent and non-emergent transportation providers; behavioral health providers. A comprehensive list of eligible provider types is available in 7 AAC 105.200 at <http://www.legis.state.ak.us/basis/folio.asp>.

To enroll, providers must meet state and federal licensing and/or certification requirements and adhere to all Medicaid program participation requirements. Providers must also comply with clinical and financial recordkeeping requirements, Health Insurance Portability and Accountability Act (HIPAA) privacy, enumeration, and electronic standards requirements.

## Medicaid Reimbursement Rate Methodologies

There is no single Alaska Medicaid rate, nor is there a single formula or methodology for calculating Alaska Medicaid provider rates. A distinct payment methodology is established for each provider type, and within most methodologies there are multiple rates. For example:

- In-state physician rates are established at 100% of the Resource-Based Relative Value Scale (RBRVS) rate setting methodology. RBRVS is the most widely used methodology for establishing rates for professional services. The formula consists of a work component, relative value units work (RVUw) component that reflects the time and intensity of effort to perform or provide a service; a RVU practice (RVUp) expense component that reflects costs related to the provision of a service; a RVU malpractice (RVUm) expense component that reflects professional liability insurance costs; a geographic practice cost index (GPCI) that modifies each RVU to reflect the cost of practicing in each state; and a conversion factor (CF) that is used to adjust rates so that the overall net change in rate for all procedures equals the percent change from the previous year in the most recent annual Consumer Price Index for all Urban Consumers (CPI-U) for Anchorage. The RBRVS formula,  $[(RVUw \times GPCI \text{ Work}) + (RVUp \times GPCI \text{ PE}) + (RVUm \times GPCI \text{ MP})] \times (CF)$ , is used to assign a distinct rate to each of the thousands of physician services. Rate; rates are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>.
- Rates for in-state mid-level practitioners such as ANP, PA and DEM are established at 85% of the RBRVS rate setting methodology. As with physicians, rates for mid-level practitioner services are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>.

- In-state hospitals and ambulatory surgical centers are paid based on a prospective rate system. Distinct per-day rates are set by the Office of Rate Review (ORR) for each individual facility and are based on operating costs reported by the facility for the previous reporting period. Rates from facility to facility vary as do their reported operating costs.  
Inpatient hospital stays for Department of Corrections (DOC) inmates who are Medicaid eligible are reimbursed based on Medicaid rates instead of higher DOC contracted rates.
- Rates for HCB and PCA services are established by ORR and are published in the department's Chart of Personal Care Attendant and Waiver Services Rates. Each service unit is assigned a rate associated to a specific procedure code and modifier pertaining to the HCB program that can bill for that service. Specific requirements for the determination of payment rates and provider responsibilities for accounting and cost reporting are published at <http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx>.
- Ground ambulance provider rates are established by the department and are paid based on mileage and on level (intensity) of life support services required during transport. Air ambulance providers are paid a per liftoff fee and a per mile rate. Rural ground and air ambulance services are paid at higher rates than urban. Non-emergent transportation and accommodation provider rates are paid in accordance with multiple payment methodologies. Current transportation and accommodation rates are published at <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>.
- Rates for prescription drugs from in-state pharmacies are set at the lower of (1) the submitted covered outpatient drug cost plus a dispensing fee; (2) the federal upper limit established by CMS, plus a dispensing fee; (3) the estimated acquisition cost of the drug plus a dispensing fee; and (4) the maximum allowable cost plus a dispensing fee. Dispensing fees are based on several factors, including location (in-state or out-of-state; on or off the road system); Mediset, and compounding of drugs, and the number of refills within a specified period of time.

Regardless of payment methodology or rate for a service, all providers are paid at the lower of the rate established by regulation, the provider's billed charges, and the provider's lowest advertised, quoted, or discounted charge for any other purchaser of services.

### Third Party Liability

Federal law requires Medicaid to be the payer of last resort. Any other health insurance or program (except the Indian Health Service or its tribal providers) that is responsible for a recipient's medical costs is known as a third-party liability (TPL), or a third-party resource. Recipients are required to disclose the existence of any TPL and providers are required to bill TPLs prior to submitting claims to Medicaid, with the following exceptions:

- Dental services
- Transportation and accommodation services (except air and ground ambulance services)
- HCB services

- PCA services
- EPSDT and preventive pediatric services
- Prenatal services
- Eyewear (lenses and frames)

## Claims Submission, Processing, and Payment

Xerox processes Medicaid, DKC, and CAMA claims submitted by enrolled providers. Claims must conform to all applicable federal, state, and professional standards, and may be submitted electronically or on paper. When a claim is received, it is assigned a Claim Control Number (CCN) for identification.

### Timely Filing of Claims

A claim must be submitted within 12 months of the date the service was provided to the Medicaid recipient. The 12-month timely filing limit applies to all claims, including those that must first be filed with a third-party carrier. Exceptions are allowed only when eligibility is established retroactively and beyond the 12-month filing limit, when an eligibility decision is reversed based on an administrative hearing decision or court order, or when circumstances such as natural disaster establish good cause for an extension.

### Claims Submission

Providers or their representatives may submit electronic or paper claims. Electronic claims may be submitted through Payerpath, provided free of charge to Alaska Medicaid providers, or through a HIPAA-compliant software of the provider's choice. Claims may also be submitted by paper, using the appropriate claim form for the provider.

### Claims Processing and Adjudication

As claims are received, they are processed through the Alaska's MMIS, which reviews them for a number of factors including

- Provider eligibility at the time of service
- Recipient eligibility at the time of service
- Coding accuracy based on National Correct Coding Initiative (NCCI) edits
- Compatibility of procedures and diagnoses
- Third party liability
- Duplication of previously paid claims
- Service authorization, if applicable
- Service limitations, if applicable.

Following claim processing, MMIS adjudicates the claim with one of three possible outcomes:

## *Payment*

If MMIS validates the information on the claim and information successfully passes all edits and audits, DHCS will pay on the claim and record the payment in the provider's weekly remittance advice.

## *Denial*

A claim may be denied for one or more reasons. Some of the more common denial reasons include non-coverage of service, ineligibility of the patient, and absence of a required service authorization.

## *Pend*

A pended claim is one that has been temporarily placed into a suspense status because additional action (e.g., manual review, clinical documentation from provider) is required.

## **Remittance Advice**

Following the weekly adjudication of claims, a remittance advice (RA) is issued to providers. The RA details the status of all claims that were processed and adjudicated or pended since the last report. The RA also includes important messages to providers, such as changes to processes, new program requirements, office closures, deadlines, and other critical information.

## **Provider Training**

Alaska Medicaid, in conjunction with Xerox, uses the Alaska Medicaid Learning Portal to train Alaska Medicaid health care professionals and service providers. The portal offers web-based courses, computer-based training, online tutorials, workbooks, job aids and links to other important resources.

Providers can access the portal at <http://learn.medicaidalaska.com>, 24 hours a day, 7 days a week from the convenience of their home or offices.

## **Provider Appeals**

Providers may request an appeal if they disagree with the decision made by DHCS regarding claims, service authorizations, or enrollment. All appeals must be submitted in writing.

## **Pre-Appeals**

This process is available only for services that providers feel are exceptions to current Alaska Medicaid policies.

## **First Level Appeal**

A provider may request a first-level appeal when a claim is denied, reduced, or recouped, when an authorization request is denied or partially denied, or when enrollment is denied or

terminated. First level appeals must be requested in writing, no later than 180 days after the date of the disputed decision, and must be submitted to the entity whose decision is disputed.

## **Second Level Appeal**

If the initial decision is upheld in the first level appeal, the provider has the right to file a second level appeal. Depending on the type of service, second level appeals must be submitted to the appropriate DHSS division:

- Division of Health Care Services
- Division of Behavioral Health
- Division of Senior and Disabilities Services
- Office of Children Services, Infant Learning Program

## **Commissioner Level Review**

The provider may request a commissioner level review if they are not satisfied with the outcome of the second level appeal and only if the issue relates to the timely filing requirement.

## **Recipient Fair Hearings**

Recipients have the right to request a fair hearing if they disagree with a decision or action taken. Requests for Medicaid fair hearings must be made in writing and sent to the appropriate agency for consideration.

### **Division of Public Assistance Fair Hearings**

Recipients may contact any of the DPA offices if they have questions about their Medicaid case or any action taken on their application or recertification. In the event that a recipient decides to file a fair hearing request, they may submit the request to any DPA office. Examples of fair hearing issues handled by DPA include:

- Application for Medicaid is denied or is not acted upon within the required timeframe
- Request to add a recipient to the existing Medicaid case is denied
- Medicaid coverage is terminated

Appeals related to Medicaid eligibility decisions made by the Federally Facilitated Marketplace for those who applied on [healthcare.gov](http://healthcare.gov) are handled by the Marketplace.

### **Division of Health Care Services Fair Hearings**

If the fair hearing request is regarding a decision related to medical services or billing, the request is handled by DHCS. Examples of fair hearing issues handled by DHCS include:

- Request for travel for medical care is denied
- Request for a covered Medicaid service is denied

## **Division of Senior and Disabilities Services Fair Hearings**

Fair hearings related to HCB and PCA programs are the responsibility of DSDS. Examples of fair hearing issues handled by DSDS include:

- Request for additional PCA hours is denied
- Level of care was denied for TEFRA Medicaid

## **Care Management Program**

The Care Management Program (CMP) was established to combat harmful and costly inappropriate use of Medicaid-covered services. The CMP limits a recipient to a primary care provider and a single pharmacy to reduce misuse of Alaska Medicaid services, encourage continuity of care, and promote communication between the recipient's primary care provider and pharmacy. Providers eligible to serve as a primary care provider under the CMP include:

- Physicians
- Advanced Nurse Practitioners
- Physician Assistants

Recipients who could benefit from the CMP are most often identified by the Department or its fiscal agent, Xerox State Healthcare, but are also referred to the program by medical providers or other concerned individuals. A utilization review of the most recent 12 months of medical and pharmacy records is then conducted to determine if the individual meets criteria for CMP. If CMP placement is determined appropriate, the recipient is sent a notice explaining the reason for, and the date of placement into the program. The notice includes reports detailing the area(s) the patient has overused medical services.

Care Management Program participation generally lasts for twelve months, during which time the recipient is limited to services rendered by the primary care provider and a single pharmacy. With the exception of emergency services, a recipient may seek treatment from other providers only after receiving an advance written referral from the primary care provider.

## **Case Management Program**

In 1997 Alaska Medicaid initiated a Case Management (CM) pilot project focused on helping patients with highly complex and/or costly health care needs to receive appropriate cost-effective care.

The pilot CM program was initially limited to the Anchorage area, and was expanded in 1998 to all Alaska Medicaid recipients and was incorporated with Qualis Health's existing UM services in order to coordinate referral of patients from UM to CM as appropriate.

Referrals to CM generally originate from the UM program, but may also come from the recipient, health care professionals, Department staff, or other agency staff.

Patient participation in CM is voluntary and the clients selected represent a multitude of medically complex conditions with expectation of long-term and/or costly health care needs.

Alaska's CM program includes, but is not limited to the following activities:

- Assessing the recipient's personal situation and challenges
- Providing information, resources, and referrals to support treatment and coverage options
- Working with the recipient, his/her family, physician, and other medical providers and suppliers to develop a coordinated care plan for management of the recipient's illness or injury
- Coordinating services provided by the professionals involved in a recipient's care to best meet health management goals
- Coordinating services of multiple agencies
- Collaboration with hospital discharge planners

CM is provided by registered nurses and licensed clinical social workers skilled in the provision of patient care. The CM contractor arranges for case managers to receive focused CM training and certification and ensures that URAC standards established for CM activities are followed.

## Utilization Management

Since 1985, the Department has contracted with a Medicaid Quality Improvement Organization to review selected inpatient admissions and other medical services. Qualis Health is the current QIO contractor and, as such, conducts UM reviews as follows:

- Certification at or before initial hospitalization or outpatient treatment for specified procedures and diagnoses
- Continued stay certifications for all hospital inpatient admissions (except certain maternal and newborn stays) exceeding three days

URAC standards established for UM activities are followed by the current Contractor when conducting UM reviews.

## Medicaid Audit and Review Authorities

### Medicaid Program Integrity

Medicaid Program Integrity is a system of reasonable and consistent oversight of the Medicaid program. It encourages compliance, maintains accountability, protects public funds, supports awareness and responsibility, ensures that providers meet participation requirements, ensures that services are medically necessary, and ensures payments are for the correct amount and for covered services. The goal of Medicaid Program Integrity is to reduce and eliminate fraud, waste and abuse in the Medicaid Program, which is supported by their common functions including prevention, investigation, education, recovery of improper payments, and cooperation with the Medicaid Fraud Control Unit (MFCU).

## **Payment Error Rate Measurement**

Commonly known as PERM, the federal Payment Error Rate Measurement audit process was developed and implemented by CMS to measure the accuracy of program payments. Individual state error rates are measured for the Medicaid program and are then combined to form a national error rate which is reported to Congress. In Alaska, the program is overseen by the Medicaid Program Integrity Unit.

## **Surveillance and Utilization Review**

Surveillance and Utilization Review (SUR) is a program that monitors and reviews services and claims to detect and prevent fraud, waste, abuse and misuse of the Medicaid program by recipients and providers. The goal of SUR is to provide a manageable approach to the process of aggregating and presenting medical care and service delivery data in order to monitor and evaluate covered services and utilization.

SUR staff analyzes claims data to identify potential fraud and abuse, and to ensure standards for a proper Medicaid payment are met including approval of services and rates, and eligibility of providers and recipients. Review outcomes can include recoupment of overpayments, provider education, and referrals to MFCU for criminal investigation and prosecution.

In addition to analyzing claims data to identify potential problems, SUR also relies on referrals, complaints and tips from various sources including individuals, agencies and other government entities. Investigations and data mining include review of policies and procedures, claim payments, and other outliers (e.g., spikes in payment for certain provider types, high use of specific codes, high risk claims).

## **Medicaid Fraud Control Unit**

The Alaska Medicaid Fraud Control Unit (MFCU) has been a part of the Attorney General's Office since January 1992. The unit is located in Anchorage and has statewide jurisdiction. It has the responsibility for investigating and prosecuting Medicaid fraud and the abuse, neglect or financial exploitation of patients in any facility that accepts Medicaid funds.

Additional information about MFCU and their successes are available at <http://www.law.alaska.gov/department/criminal/mfcu.html>.

