

Alaska Medicaid and Alaska Behavioral Health 2025 Spring Provider Outreach

May 7 & 8, 2025

9:00 am – 3:00 pm AKT

Comagine Health

JOINTLY ACCREDITED PROVIDER™

INTERPROFESSIONAL CONTINUING EDUCATION

Welcome to 2025 Spring Provider Outreach Accreditation Statement & Disclosure

Approved Provider Statements: In support of improving patient care, the Alaska Department of Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education and the National Association of Boards of Pharmacy (NABP), and the American Nurses Credentialing Center (ANCC), American Academy of Physician Assistants (AAPA), American Psychological Association (APA), Association of Social Work Boards (ASWB), American Dental Association's Continuing Education Recognition Program (ADA CERP), Commission on Dietetic Registration (CDR), and the Council on Optometric Practitioner Education (COPE) to provide continuing education for the healthcare team.

Joint Provider Statement: This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint Providership of the Alaska Department of Health (AKDOH) and the University of Alaska Anchorage College of Health. AKDOH is accredited by the ACCME to provide continuing education for the healthcare team.

Contact Hours: AK DOH designates this activity for a maximum of 9.25 contact hours, commensurate with participation.

- American Medical Association (AMA) Physician's Recognition Award (PRA) Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
- American Nurses Credentialing Center (ANCC) Continuing Nursing Education
- American Psychology Association
- Association of Social Work Boards (ASWB)
- Other members of the Healthcare Team

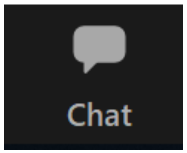
Financial Disclosures: No commercial or in-kind support was received for this educational activity. All speakers and planners report no relevant financial relationships related to the content of this activity.

Requirements for Successful Completion: To receive CE credit please make sure your attendance is recorded, you have attended at least 80% of each day credit is claimed, and you've completed the course evaluation provided by the program facilitators to claim your credit.

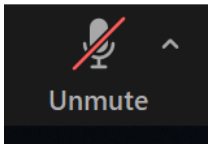
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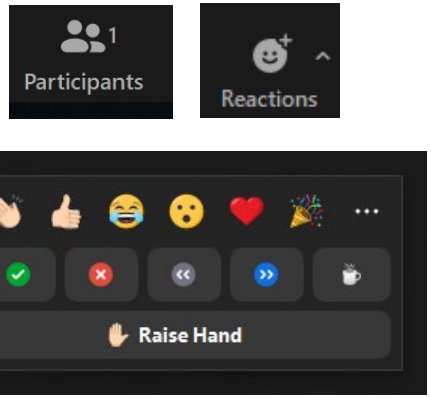
Use the **Chat** as a backchannel for questions and comments & to participate in activities



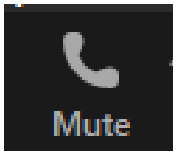
Remain on **mute** when you're not speaking. Unmute yourself only when you want to speak.



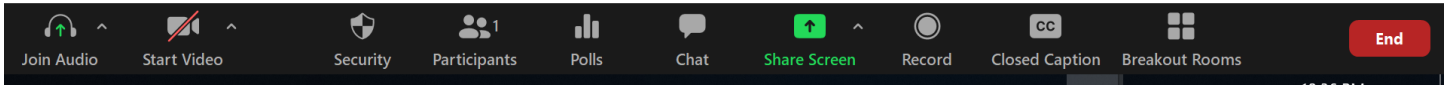
Click on **Participants** or **Reactions** to share reactions



If you are joining us **by phone**, please **dial *6 to mute / unmute.**



Note: This session is being recorded. The recording and slide deck will soon be posted to the Comagine Health website.



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Agenda Day 2

9:00 - 9:10 am **Opening Remarks**

Yvette Stratton, RN BSN CCM
Executive Director, Care Management, Comagine Health

9:10 – 10:10 am **Crisis Now Initiatives and Updates**

Eric Boyer
Senior Program Officer, Alaska Mental Health Trust Authority

10:10– 11:10 am **Integrated Behavioral Health Models**

Dr Sarah McCutcheon, MD, FAPA, BCPA
Regional Medical Director. Care Management, Comagine Health

11:10 am – 12:10 pm **TEFRA and SDS Programs**

Grace Ingrim RN, CCM
Manager, AMCCI, TEFRA and DSDS Waivers, Comagine Health

12:10 pm – 12:40 pm **Lunch Break**

12:40 pm – 1:45 pm **Medicaid Travel Presentation**

Carrie Silvers, RHIT, CPC
Medicaid Program Specialist IV, Division of Health Care Services