## **Alaska Division of Legislative Audit**

The Alaska Division of Legislative Audit serves as one of the Legislature's most significant checks in the balance of powers with the executive and judicial branch of the government. The Division's primary responsibility is to hold government agencies accountable to the laws enacted by the legislature. All audits conducted by the Division are done in accordance with government auditing standards.

## **Centers for Medicare and Medicaid Services**

Under the U.S. Department of Health and Human Services (HHS), CMS provides oversight to the Medicaid program and work in partnership with state governments. In April 2015, the Medicare and Medicaid program integrity functions were aligned with the creation of the Center for Program Integrity. This newly established center brought together oversight of Medicare and Medicaid program integrity to coordinate resources and best practices for overall program improvement.

## **U.S. Health and Human Services' Office of Inspector General**

The Office of Inspector General's (OIG) mission is to protect the integrity of HHS programs as well as the health and welfare of program recipients. HHS OIG is the largest inspector general's office in the Federal Government, with approximately, 1,600 employees dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs.

## Home and Community-Based Services

The Medicaid Home and Community-Based (HCB) services program, authorized under 1915(c) of the Social Security Act, allows the State to furnish an array of less costly and less restrictive services that allow Medicaid recipients to avoid the need for institutional care. States have broad discretion to design waiver programs to address the needs of the target population.

Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide. In order to access programs, a person must be eligible for Medicaid. This involves meeting financial and resource limits, as found through an interview and application process with DPA. Once eligible for waiver, examples of possible services include respite care, chore, residential living, care coordination, environmental modifications and various other services.

Alaska Medicaid offers four waiver programs:

- Alaskans Living Independently (ALI)
- Adults with Physical and Developmental Disabilities (APDD)
- Children with Complex Medical Conditions (CCMC)
- Intellectual and Developmental Disabilities (IDD)

## Telehealth Program

Telemedicine refers to the process by which medical services are provided when patient and health care provider are separated by physical distance. A practitioner (e.g., physician, ANP, PA, and health aid) is present with the patient to obtain information such as the patient history, blood pressure, EKG, images and sounds. The information is stored in a digitized or electronic format for immediate transmittal to a specialist in a different location, or archived for later transmittal. Telemedicine is not a separate medical specialty. Instead, it affords care traditionally provided with the patient and provider in the same location to patients who live in remote areas, or who cannot travel to the provider location.

The term **telemedicine** refers specifically to patient and health care provider encounters for diagnosis and treatment, while the term **telehealth** is a broader term to include telemedicine, but also includes using the technology for preventative, educational, and health-related administrative activities.

Alaska's telehealth program is designed to bring quality primary care and specialty services to remote areas of the state, where it might not otherwise be feasible to do. It brings more timely services to the patient when time is of essence, it saves the patient the inconvenience of traveling to receive care, and it reduces Medicaid program travel expenditures.

# Medicaid Transportation

## Emergency Transportation Services

Alaska Medicaid covers medically necessary emergency air and ground ambulance transportation to the nearest facility that provides emergency care or, for recipients who are American Indian/Alaska Native, to the nearest tribal health facility if requested.

## Non-emergent Transportation and Accommodation Services

Alaska Medicaid covers out-of-area and local transportation and out-of-area accommodation services when travel is required to receive medically necessary services. All non-emergent transportation and accommodation services must be authorized in advance of the travel.

### Out of Area Travel

Alaska Medicaid will pay for the least expensive and appropriate mode of transportation and for accommodation (hotel and meal) services for a recipient who has been referred to receive medically necessary services outside his or her community of residence if:

- the services are unavailable locally, or
- the total cost of services and transportation costs is less than the cost of local services, or
- the recipient is American Indian/Alaska Native and has requested services from a tribal health provider when one is unavailable locally

### Local Travel

Medicaid will pay for the least expensive and appropriate mode of local ground transportation services to/from a medical appointment if the recipient has no other means of transportation (e.g., public transportation, recipient's own vehicle or that of a friend or family member who is able and willing to provide transportation) and if authorized in advance.

### Travel Escort

Medicaid will pay for the travel expenses of an escort to accompany a recipient under certain conditions. In general, the recipient must be age 17 or younger, or must provide medical justification that an escort is medically necessary. The travel escort's time is not compensable. Travel escort services must be authorized in advance.

### Travel Authorization Considerations

Travel authorization requests typically must originate from the recipient's referring medical provider however in some instances the request may be submitted by the receiving provider.

Travel arrangers are encouraged to coordinate appointments so that all necessary provider visits may occur during a single trip when possible, and to coordinate appointments into a single

trip when multiple recipients within a family require care. Travel may not be arranged for recipients' personal needs.

The following chart was developed to guide both the provider in making the travel request and the fiscal agent, on behalf of the department, in making the appropriate authorization decision.

<b>Medicaid Recipient Travel</b>	<b>Child - 21 years or younger</b>	<b>Adult - 22 years or older</b>
<b>Non-emergent diagnostic or treatment services</b> available locally by CHA, licensed provider, and/or telemedicine, or expected to be locally available within 3 months (by traveling provider or by telemedicine).	Not covered	Not covered
<b>Non-emergent diagnostic or treatment services</b> recommended by non-licensed provider (e.g., CHA, medical assistant) without consulting licensed provider.	Not covered	Not covered
<b>Non-emergent diagnostic or treatment service</b> determined by a licensed provider (MD, ANP, PA, DMD) to be medically necessary for a specific condition at a level higher than available locally or with telemedicine, and not expected to be available for at least 3 months.	Covered	Covered
<b>Non-emergent diagnostic or treatment service</b> expected to be locally available within 3 months, but licensed provider specifies that care is needed before available locally.	Covered, with letter of medical necessity <sup>1</sup> from appropriate licensed provider <sup>2</sup>	Covered, with letter of medical necessity <sup>1</sup> from appropriate licensed provider <sup>2</sup>
<b>Screening:</b> Routine screening colonoscopy or flexible sigmoidoscopy.	N/A	Not covered
<b>Screening:</b> Other recommended <b>adult</b> preventive services not available in local community (e.g., screening women exams, routine immunizations, routine vision screens).	N/A	Covered, with letter of medical necessity <sup>1</sup> from appropriate licensed provider <sup>2</sup>
<b>Pediatric screening:</b> Recommended preventive services not available in local community from CHA or licensed provider, and not expected to be available within three months.	Covered	N/A
<b>Therapies (PT/OT/Speech):</b> non-emergent behavioral health care or therapeutic services which are not available locally or by telemedicine, and not expected to be available, with no letter from provider.	Not covered	Not covered
<b>Therapies (PT/OT/Speech):</b> as above, with letter from provider, or with ILP plan for children 3 and under.	Covered	Covered
<b>Therapies (Behavioral Health):</b> recipient requires behavioral health counseling services but has personal relationships with all local counselors and behavioral telemedicine is unavailable.	Covered, with letter of medical necessity <sup>1</sup> from appropriate licensed provider <sup>3</sup>	Covered, with letter of medical necessity <sup>1</sup> from appropriate licensed provider <sup>3</sup>

<sup>1</sup> Letter of medical necessity must be signed and dated, and must include:

- Provider name and Medicaid ID number
- Recipient's name and Medicaid ID number
- A detailed explanation why travel is medically necessary
- Explanation why services cannot be performed locally or through telemedicine; if local services will be available within 3 months, why the recipient cannot wait until an appropriate provider is available locally.

<sup>2</sup> MD, ANP, PA, DMD

<sup>3</sup> MD, ANP, PA, psychologist, social worker, mental health clinician

<b>Medicaid Escort Travel</b>	<b>Child Recipient - 17 years or younger</b>	<b>Adult Recipient - 18 years or older</b>
Adult recipient receiving screening or preventive services	N/A	Not covered
Adult recipient with limited English language ability	N/A	Not covered
Elderly recipient who is <b>not</b> mobile or who cannot ambulate on his/her own or with cane/walker	N/A	Covered
Elderly recipient who is mobile and able to ambulate on his/her own or with cane/walker	N/A	Not covered
Recipient with significant cognitive or physical dysfunction from developmental disability or from acquired conditions such as stroke or dementia.	Covered	Covered
Developmentally disabled <b>adult</b> , without significant cognitive dysfunction or physical disability (e.g., CP or muscular dystrophy)	N/A	Not covered
Confined to a wheelchair or blind	Covered	Covered
Recipient age 21 years or younger who does not meet PA criteria for travel coverage	Not covered	Not covered
Recipient age 17 or younger, who does meet criteria for travel coverage	Covered	N/A
Recipient age 18-21, who meets criteria for travel coverage, but does not meet adult escort criteria	Not covered	Not covered
Recipient age 18-21, who meets criteria for travel coverage, and also meets adult escort criteria	Covered	Covered

## Tribal Health Program

Established in 2002, the Department's Tribal Health Program was created to support the delivery of Medicaid services provided through Tribal Health Organizations statewide. Through written consultations, ongoing dialogue, and formalized meetings, the Tribal Health program develops and maintains a cohesive and meaningful relationship with tribal health organizations and communities. Among its efforts to improve the health status of Alaska Native people and to maximize federal Medicaid funding, the Department:

- Advocates for enhanced federal funding for American Indians and Alaska Natives under Medicaid for all services and contract health referrals made by the Tribes
- Supports the infrastructure development of the Tribal Health care delivery system
- Collaborates with the Tribes and Tribal Health Organizations on various initiatives and department programs

The Tribal Health Program acts as a liaison to the Tribal Health Organizations across the state and to each division and program within the Department.

### Managing the Tribal Health Program

Tribal Health program staff members have in-depth knowledge of the Medicaid eligibility and payment system, tribal health programs, and the Alaska Native population. Staff serves as liaisons between the tribal health organizations, Indian Health Services (IHS), CMS and the Alaska Medicaid program. They are also responsible for collaborating across divisions within the Department of Health and Social Services to ensure that tribal health organizations are a partner to the Department in the delivery of healthcare to the Alaska Native population. Some services provided by the Tribal Health Program include:

- Assistance with understanding and researching Medicaid claims and resolving billing issues
- Assistance with Medicaid-related travel
- Provider training and outreach
- Support to the Community Health Aide Program
- Meeting DHSS federal responsibility regarding Tribal Consultation to ensure that tribal health designees are afforded the opportunity to provide input when State Plan changes are made

### Medicaid Funding and Tribal Health Care

Healthcare funding for American Indian and Alaska Native people originated in 1910 with the Bureau of Indian Affairs and responsibility for the program was transferred to IHS in 1956. Congress authorized Medicaid reimbursement to states for payment to IHS and tribal facilities operating health programs under self-determination agreements at 100 percent FMAP.

Because of escalating health care costs and severe federal funding shortfalls, the additional revenue generated by Medicare, Medicaid and other third-party payors has become a significant part of the Tribal Health Program's budget. Similar to any other health care provider, the stability of third-party funds is critical to the financial viability of tribal health programs.

## Challenges of Health Care Delivery in Alaska

Alaska's vast size, rural nature, limited road system, and arctic climate add a unique level of complexity in providing health care services to our residents. In addition to these challenges, Alaska is faced with insufficient numbers of health care providers throughout non-urban areas of the state. To receive many specialty services, Medicaid recipients must travel out of state, and those that are available in-state are limited principally to Anchorage, Fairbanks and Juneau.

The following are examples of the challenges faced by Alaska Medicaid recipients, their families, and Medicaid program staff.

Note: Names and some details have been changed to protect the privacy of the recipients.

### **Kaitlin**

One week before her sixth birthday, Kaitlin, who lives with her grandparents in a village on Sarichef Island in the Chukchi Sea, developed symptoms of meningitis. Because she was stable, Kaitlin was transported on a non-emergent flight to Nome to be evaluated at Norton Sound Regional Hospital (NSRH).

Kaitlin's condition worsened and, due to limited medical resources available at NSRH, she was medevaced to Alaska Native Medical Center (ANMC) in Anchorage. She spent several weeks at ANMC before she was stable to return home to the village. Her chronic health care issues resulting from meningitis, including respiratory distress and intractable seizures required her to be medevaced to NSRH and ANMC several more times over subsequent years.

### **Annie**

Annie was born with hypoplastic left heart syndrome, a congenital defect that results in diminished blood flow. At age three, after several heart surgeries, Annie was placed on the national transplant register. Annie and her mother Kate moved from their home in Juneau to the Ronald McDonald House (an Alaska Medicaid-enrolled accommodation provider) in Seattle to be near the transplant hospital. Annie's father remained in Juneau to maintain employment; his parents moved in to assist with the care of Annie's three siblings.

After 22 months Annie's family received the long-awaited and joyful news that a compatible heart was available. Four years post-transplant, Annie has had a few setbacks but overall is doing well. Travel to Seattle twice a year for follow up visits will continue to be necessary.

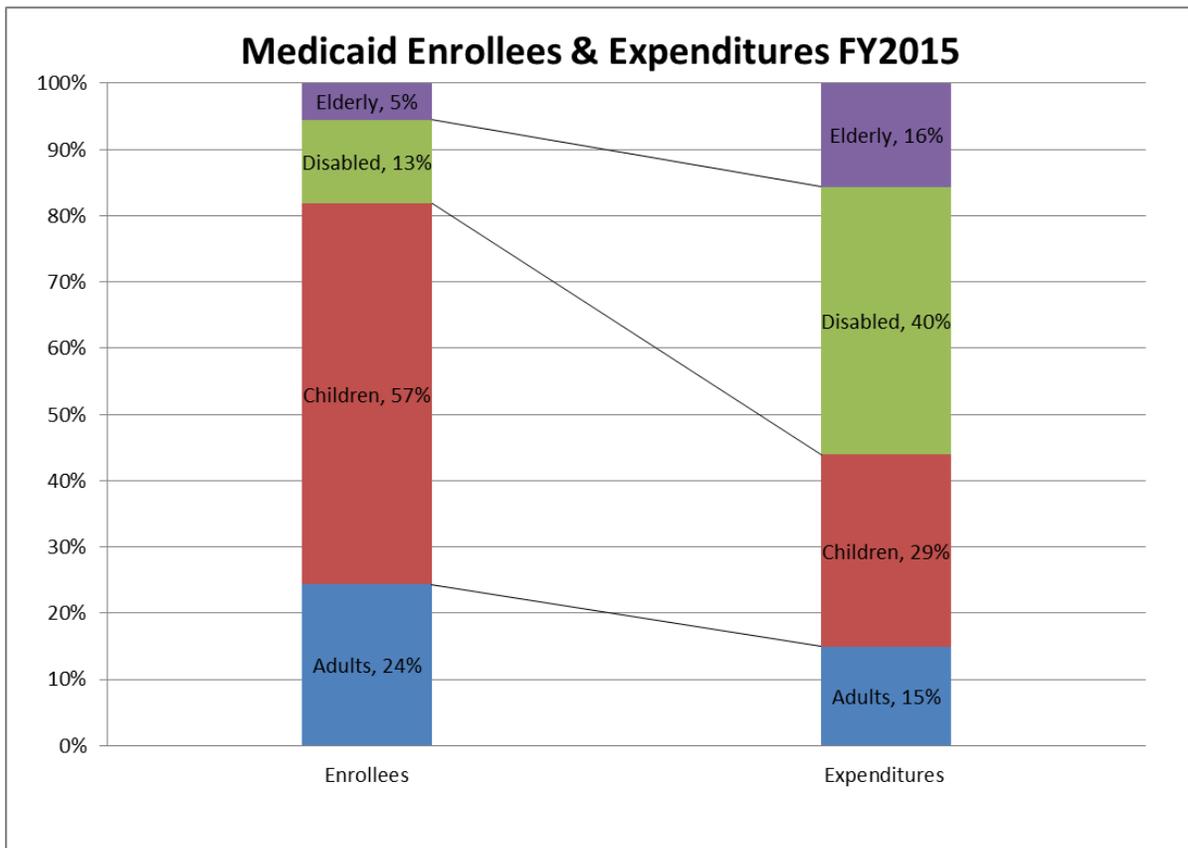
### **Henry**

Henry, a 43-year diabetic from Tok developed symptoms of renal failure and was transported to Providence Hospital in Anchorage. It was determined that Henry would require dialysis 3 times weekly. Because dialysis is not available in Tok, it was necessary for Henry to move to Anchorage from his home in Tok where he had lived since birth.

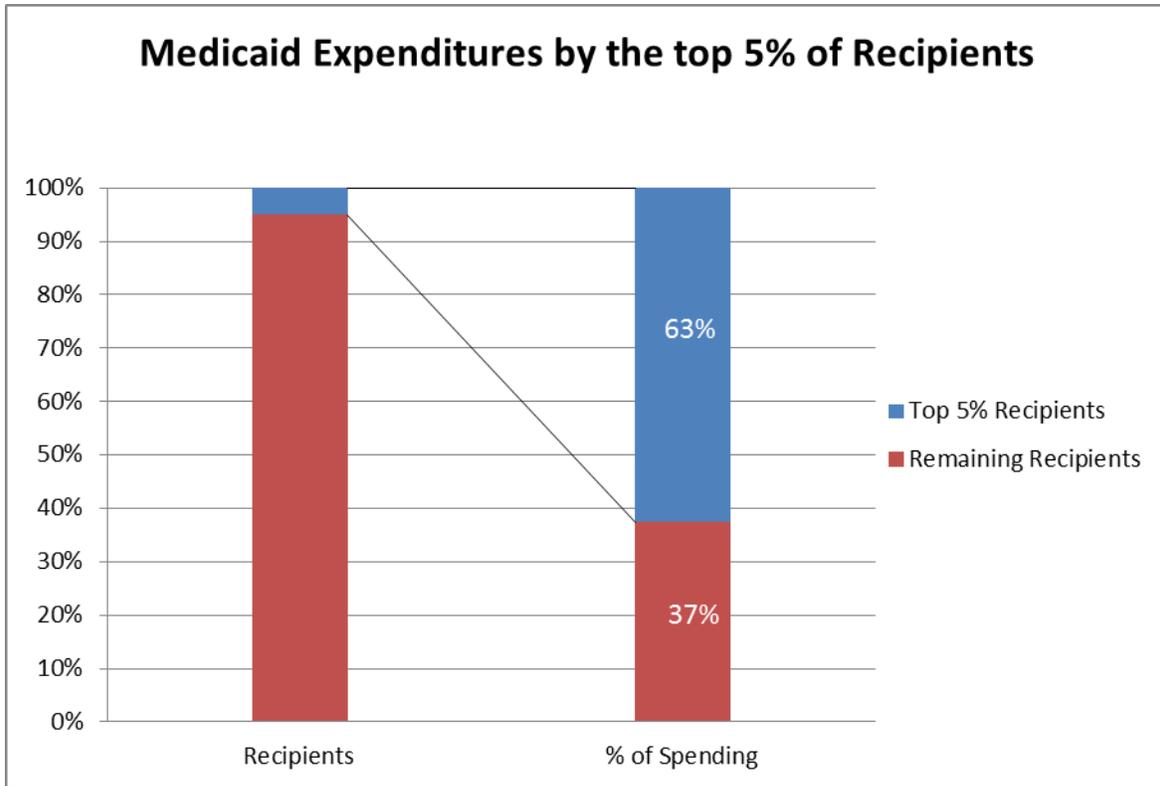
## Alaska Medicaid SFY2015 Data

The Alaska Medicaid program paid more than \$1.3 billion during FY2015 to provide health coverage to eligible Alaskans in need. Enrollees are defined as individuals eligible for Medicaid benefits. Recipients are enrollees who utilize Medicaid benefits.

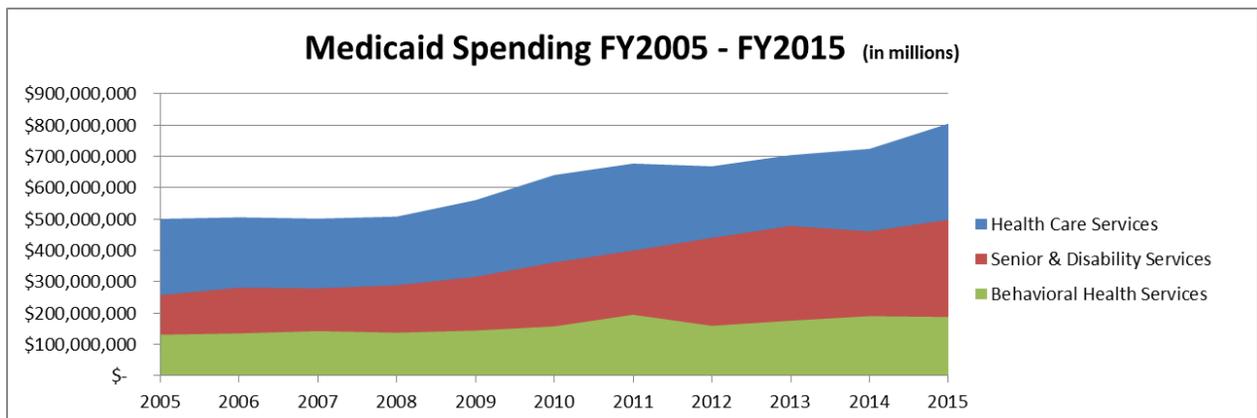
As illustrated in the following chart, the percentage of total enrollees by a subgroup is not necessarily proportional to the subgroup's percentage of total expenditures.



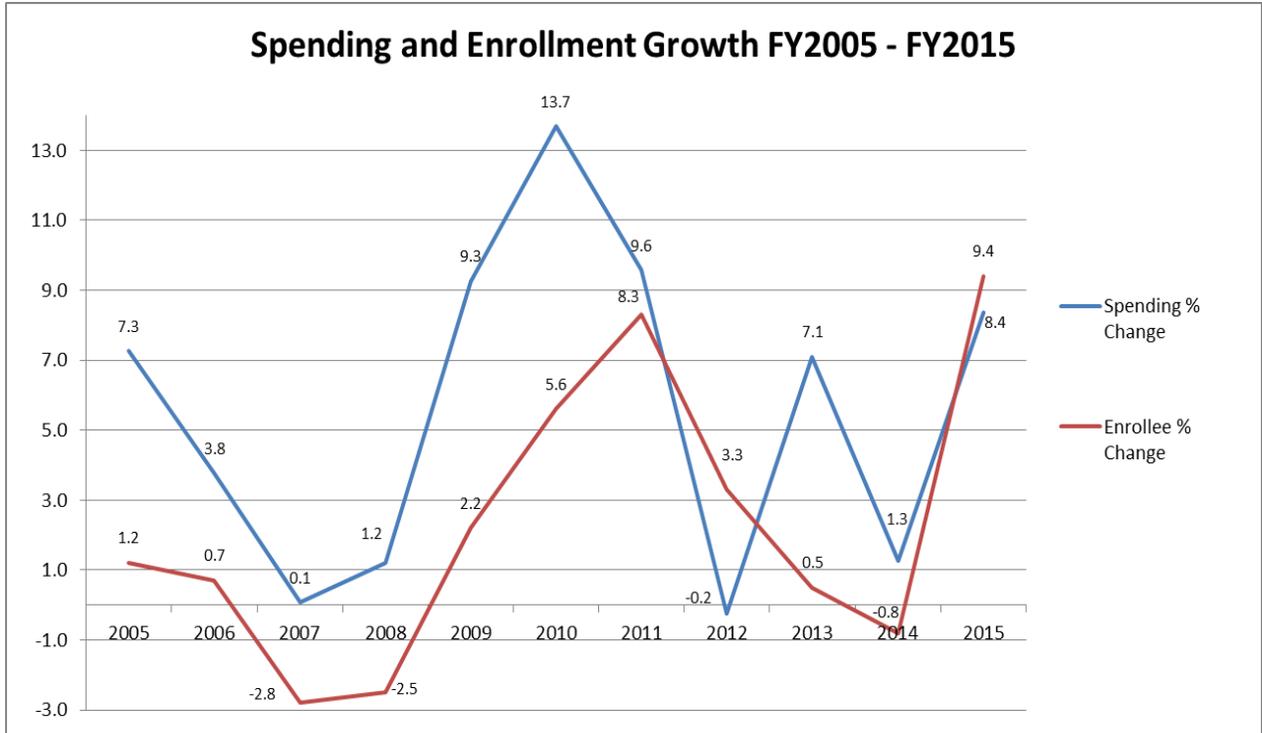
The majority of Medicaid expenditures are driven by 5% of Medicaid recipients.



The following chart illustrates the amount of expenditures within each Division since FY2005.

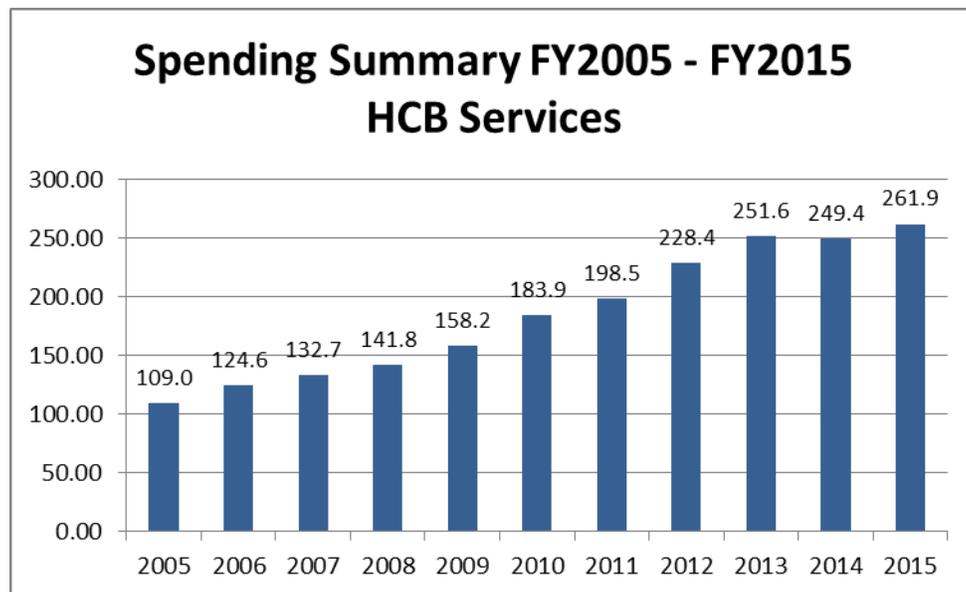
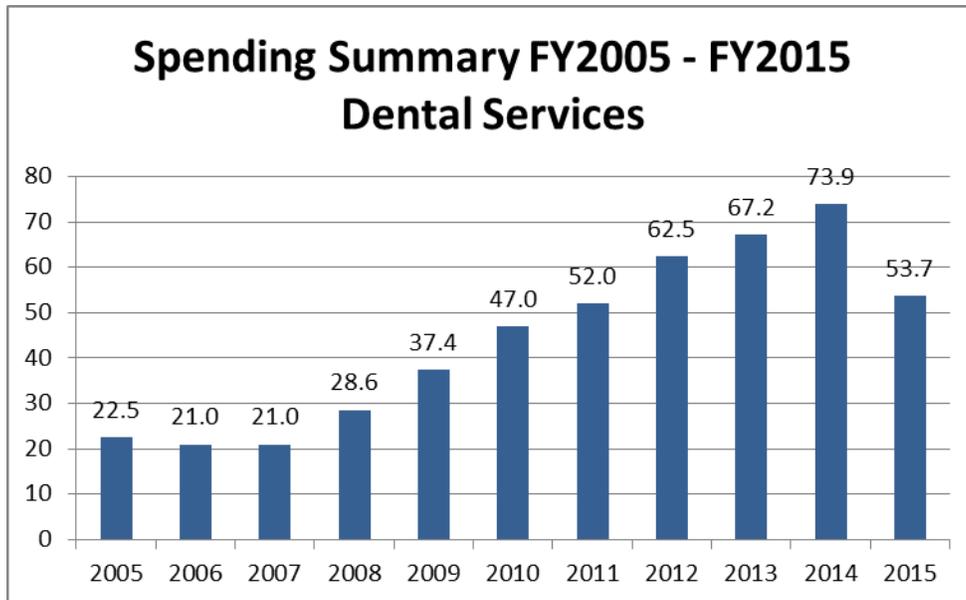


The following chart illustrates the spending & enrollment growth within Medicaid since FY2005.