1:45 – 2:45 pm **Zero Suicide Initiatives and Updates**

Mya Robinson
Zero Suicide Program Coordinator, SOA DOH Division of Behavioral Health, Section of Prevention & Early Intervention

Amy Molloy
Senior Project Associate, Education Development Center

2:45 – 3:00 pm **Closing Remarks**

Yvette Stratton, RN BSN CCM
Executive Director, Care Management, Comagine Health

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Welcome and Introduction

Yvette Stratton, RN, BSN, CCM
Executive Director, Care Management, Comagine Health

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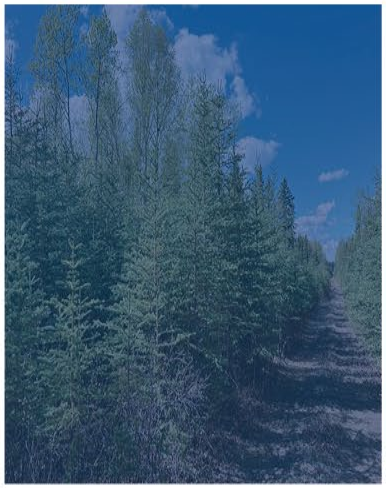
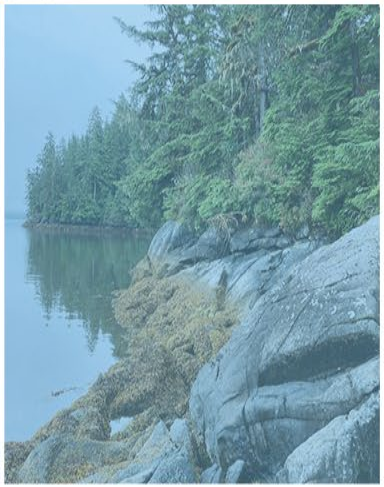
Crisis Now Initiatives and Updates

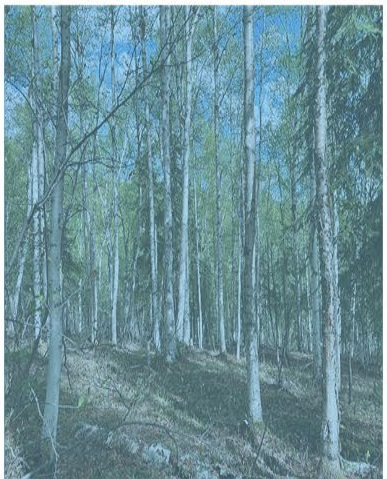
Eric Boyer

Senior Program Officer, Alaska Mental Health Trust Authority

Trust
Alaska Mental Health Trust Authority






From Ketchikan to Kotzebue:
The Transformation of the Crisis Behavioral Health Response System of Care

Presenters: Eric Boyer, MPH
Becky Bitzer, LMSW

What We Will Cover Today

- What is the behavioral health crisis response problem?
- What does the data tell us?
- Partners and champions!
- What is the impact of a rural behavioral health response?
- The pathway forward!



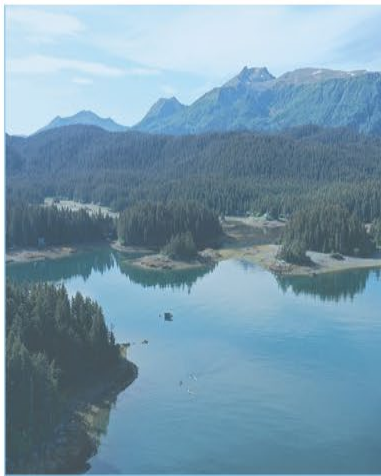




GOAL: Design and implement a behavioral health crisis response system analogous to the physical health system.







Physical **Health Emergency**



Behavioral **Health Emergency**



Alaska's Behavioral Health Crisis Response Innovation Timeline

Key milestones in the implementation of a coordinated, connected system of behavioral health crisis care in Alaska.