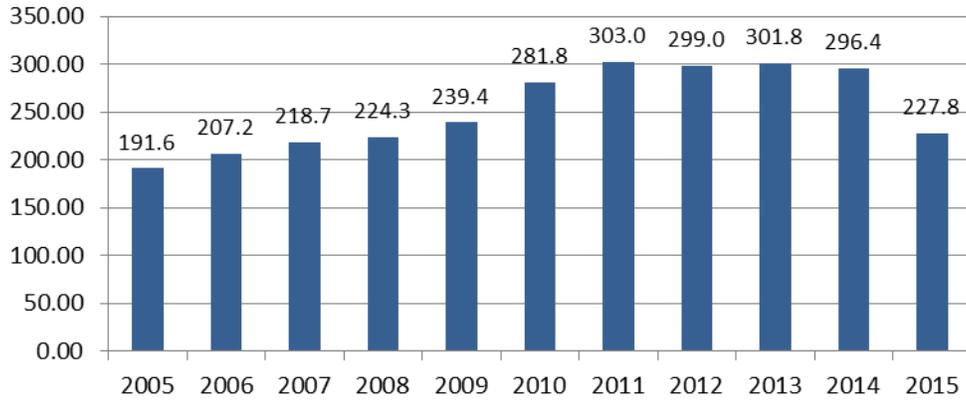


## Medicaid Expenditures by Category of Service

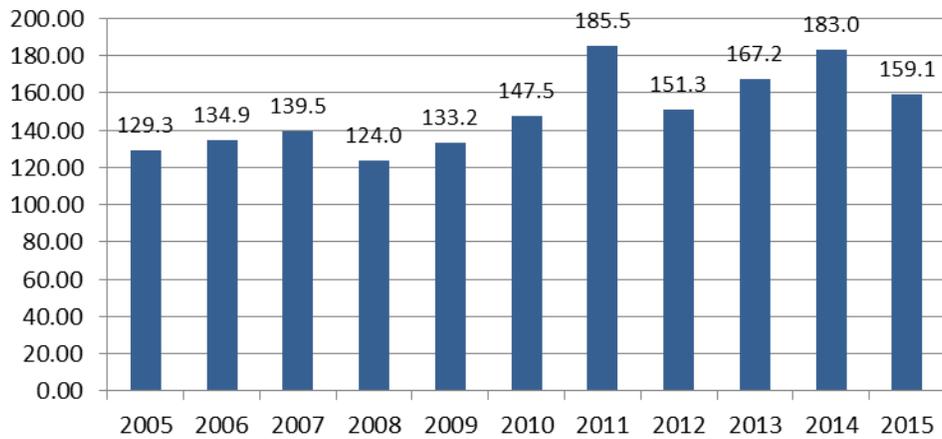
The following charts represent the breakdown (in millions) of Medicaid expenditures since FY2005 within these categories of service; Dental, Home and Community-Based (HCB), Hospital, Mental Health, Pharmacy, Physician, Transportation, and Tribal.



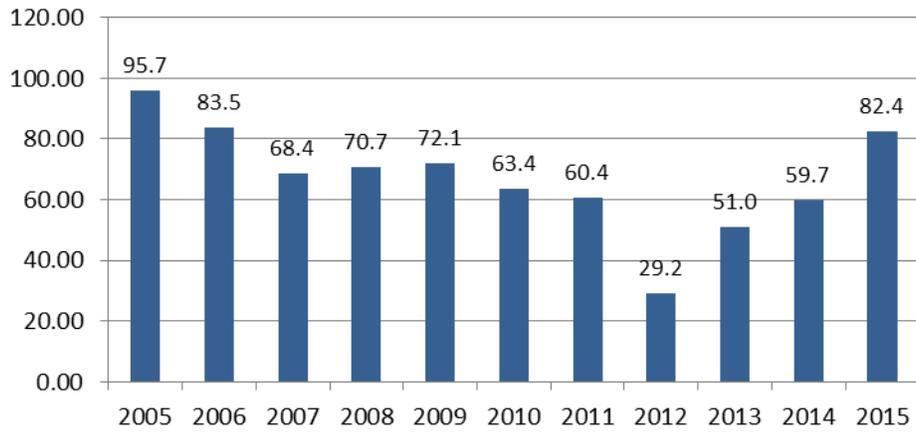
### Spending Summary FY2005 - FY2015 Hospital Services



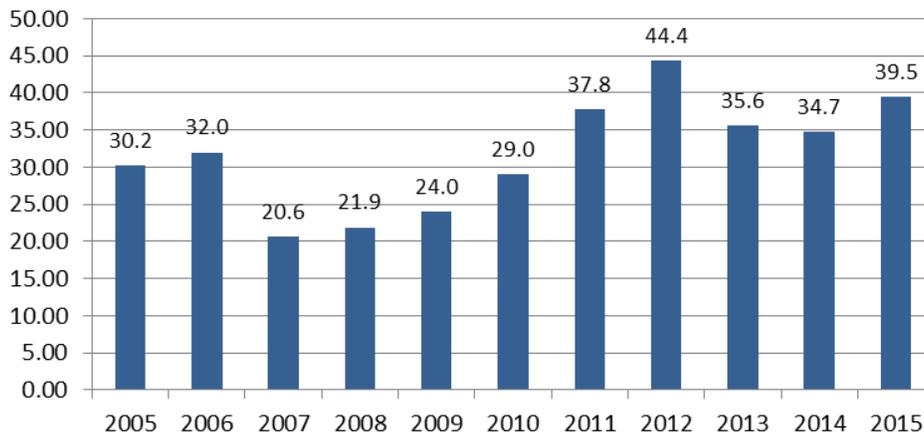
### Spending Summary FY2005 - FY2015 Mental Health Services



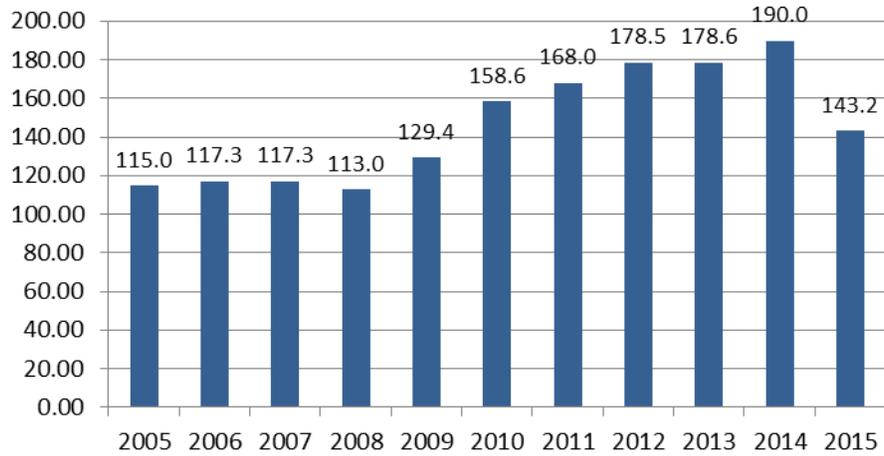
### Spending Summary FY2005 - FY2015 Pharmacy Services



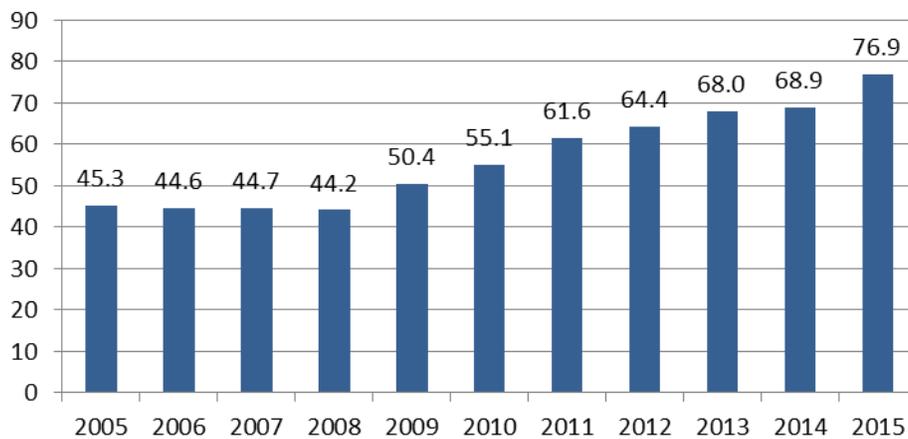
### Spending Summary FY2005 - FY2015 Pharmacy Rebates



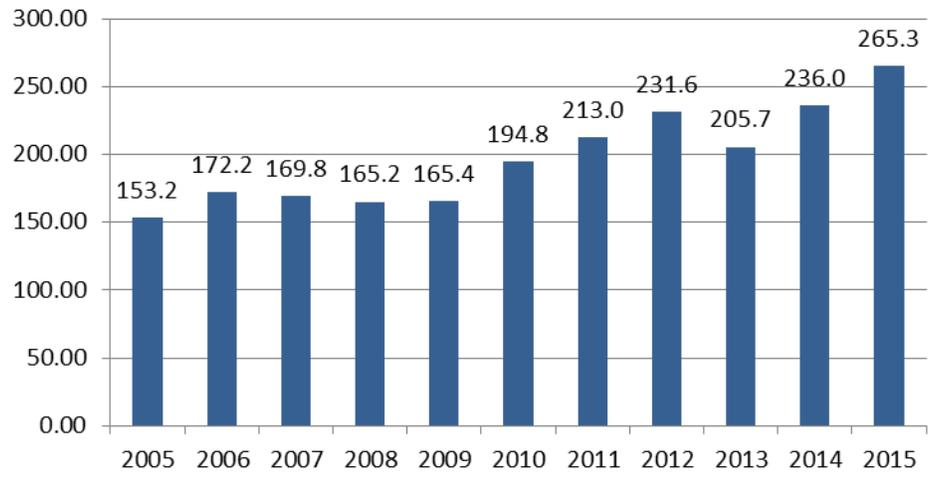
### Spending Summary FY2005 - FY2015 Physician Services



### Spending Summary FY2005 - FY2015 Transportation Services



## Spending Summary FY2005 - FY2015 Tribal Health Services



## Medicaid Data by Senate District

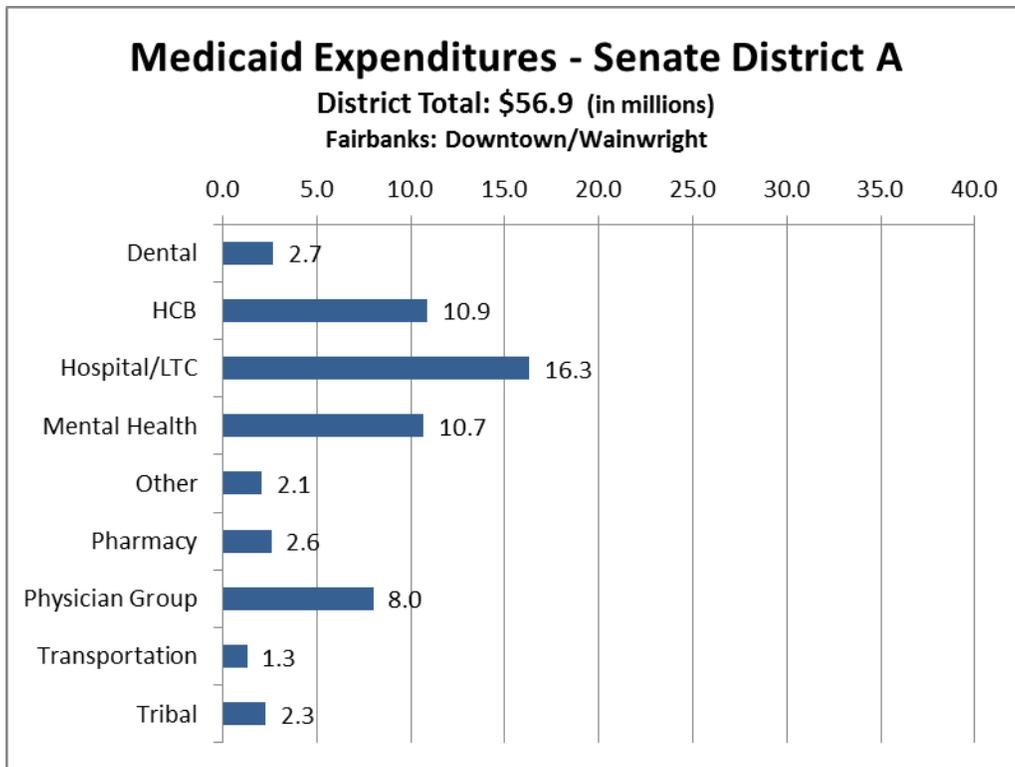
The following pages provide, for each senate district, charts reflecting the number of Medicaid recipients, the number of enrolled Medicaid providers, and Medicaid expenditures (in \$millions) for the following services: dental, HCB, hospital/LTC, mental health, other, pharmacy, physician group, transportation, and tribal. The *'other'* category represents smaller provider types including dietitians, direct-entry midwives, labs, nurses, nutritionists, personal care assistants, school-based services, therapies, and vision.