2018

Federal approval (CMS) for SUD component of 1115 Medicaid Waiver

Initial conversations about Crisis Now framework in Alaska

Behavioral Health Improvement Project focuses on psychiatric boarding in emergency departments [Pub.A]

2019

Forensic Psychiatric Hospital Feasibility Study completed [Pub.B]

Federal approval (CMS) for behavioral health component of 1115 Medicaid Waiver

RI International conducts Crisis Now implementation readiness assessment in Anchorage, Mat-Su and Fairbanks [Pub.C]

Statewide convening on behavioral health crisis continuum

First site visit to Arizona to see Crisis Now in action

2020

Community planning workgroups convened in Anchorage, Fairbanks and Mat-Su

Concept-level pro formas developed for crisis services

SB 120 amends Title 47 to include crisis stabilization centers as locations for emergency detention

Settlement agreement with Disability Law Center identifies Crisis Now as a systems improvement initiative

2021

Crisis Now community coordinator positions funded in Fairbanks and Mat-Su

Mobile crisis teams launch in Anchorage and Fairbanks

2022

HB 172 signed into law

988 goes live nationwide

Mat-Su dispatch agency begins transferring behavioral health calls to Careline

Ketchikan Crisis Now community coordinator position funded and community planning begins

Five organizations across the state exploring 23-hour stabilization and/or short-term stabilization services

Planning begins in Kotzebue, Juneau, Copper Basin and Unalaska

Crisis Now Core Principles and Practices webinars begin

Child and Adolescent Behavioral Healthcare Improvement Project completed [Pub.D]

US Department of Justice report on Alaska's behavioral health system for children released [Pub.E]

2023

Careline launches law enforcement backline. Anchorage Police Department begins transferring calls

Mobile crisis team launches in Mat-Su

Ketchikan City Council approved positions for Mobile Integrated Healthcare program

Juneau community planning workgroup begins

Groundbreaking for Providence Crisis Stabilization Center

State of Alaska hosts Behavioral Health Roadmap meetings across the state

HB 172 Psychiatric Patient Rights Report submitted to the State Legislature [Pub.F]

2024

Groundbreaking for Southcentral Foundation Crisis Stabilization Center

Bartlett Regional Hospital and Capital City Fire and Rescue partner to launch MCT in Juneau

Trust hosts Crisis Now convening

Alaska Behavioral Health launches Mobile Outreach for Children and Families program in Fairbanks

Volunteers of America launches Rapid Response team

Anchorage Fire Department MCT pilots 24/7 response and is codified as an essential service

Milliman completes assessment of Alaska's behavioral health crisis continuum of care [Pub.G]

Ketchikan launches Mobile Integrated Health program

Central Peninsula Hospital begins mobile crisis response planning

Fairbanks MCT begins response to calls when requested by Alaska State Troopers

Department of Health begins Medicaid Rate Review project

Mat-Su MCT expands their service area

Publications

A. Behavioral Health Improvement Project
B. Forensic Psychiatric Hospital Feasibility Study
C. Crisis Now implementation readiness assessment
D. Child and Adolescent Behavioral Healthcare Improvement Project
E. US Department of Justice report on Alaska's behavioral health system for children
F. HB 172 Psychiatric Patient Rights Report
G. Assessment of Alaska's Behavioral Health Crisis Services Continuum of Care

Trust Investments: Fiscal Years 2021—2024

Call Center
Total investment (FY21-24): $468,519

Mobile Crisis
Total investment (FY21-24): $4,894,486

Center-Based Crisis Services
Total investment (FY20-24): $3,664,269

Community Coordination
Total investment (FY21-24): $1,540,800

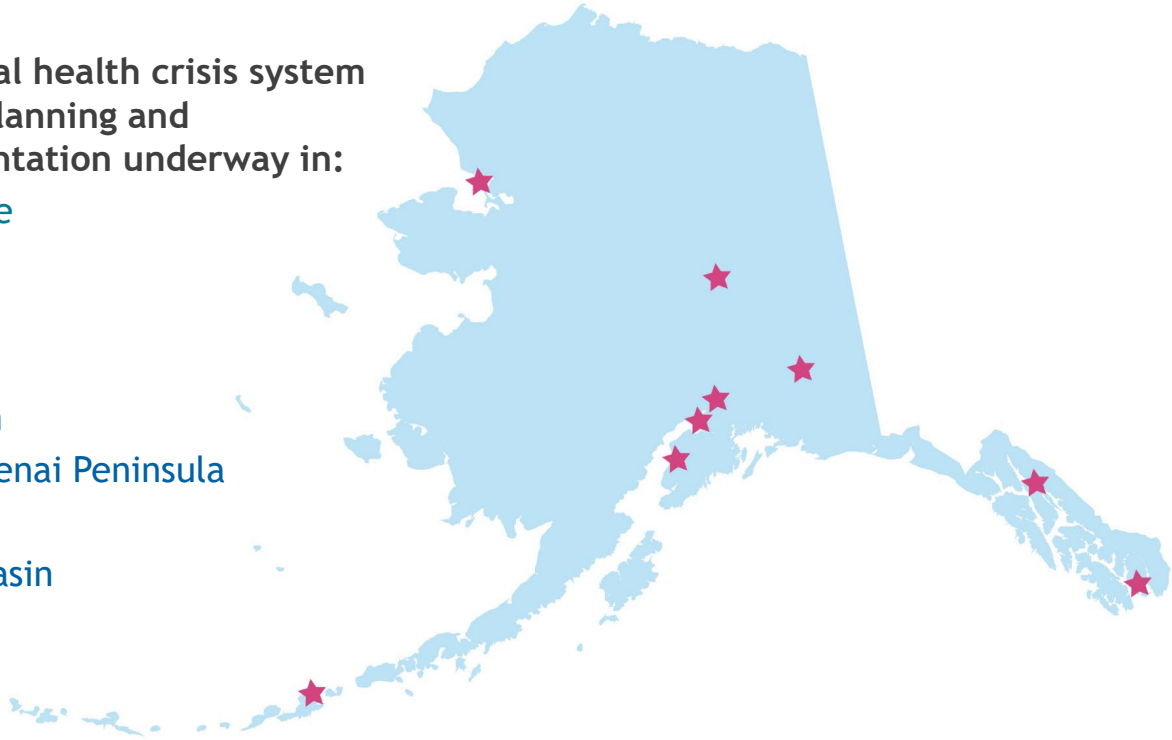
System Support
Total investment (FY21-24): $901,339

Additionally, Trust funding supports Alaska partner participation in crisis system immersion trips to Arizona, with 15 trips supported between 2018-2024.

Community Implementation

Behavioral health crisis system of care planning and implementation underway in:

Anchorage
Mat-Su
Fairbanks
Juneau
Ketchikan
Central Kenai Peninsula
Kotzebue
Copper Basin
Unalaska



Someone to Respond: Ketchikan MIH
First Seven Months of Operation June-December 2024



Top 25 High Utilizers of EMS

17 participants reduced their 911 and EMS use by 80% and are no longer considered high utilizers

Led to a10% decrease in KFD calls in 2024, compared to 2023.

4 participants continue to receive assistance to reduce EMS use

4 individuals declined participation

33% of participants received behavioral health services as part of their MIH intervention

High-utilizers of EMS call for assistance 20-56 times per year. Assisting 5 high-utilizers in reducing their EMS use will prevent over 400 calls for non-emergent needs.

A Safe Place for Help: High-Intensity Services



Hospital-Based Emergency Stabilization Unit

- "EmPATH"
- Accept all levels of acuity outside of an inpatient setting

Planning:
Kotzebue

High-Intensity Behavioral Health Emergency Center

- No barrier access
- Emergency behavioral health stabilization
- Stays <24 hours

Planning:
Anchorage
Fairbanks

High-Intensity BH Extended Stabilization Center

- Additional stabilization, typically following an emergency center stay
- Stays of 2-7 days

Planning:
Anchorage

Additional low-barrier crisis stabilization services and/or referral-based crisis residential services available or planned in other locations around the state.

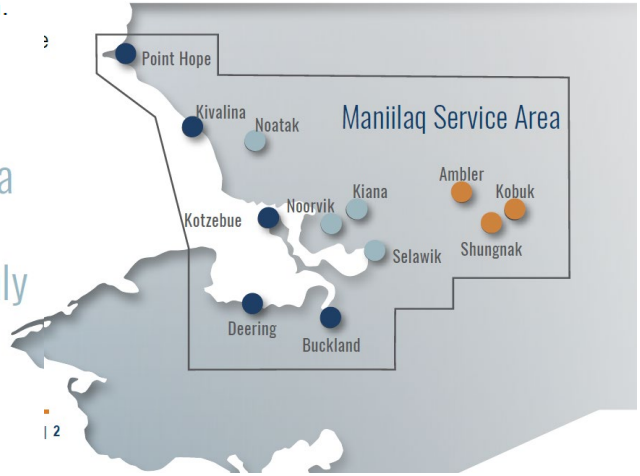
MANIILAQ ASSOCIATION

HEALTHY PEOPLE, THRIVING COMMUNITIES

MANIILAQ OVERVIEW

Maniilaq Association is a 501(c)(3) Tribal Non-Profit organization who for over 30 years has been providing health, tribal, and social services to twelve villages in the Maniilaq service area (MSA). Kotzebue is the regional hub with a population of 3,287. The total population in our service area is 8,430 residents, approximately 81% are Alaska Native/American Indian.

The Maniilaq service area encompasses 38,000 square miles. It is roughly the size of Indiana.