**Senate District A - Fairbanks: Downtown / Wainwright**

Medicaid Recipients	
Age	Number within District
0-10	2,068
11-20	1,381
21-59	2,066
60+	638
<b>Total</b>	<b>6,153</b>

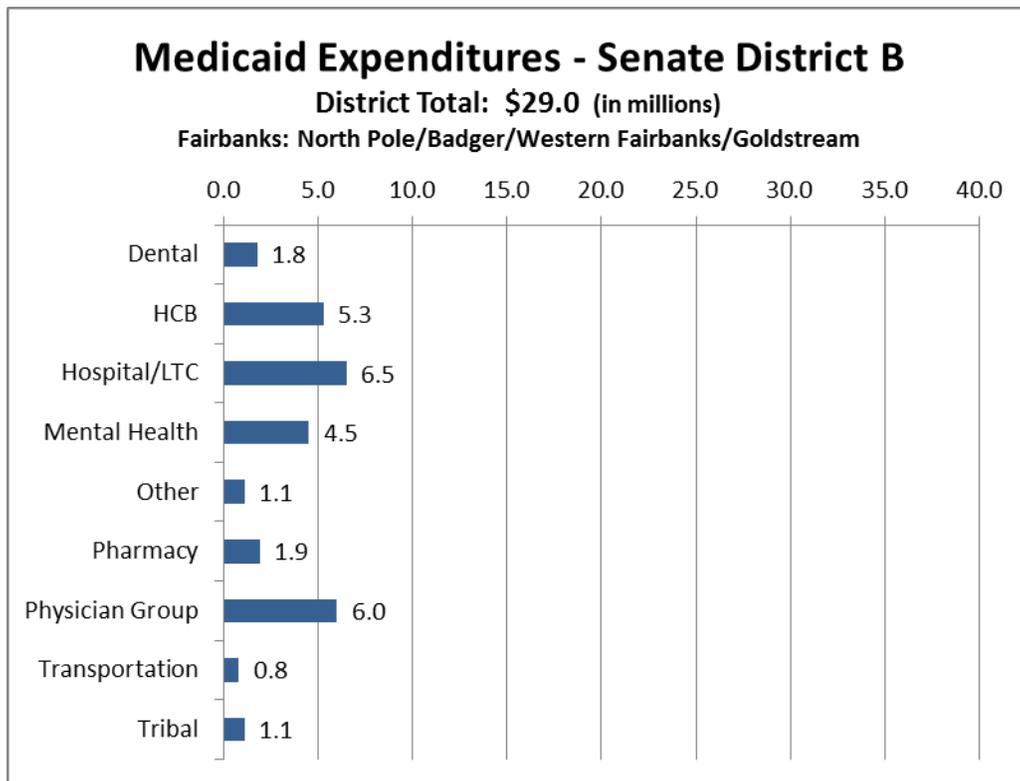
  

Medicaid Providers	
Types	Number within District
Dental	65
HCB	61
Hospital	2
LTC	2
Mental Health	25
Other	147
Personal Care Services	375
Pharmacy	28
Physician Group	594
Transportation	21
Tribal	1
<b>Total</b>	<b>1321</b>



**Senate District B - Fairbanks: North Pole / Badger / Western Fairbanks / Goldstream**

Medicaid Recipients	
Age	Number within District
0-10	1,810
11-20	1,061
21-59	1,480
60+	269
<b>Total</b>	<b>4,620</b>
Medicaid Providers	
Types	Number within District
Dental	5
HCB	9
Other	17
Personal Care Services	107
Pharmacy	3
Physician Group	2
Transportation	6
<b>Total</b>	<b>149</b>

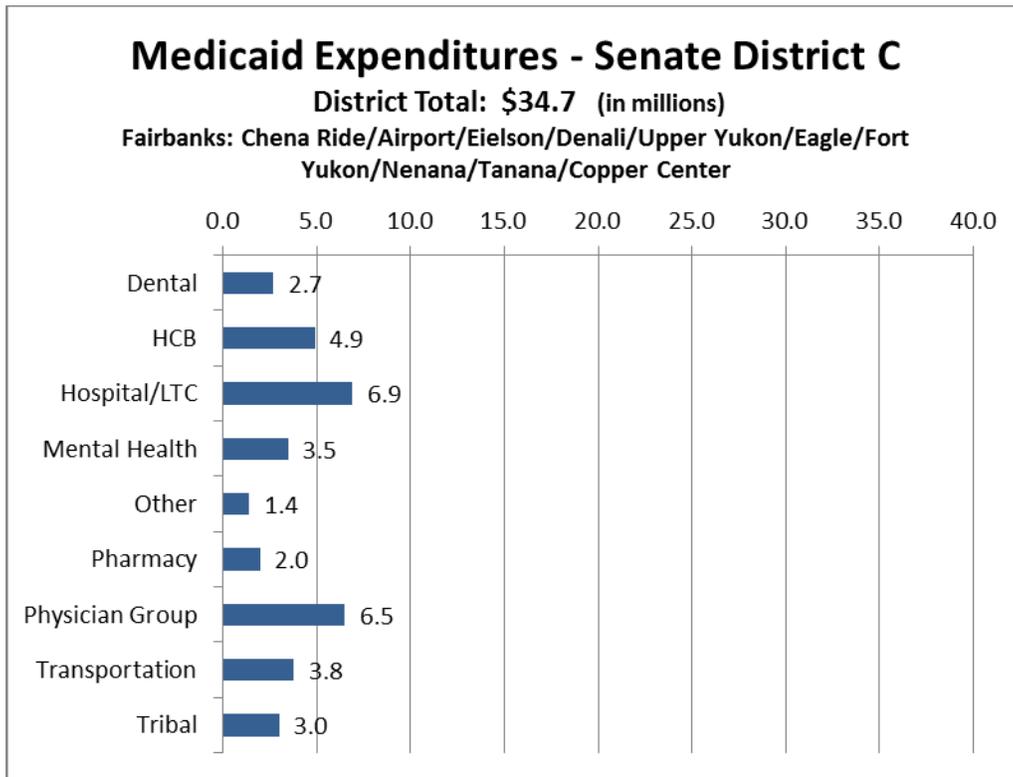


**Senate District C - Fairbanks: Chena Ride/ Airport / Eielson / Denali / Upper Yukon/ Eagle / Fort Yukon / Nenana / Tanana / Copper Center**

Medicaid Recipients	
Age	Number within District
0-10	2,083
11-20	1,398
21-59	1,961
60+	546
<b>Total</b>	<b>5,988</b>

Medicaid Providers	
Types	Number within District
Dental	8
HCB	1
Mental Health	4
Other	1
Personal Care Services	70
Physician Group	67
Transportation	12
Tribal	7
<b>Total</b>	<b>170</b>

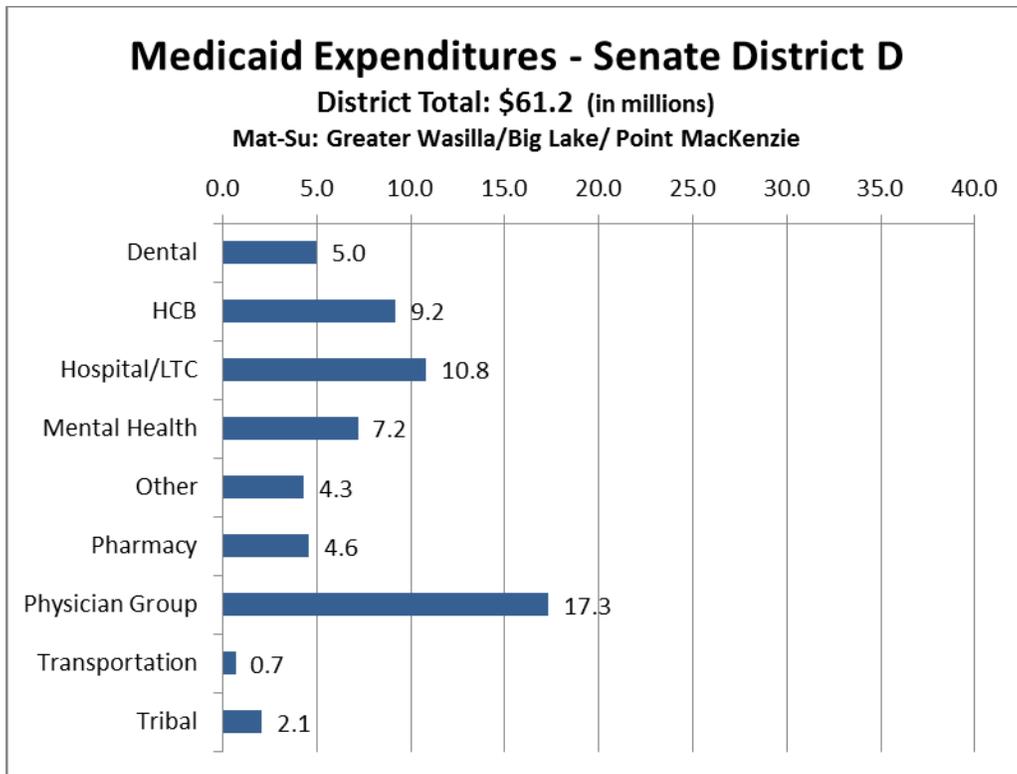


**Senate District D - Mat-Su: Greater Wasilla / Big Lake / Point MacKenzie**

Medicaid Recipients	
Age	Number within District
0-10	5,424
11-20	2,451
21-59	3,263
60+	458
<b>Total</b>	<b>11,596</b>

Medicaid Providers	
Types	Number within District
Dental	62
HCB	93
Hospital	1
LTC	1
Mental Health	14
Other	103
Personal Care Services	993
Pharmacy	23
Physician Group	285
Transportation	7
Tribal	2
<b>Total</b>	<b>1584</b>

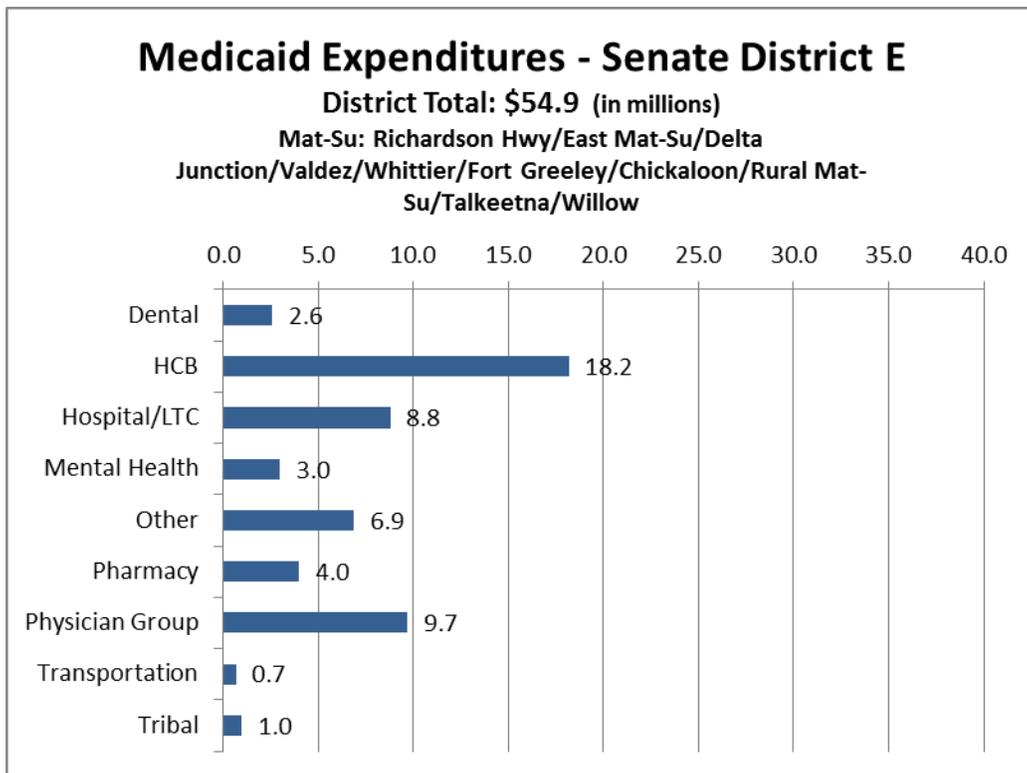


**Senate District E - Mat-Su: Richardson Hwy / East Mat-Su / Delta Junction / Valdez / Whittier / Fort Greeley / Chickaloon / Rural Mat-Su / Talkeetna / Willow**

Medicaid Recipients	
Age	Number within District
0-10	1,501
11-20	1,346
21-59	2,688
60+	883
<b>Total</b>	<b>6,418</b>

Medicaid Providers	
Types	Number within District
Dental	19
HCB	21
Hospital	5
LTC	1
Mental Health	5
Other	8
Personal Care Services	247
Pharmacy	5
Physician Group	67
Transportation	8
Tribal	2
<b>Total</b>	<b>388</b>

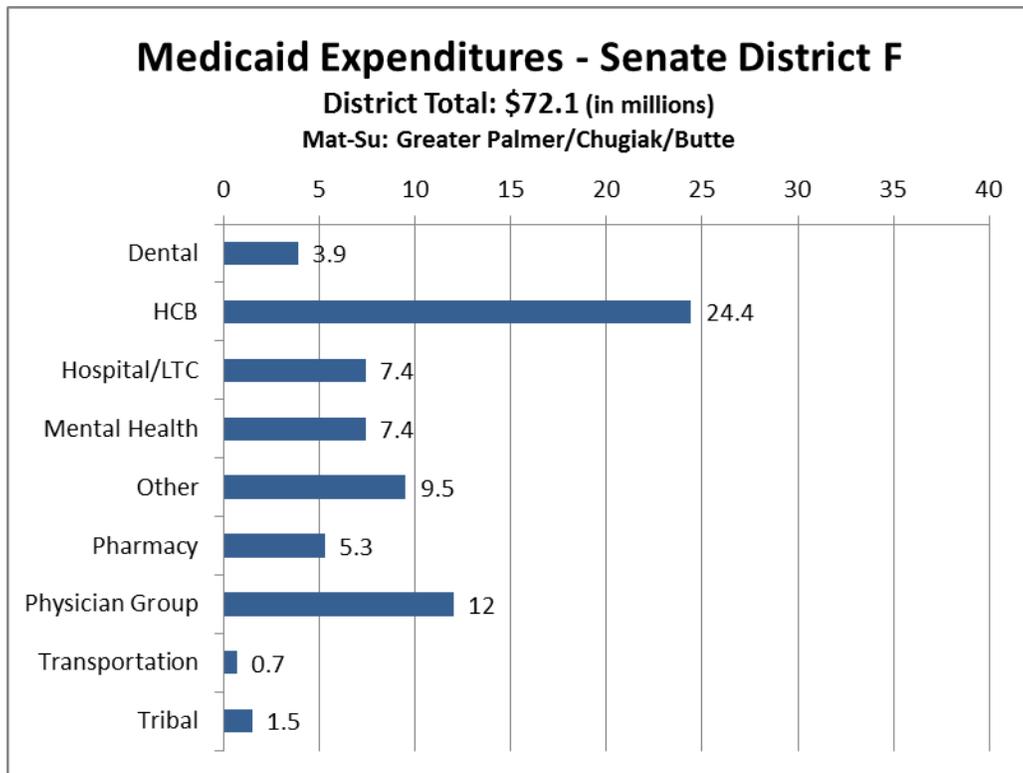


**Senate District F - Mat-Su: Greater Palmer / Chugiak / Butte**

Medicaid Recipients	
Age	Number within District
0-10	2,238
11-20	2,798
21-59	3,134
60+	764
<b>Total</b>	<b>8,934</b>

Medicaid Providers	
Types	Number within District
Dental	4
HCB	33
Hospital	1
Mental Health	8
Other	36
Personal Care Services	332
Pharmacy	8
Physician Group	191
Transportation	4
Tribal	1
<b>Total</b>	<b>618</b>