Graphic: Courtesy of Maniilaq Association

Maniilaq Leadership

- Tim Gilbert, President/CEO
- Dr. Bob Onders, Medical Director
- Bree Swanson, Social Services Administrator
- Ronto Roney, Behavioral Health Services Director

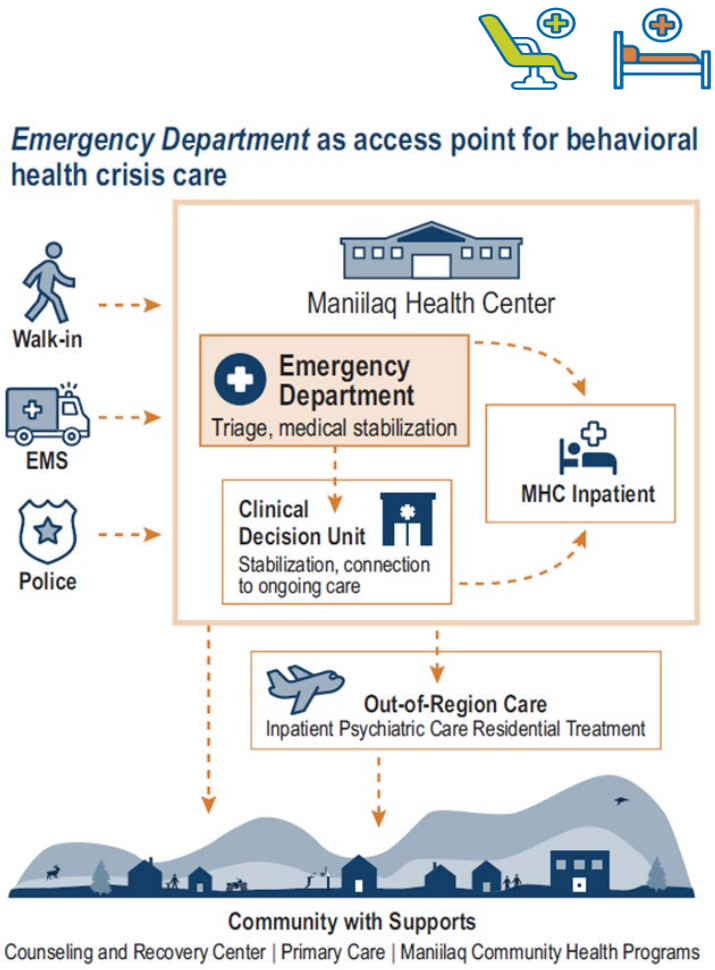
Maniilaq Association EmPATH Unit - Concept

The Maniilaq CDU will provide an alternative location for individuals with behavioral health concerns to receive evaluation and stabilization services. Individuals will access the CDU by first presenting to the Maniilaq ED. The CDU will have four recliners and two beds and will be adjacent to and managed by the MHC ED.

Goals for the CDU include:

- Create a separate ED space specifically for behavioral health patients.
- Provide mental health and substance use crisis services, including withdrawal management.
- Reduce strain on ED and inpatient unit capacity by providing an alternative location for observation for patients with behavioral health needs.

	Stays < 24 hours	Stays > 24 hours
Capacity	4 recliners	2 beds
Estimated Annual Crisis Episodes	404-672 episodes	67-184 episodes
Average Length of Stay	4.6 hours	3.1 days



Behavioral Health Crisis Response in Alaska: Voices of Partners and Champions



Successes

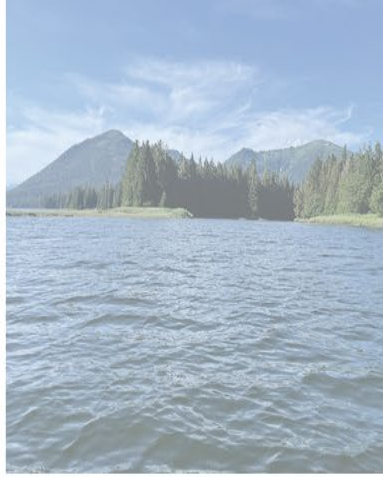
- Statewide and community vision for behavioral health crisis continuum transformation
  - Legislative and regulatory changes
  - Active community workgroups in five communities
  - Regular coordination and meetings with state division and department leadership
- Crisis Contact Center
  - Successful integration of 988 into existing statewide call center
  - Creation of a backline to support warm transfers from 911 PSAPs
- Mobile Response Planning and Implementation

2018

No mobile response teams available in Alaska

2025

7 mobile crisis programs operational, including two youth specific teams
4 mobile integrated health teams operational
2 additional mobile crisis programs being planned