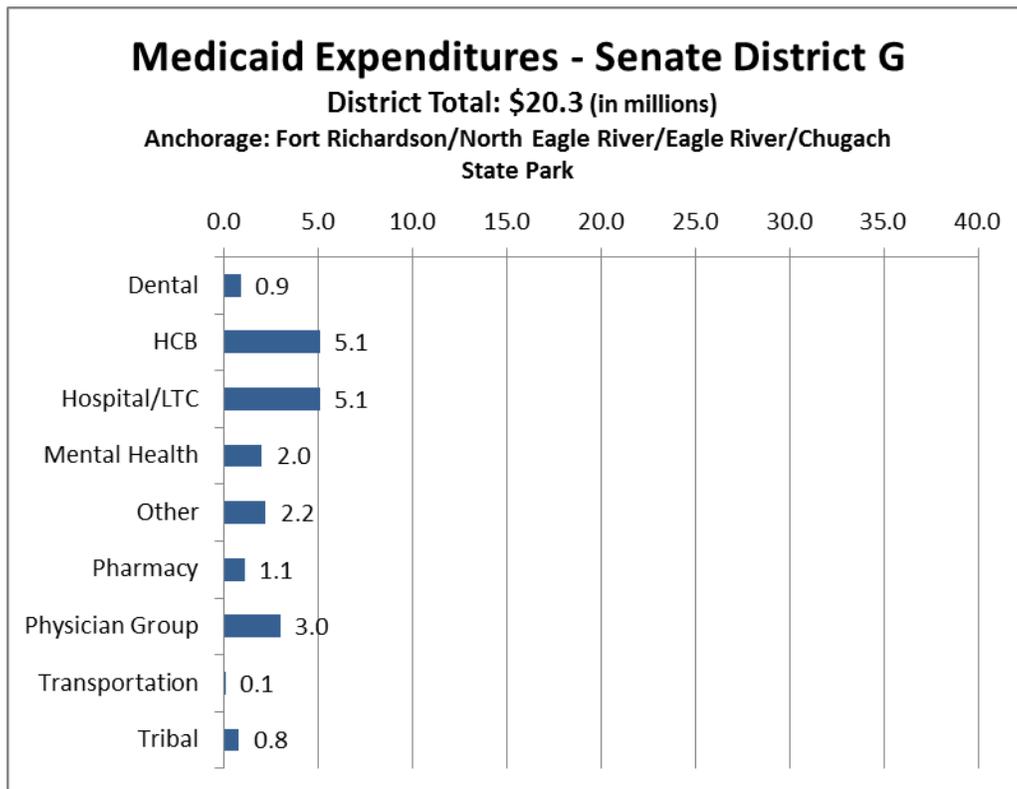


**Senate District G - Anchorage: Fort Richardson / North Eagle River / Eagle River / Chugach State Park**

Medicaid Recipients	
Age	Number within District
0-10	810
11-20	737
21-59	737
60+	271
<b>Total</b>	<b>2,555</b>

Medicaid Providers	
Types	Number within District
Dental	14
HCB	24
Mental Health	2
Other	59
Personal Care Services	113
Pharmacy	9
Physician Group	69
<b>Total</b>	<b>290</b>

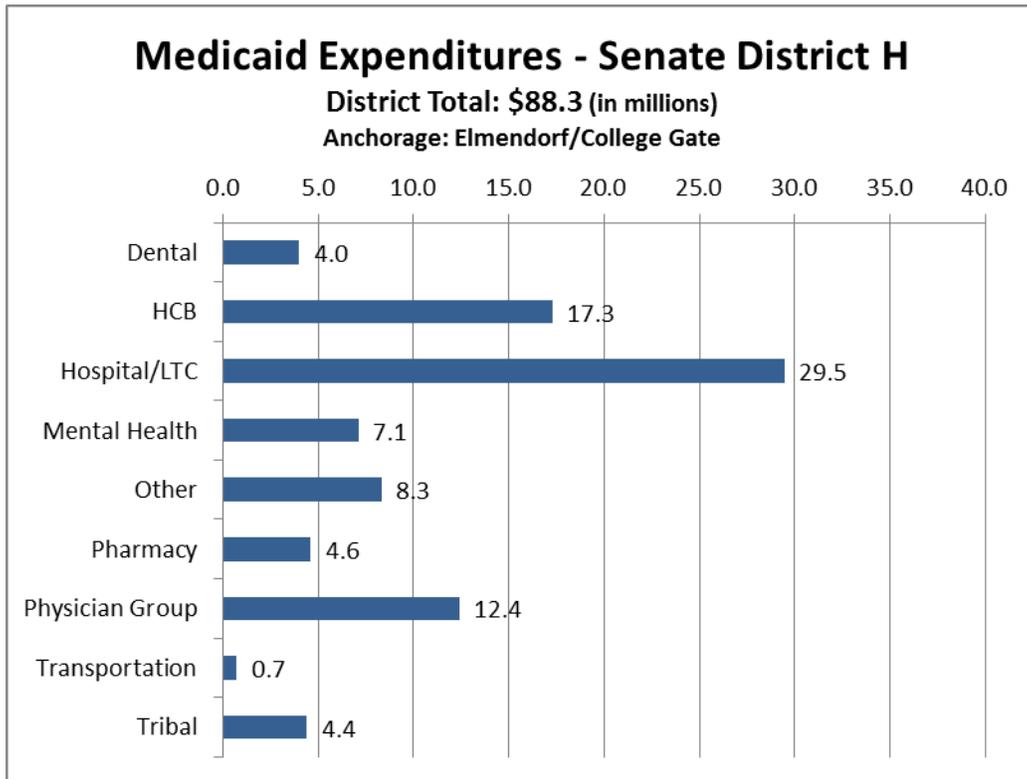


**Senate District H - Anchorage: Elmendorf / College Gate**

Medicaid Recipients	
Age	Number within District
0-10	3,390
11-20	2,431
21-59	3,182
60+	833
<b>Total</b>	<b>9,836</b>

Medicaid Providers	
Types	Number within District
Dental	39
HCB	57
LTC	3
Other	20
Personal Care Services	630
Pharmacy	14
Physician Group	36
Transportation	1
<b>Total</b>	<b>800</b>

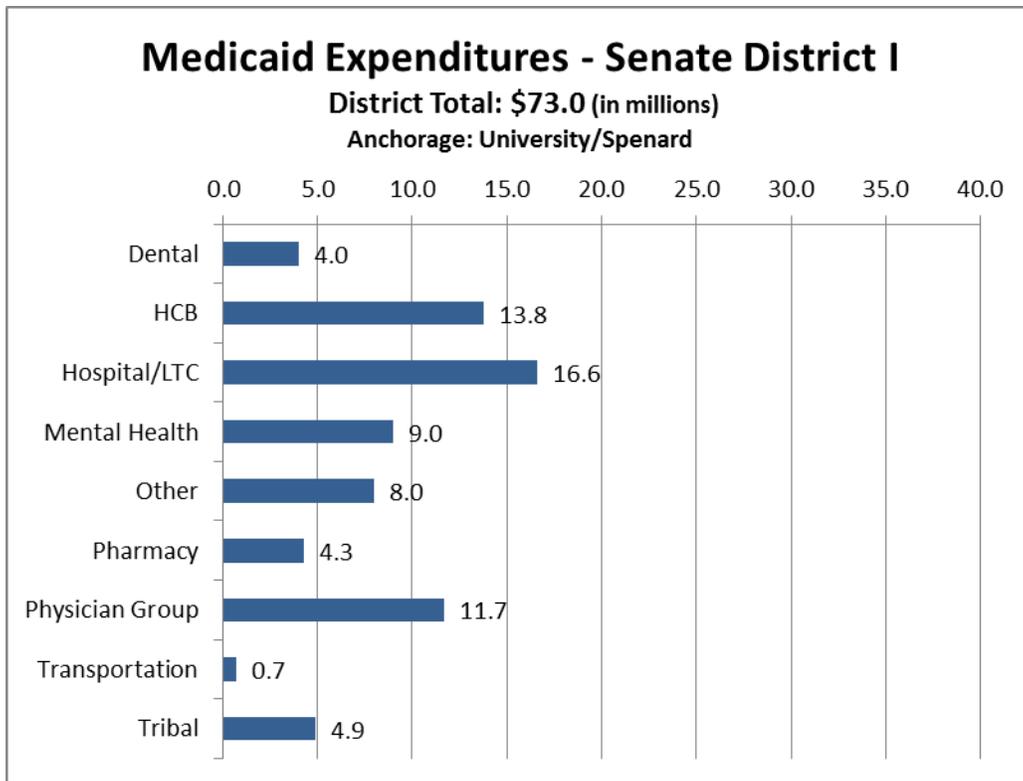


**Senate District I - Anchorage: University / Spenard**

Medicaid Recipients	
Age	Number within District
0-10	2,924
11-20	1,935
21-59	3,203
60+	962
<b>Total</b>	<b>9,024</b>

Medicaid Providers	
Types	Number within District
Dental	164
HCB	82
Hospital	1
LTC	2
Mental Health	34
Other	328
Personal Care Services	765
Pharmacy	67
Physician Group	1,892
Transportation	12
Tribal	6
<b>Total</b>	<b>3,353</b>

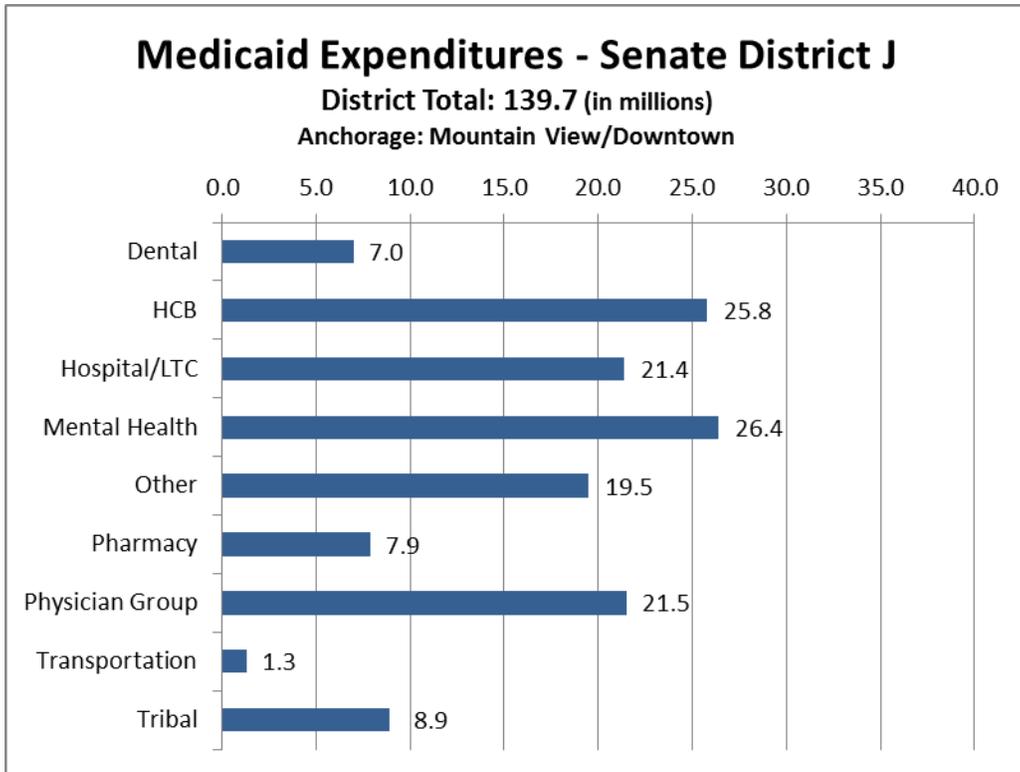


**Senate District J - Anchorage: Mountain View / Downtown**

Medicaid Recipients	
Age	Number within District
0-10	5,143
11-20	3,666
21-59	5,418
60+	1,659
<b>Total</b>	<b>15,886</b>

Medicaid Providers	
Types	Number within District
Dental	23
HCB	72
Hospital	1
LTC	1
Mental Health	20
Other	241
Personal Care Services	1,033
Pharmacy	8
Physician Group	387
Transportation	19
<b>Total</b>	<b>1,805</b>

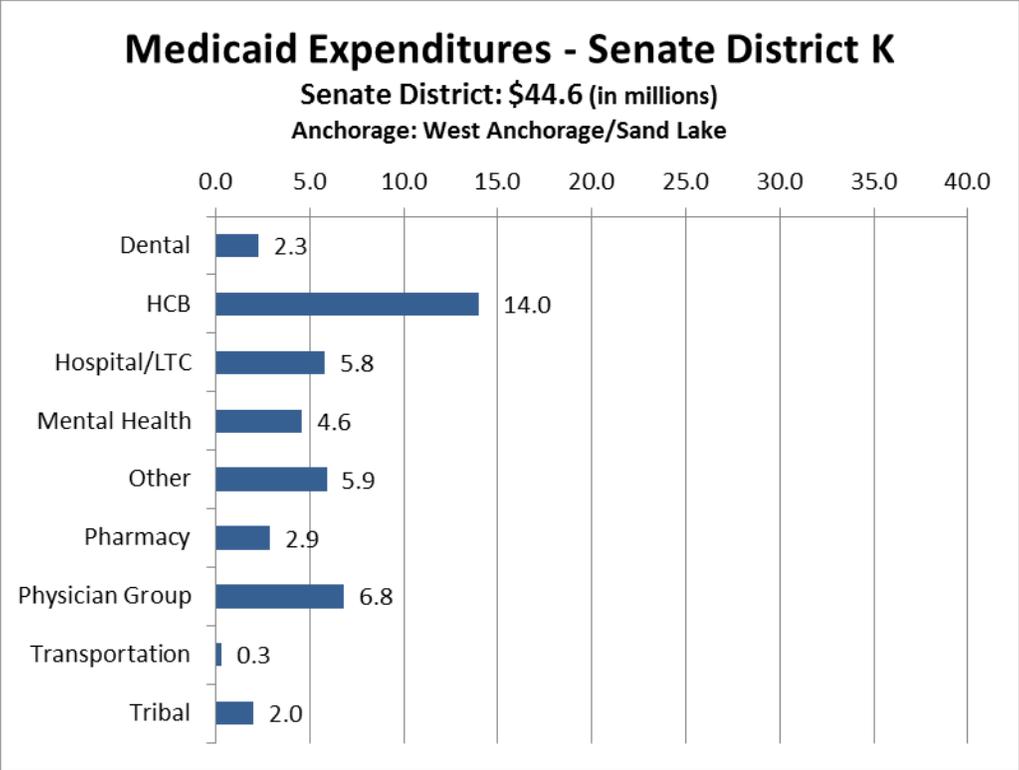


**Senate District K - Anchorage: West Anchorage / Sand Lake**

Medicaid Recipients	
Age	Number within District
0-10	1,925
11-20	1,286
21-59	1,660
60+	452
<b>Total</b>	<b>5,323</b>

Medicaid Providers	
Types	Number within District
Dental	13
HCB	29
LTC	1
Mental Health	2
Other	5
Personal Care Services	435
Physician Group	14
Transportation	10
<b>Total</b>	<b>509</b>

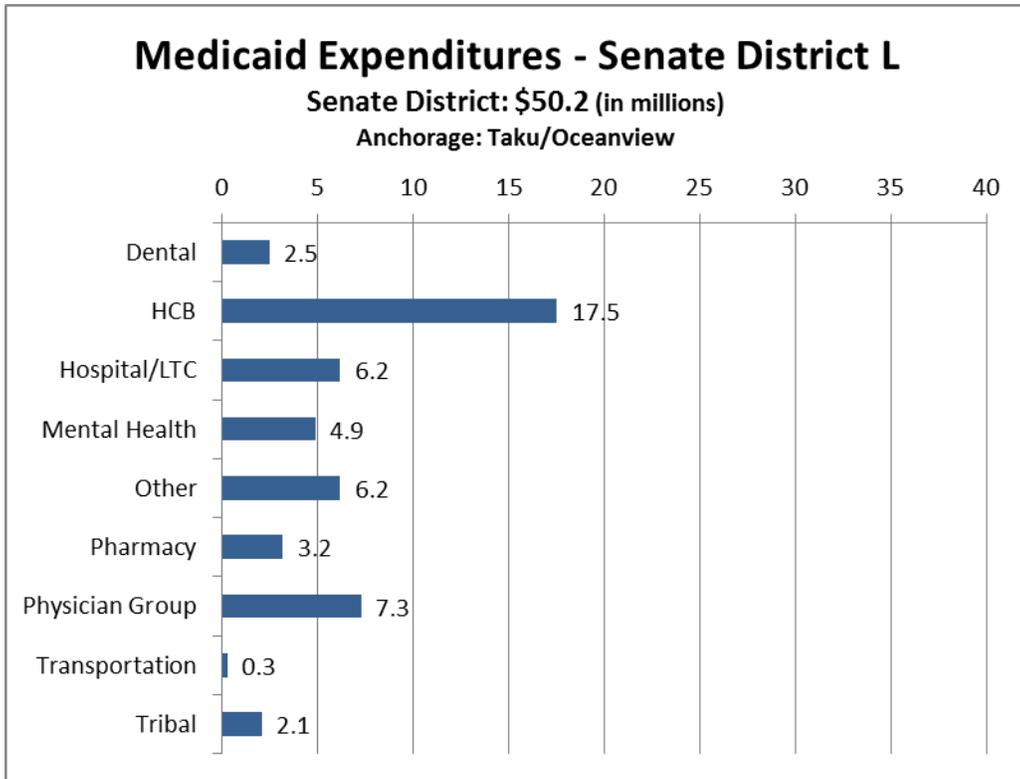


**Senate District L - Anchorage: Taku / Oceanview**

Medicaid Recipients	
Age	Number within District
0-10	2,148
11-20	1,393
21-59	1,816
60+	625
<b>Total</b>	<b>5,982</b>

Medicaid Providers	
Types	Number within District
Dental	22
HCB	113
Hospital	1
LTC	1
Mental Health	13
Other	88
Personal Care Services	617
Pharmacy	30
Physician Group	188
Transportation	8
<b>Total</b>	<b>1081</b>

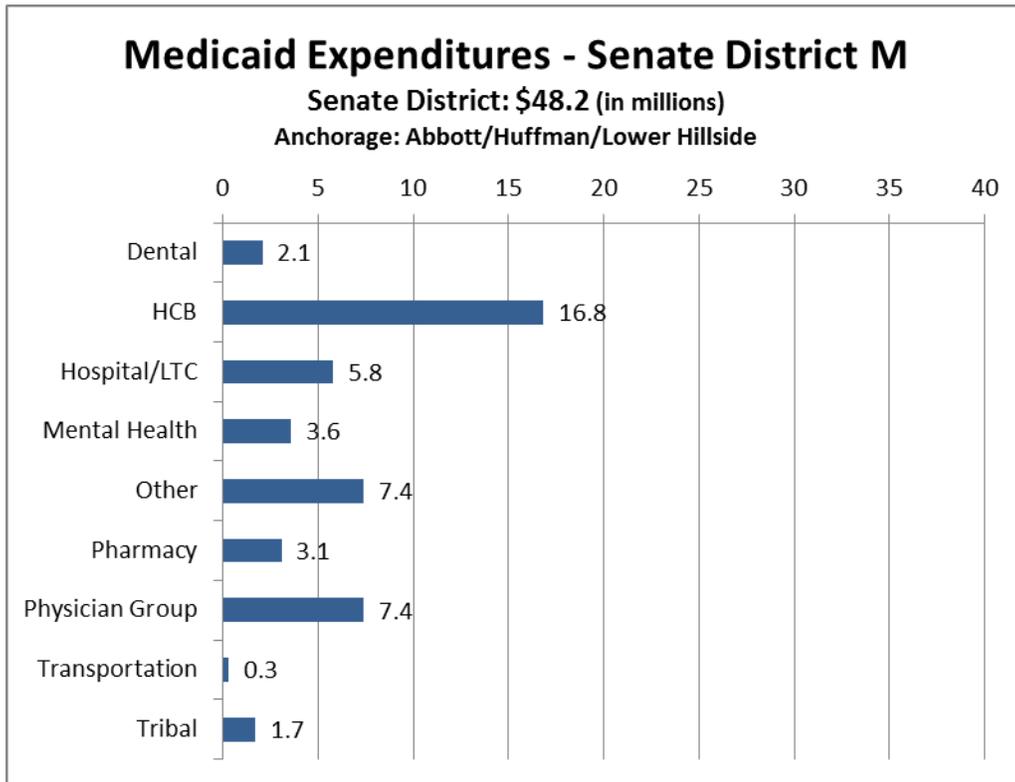


**Senate District M - Anchorage: Abbott / Huffman / Lower Hillside**

Medicaid Recipients	
Age	Number within District
0-10	1,873
11-20	1,286
21-59	1,498
60+	556
<b>Total</b>	<b>5,213</b>

Medicaid Providers	
Types	Number within District
Dental	8
HCB	99
Mental Health	3
Other	27
Personal Care Services	500
Pharmacy	8
Physician Group	57
Transportation	2
<b>Total</b>	<b>704</b>

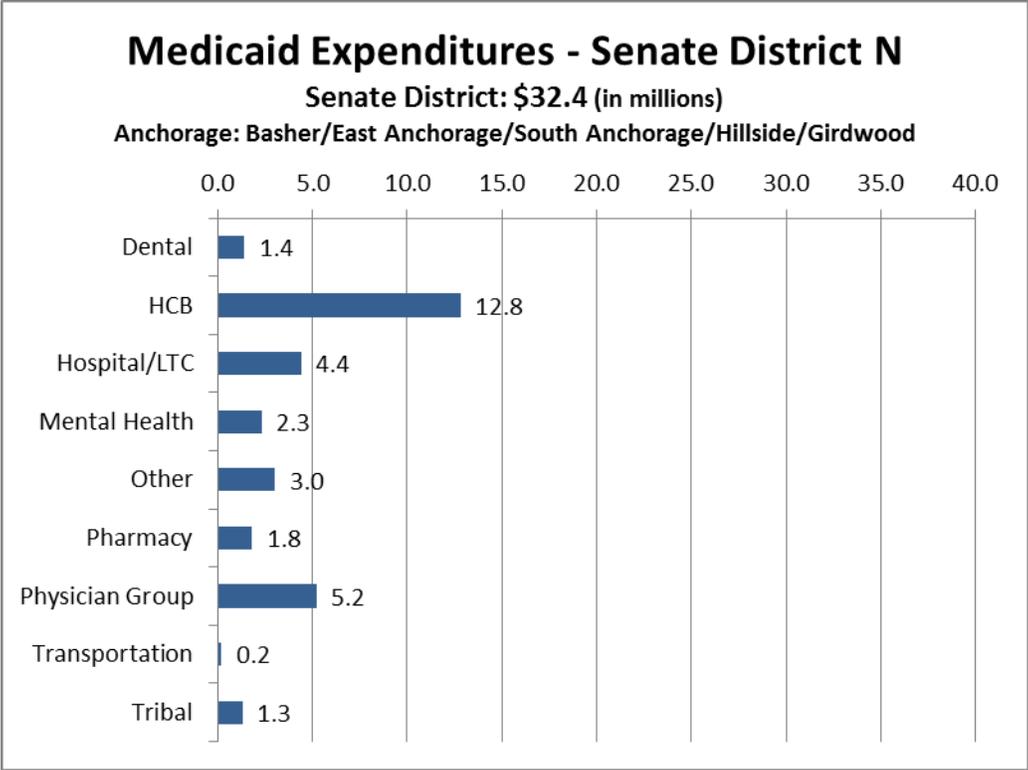


**Senate District N - Anchorage: Basher / East Anchorage / South Anchorage / Hillside / Girdwood**

Medicaid Recipients	
Age	Number within District
0-10	1,189
11-20	981
21-59	1,088
60+	295
<b>Total</b>	<b>3,553</b>

Medicaid Providers	
Types	Number within District
HCB	44
Other	3
Personal Care Services	316
Pharmacy	2
Physician Group	22
<b>Total</b>	<b>387</b>

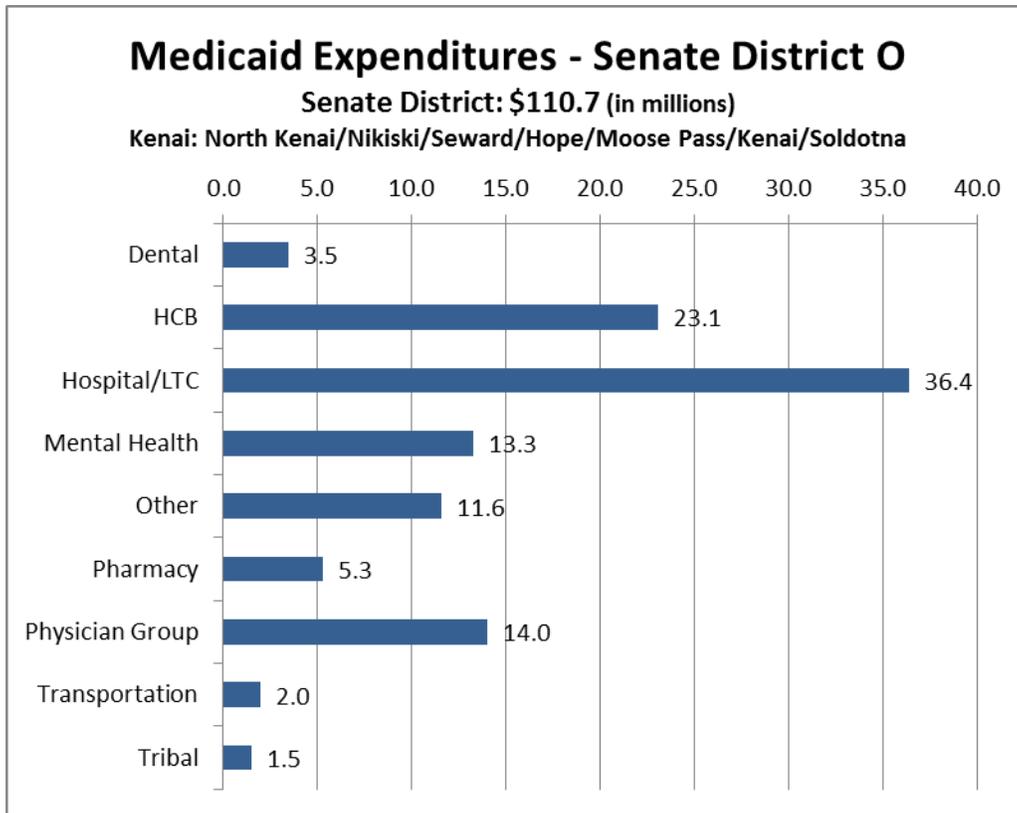


**Senate District O - Kenai: North Kenai / Nikiski / Seward / Hope / Moose Pass / Kenai / Soldotna**

Medicaid Recipients	
Age	Number within District
0-10	2,920
11-20	2,076
21-59	3,074
60+	974
<b>Total</b>	<b>9,044</b>

Medicaid Providers	
Types	Number within District
Dental	47
HCB	92
Hospital	2
LTC	2
Mental Health	23
Other	88
Personal Care Services	806
Pharmacy	24
Physician Group	289
Transportation	9
Tribal	2
<b>Total</b>	<b>1384</b>

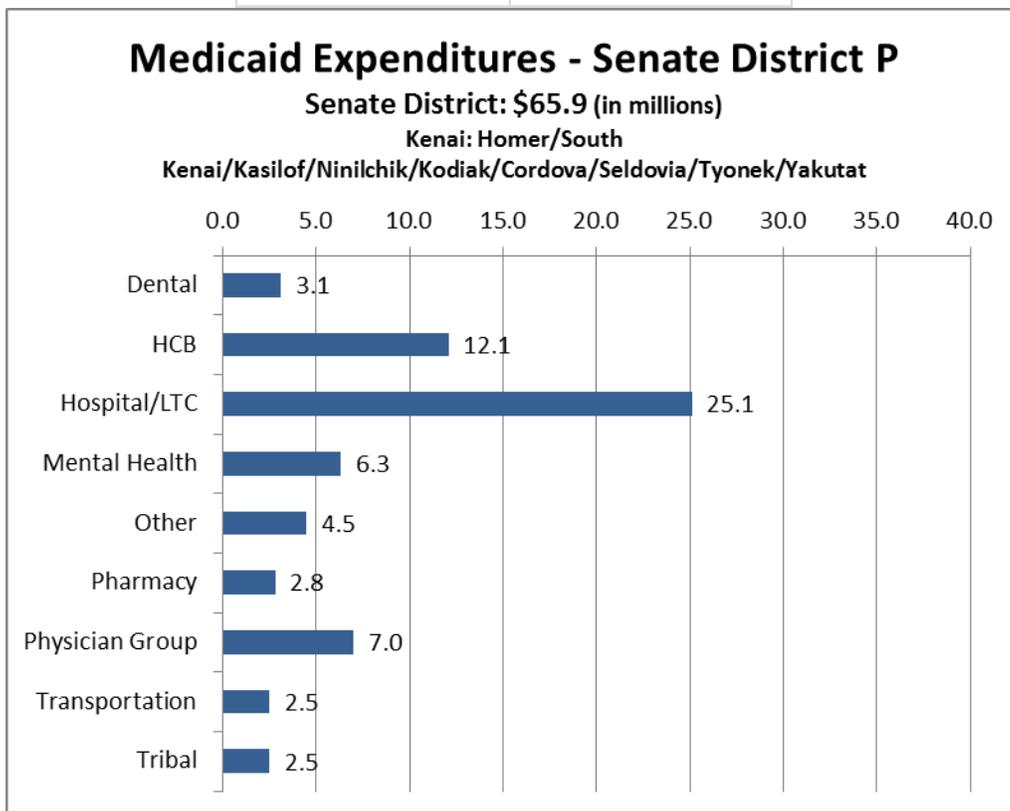


**Senate District P - Kenai: Homer / South Kenai / Kasilof / Ninilchik / Kodiak / Cordova / Seldovia / Tyonek / Yakutat**