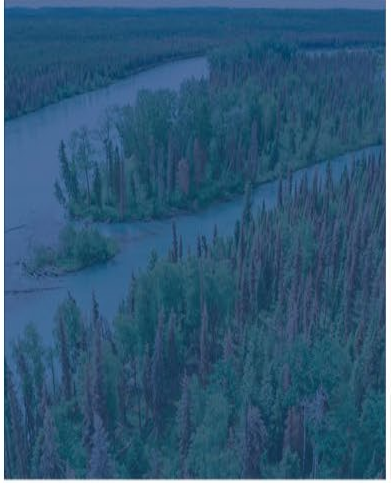


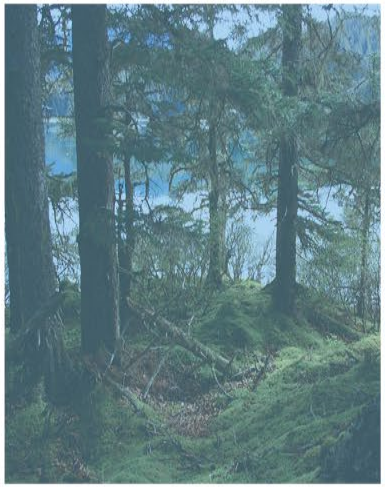
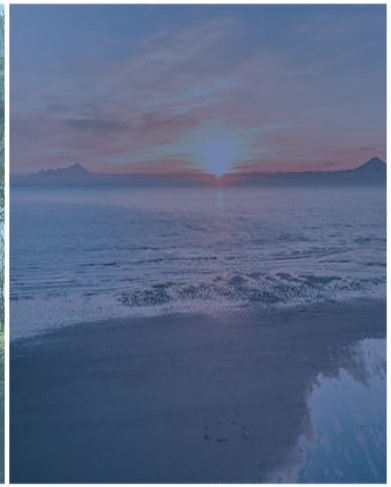




Challenges

- Sustainable funding and a mechanism for braiding funding for 24/7 crisis services
- Final regulations for sub-acute mental health facilities licensing
- Capital funding for construction of sub-acute mental health facilities
- Messaging and inclusion of substance misuse as a behavioral health crisis
- Data sharing infrastructure at the individual, provider and community level
- Workforce






30 YEARS Trust

Alaska Mental Health Trust Authority

Questions/Contact:
eric.boyer@alaska.gov

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Integrated Behavioral Health Models

Dr. Sarah McCutcheon, MD, FAPA, BCPA

Regional Medical Director, Care Management, Comagine Health



Medical Silos

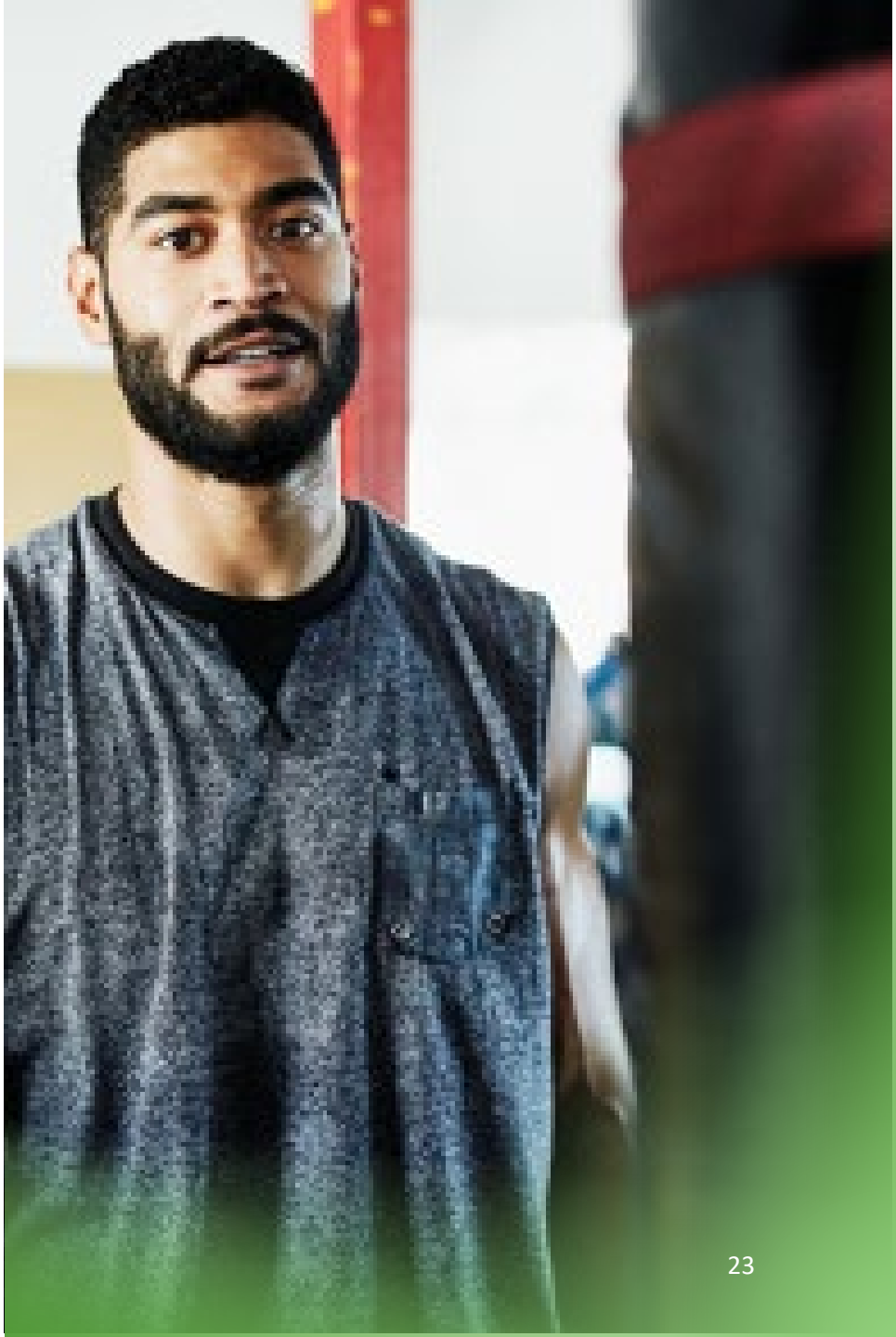


Standard Primary Care

John presents to PCP, Dr. Smith, for lower back pain

John's Story

- John is a 26-year-old otherwise healthy single man who works in construction
- Injured his back 6 weeks ago at work
- Initially seen in Urgent Care where prescribed usual care
- Here to explore options for pain management





Treatment Plan

Standard Primary Care: Visit #1

- 15 minute appointment
- Education provided about back pain
- Shared medical decision making
  - Physical therapy (PT) referral
  - Follow-up in 2-3 months

Reflections on Visit #1

Standard Primary Care



John	Dr. Smith
Expected a prescription for pain pill	Feels competent
Confused why PT was suggested	Glad for a straightforward patient
Hopeful overall, but wishes there were more time for questions	Finished appointment early and can catch up on charting
Return-to-work guidance	

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Visit #2

John returns for a 10-minute follow-up visit, 6 weeks later

Visit #2

Standard Primary Care

- Visit takes 20 minutes
- Only went to PT twice
  - Stopped because “not helping”
- He is stressed
  - Money is getting tight
  - Needs to get back to work
  - Girlfriend broke up with him
- Requests Percocet



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Treatment Plan

Standard Primary Care Visit #2

- Urine toxicology screen
  - Positive for opioids
- Admits to taking friend's Percocet
  - "Only thing that helps"
  - Minimizes significance of this
- Shared medical decision making
  - Education provided about back pain
  - Declines PT re-referral
  - Reluctantly agrees to follow-up in 6 weeks

Reflections on Visit #2



Standard Primary Care

John	Dr. Smith
Confused, less hopeful, and ashamed	Increasingly concerned about John
Wondering if he'll ever get better	Now running even more late and hungry
Worried he's been labeled an "addict"	Wishes she could do more
	Frustrated by lack of time and resources

Visit #3

John returns for a 10-minute follow-up visit, 6 months later







Visit #3

Standard Primary Care

- No-showed 6-week follow-up
  - “What was the point?”
- Low back pain persists
- Less active
  - Spending days on couch
  - Limited social support
- Not sleeping well

Treatment Plan

Visit #3



- Additional education about lower back pain
- Referral to PT
- Referral to psychiatrist for depression
- Substance use resources provided

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Reflections on Visit #3



Standard Primary Care

John	Dr. Smith
Ashamed, hopeless, and critical	Even more concerned about John
Wondering if he'll ever get better	Feeling less confident in treatment plan
Worried he's been labeled an addict	Wishes she could do more
Immediately texts "Bob" for Percocet	Feeling burned out
"Bob gets me"	

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John is brought to ER after being found unresponsive at a friend's house