Medicaid Recipients	
Age	Number within District
0-10	2,460
11-20	1,722
21-59	2,438
60+	867
<b>Total</b>	<b>7,487</b>

Medicaid Providers	
Types	Number within District
Dental	37
HCB	53
Hospital	3
LTC	3
Mental Health	5
Other	43
Personal Care Services	388
Pharmacy	15
Physician Group	216
Transportation	18
Tribal	6
<b>Total</b>	<b>787</b>

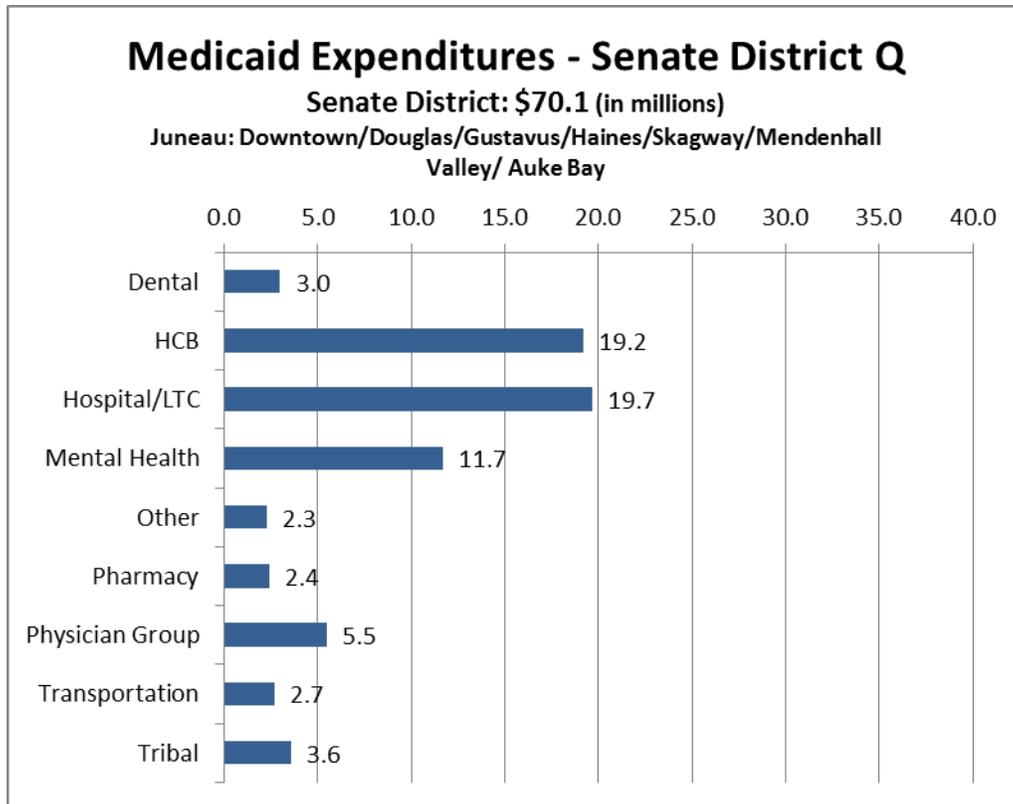


**Senate District Q - Juneau: Downtown / Douglas / Gustavus / Haines / Skagway /  
Mendenhall Valley / Auke Bay**

Medicaid Recipients	
Age	Number within District
0-10	1,947
11-20	1,299
21-59	2,258
60+	650
<b>Total</b>	<b>6,154</b>

Medicaid Providers	
Types	Number within District
Dental	56
HCB	64
Hospital	1
LTC	2
Mental Health	18
Other	59
Personal Care Services	191
Pharmacy	20
Physician Group	282
Transportation	10
Tribal	14
<b>Total</b>	<b>717</b>

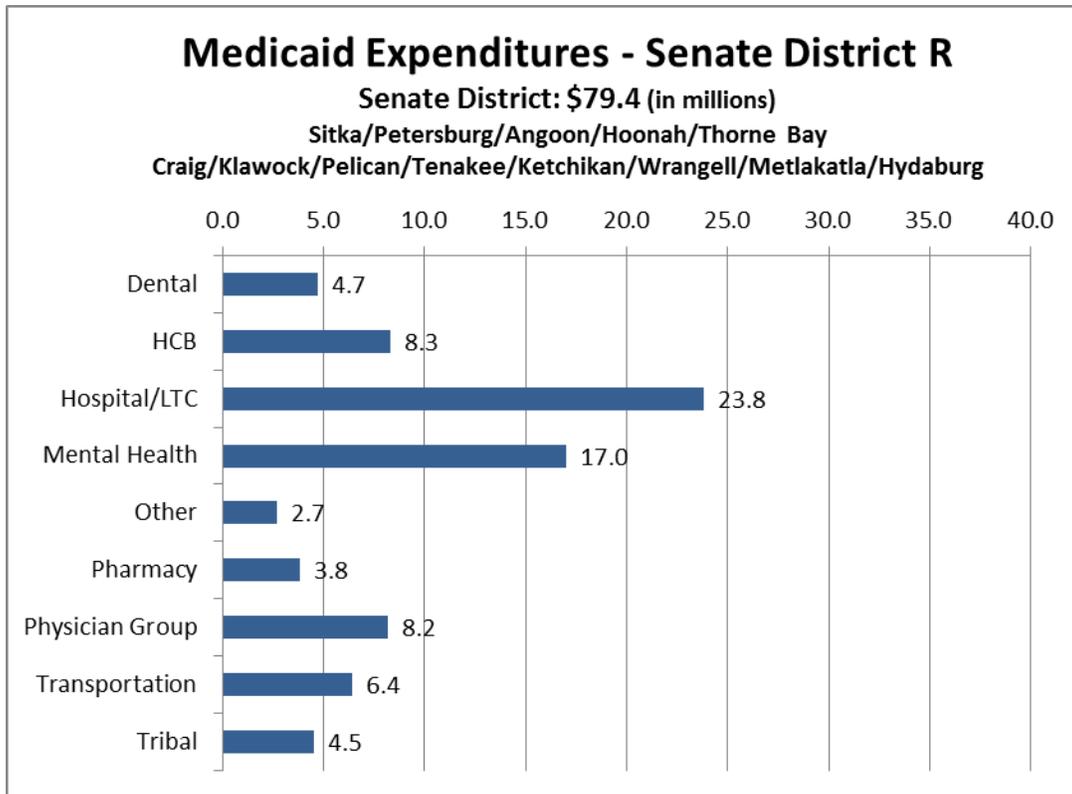


**Senate District R – Sitka / Petersburg / Angoon / Hoonah / Thorne Bay Craig / Klawock / Pelican / Tenakee / Ketchikan / Wrangell / Metlakatla / Hydaburg**

Medicaid Recipients	
Age	Number within District
0-10	2,787
11-20	2,234
21-59	3,185
60+	1,097
<b>Total</b>	<b>9,303</b>

Medicaid Providers	
Types	Number within District
Dental	46
HCB	42
Hospital	4
LTC	4
Mental Health	21
Other	57
Personal Care Services	327
Pharmacy	22
Physician Group	402
Transportation	28
Tribal	17
<b>Total</b>	<b>970</b>

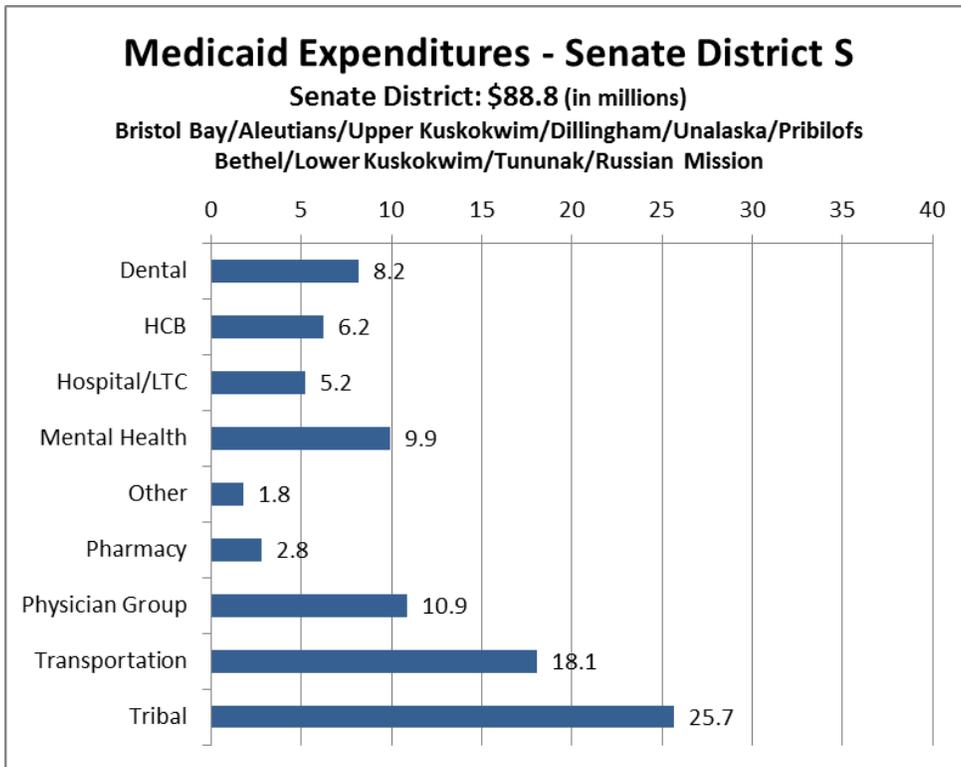


**Senate District S - Bristol Bay / Aleutians /Upper Kuskokwim / Dillingham / Unalaska / Pribilofs Bethel / Lower Kuskokwim / Tununak / Russian Mission**

Medicaid Recipients	
Age	Number within District
0-10	5,105
11-20	3,720
21-59	4,899
60+	1,216
<b>Total</b>	<b>14,940</b>

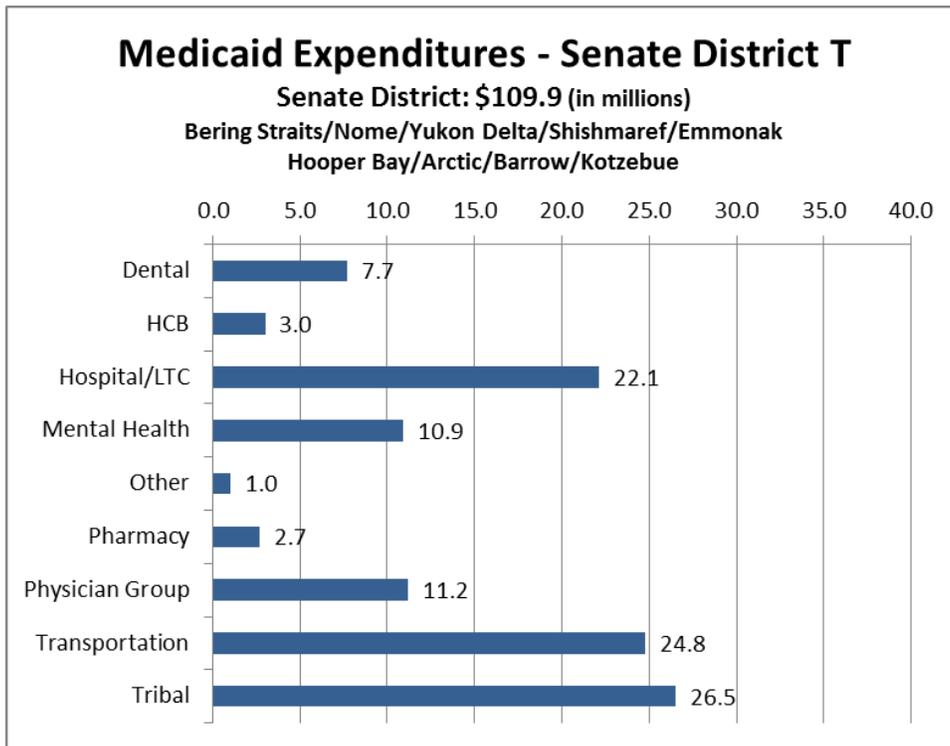
  

Medicaid Providers	
Types	Number within District
Dental	51
HCB	12
Hospital	2
LTC	1
Mental Health	15
Other	41
Personal Care Services	222
Pharmacy	6
Physician Group	455
Transportation	34
Tribal	51
<b>Total</b>	<b>890</b>



**Senate District T - Bering Straits / Nome / Yukon Delta / Shishmaref / Emmonak /  
Hooper Bay / Arctic / Barrow / Kotzebue**

Medicaid Recipients	
Age	Number within District
0-10	6,216
11-20	4,188
21-59	5,221
60+	1,149
<b>Total</b>	<b>16,774</b>
Medicaid Providers	
Types	Number within District
Dental	31
HCB	19
Hospital	1
LTC	2
Mental Health	11
Other	26
Personal Care Services	101
Pharmacy	10
Physician Group	289
Transportation	12
Tribal	40
<b>Total</b>	<b>542</b>



## Medicaid Enrolled Providers

Enrolled Medicaid providers offer medically necessary services to Medicaid recipients and are integral to success of the Medicaid program.

The tables show the number of enrolled Medicaid providers within Alaska and out of state for FY2015.

Provider Categories	In State	Provider Categories	Out of State
Dental	714	Dental	53
HCB	1,020	HCB	7
Hospital	25	Hospital	341
LTC	26	LTC	31
Mental Health	223	Mental Health	96
Other	1,397	Other	196
Personal Care Services	8,568	Personal Care Services	3
Pharmacy	302	Pharmacy	312
Physician Group	5,804	Physician Group	5,681
Transportation	221	Transportation	78
Tribal	149	Tribal	-
<b>Total Alaska Medicaid Providers</b>	<b>18,449</b>	<b>Total Out of State Medicaid Providers</b>	<b>6,798</b>