ER Visit

- EMS discovered beer and pill bottles next to John
- Narcan administered
- John became responsive and agreed to go to ER
- Urine tox screen
  - Alcohol
  - Opioids, including Fentanyl

ER Visit



ER: “wake up call”



Taking “stronger” pain pill around the clock



Unaware of risk of overdosing



Glad to be alive



Motivated to find a new path forward

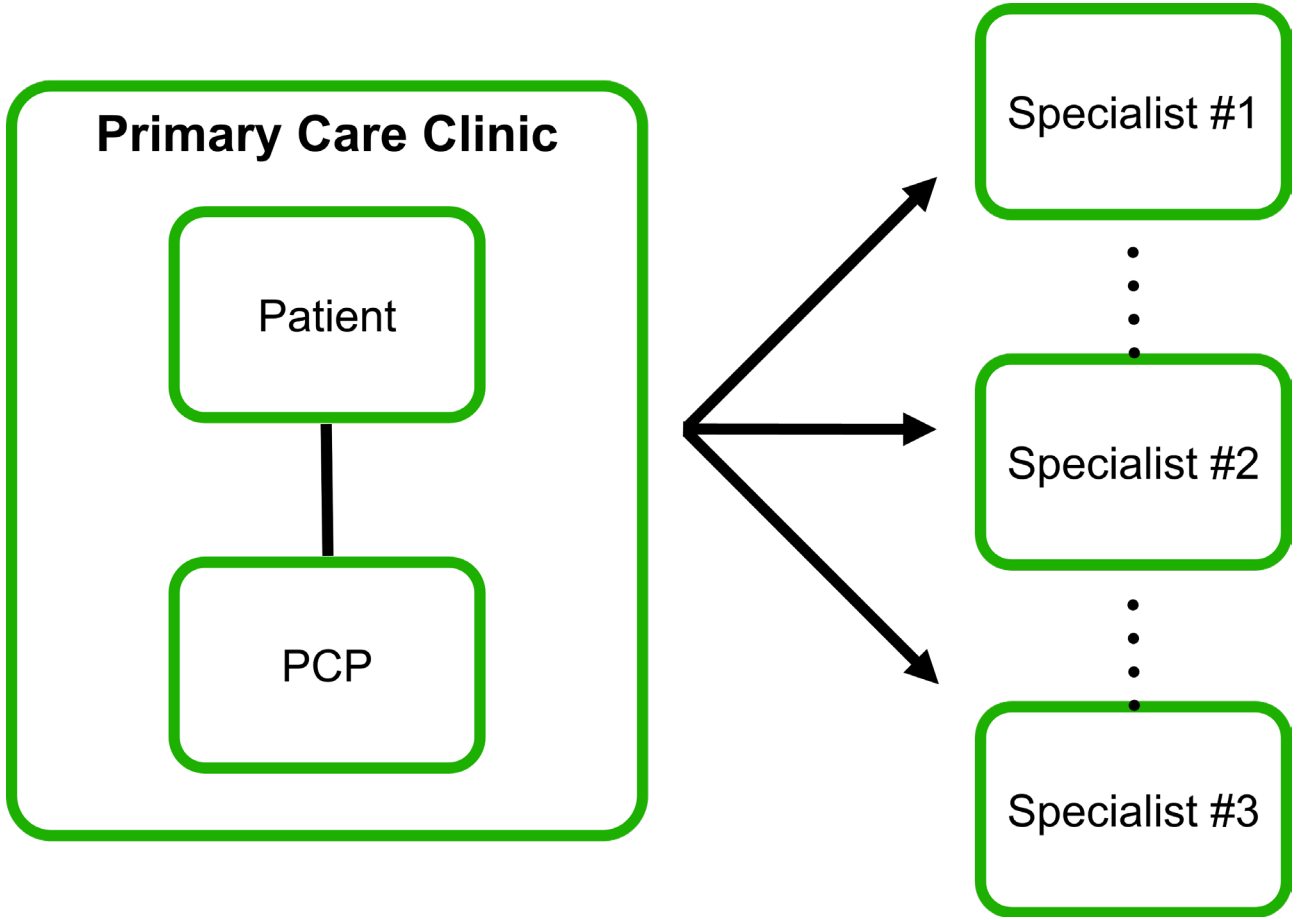


Agrees to substance use treatment

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Review

Standard Primary Care



Standard Primary Care

Pros	Cons
Well established model	Fragmented, inefficient care
Familiar to patients and providers	Problem-focused
Fee-for-service reimbursement	Limited directed access to resources
Known standard of care	Downplays social determinants of health

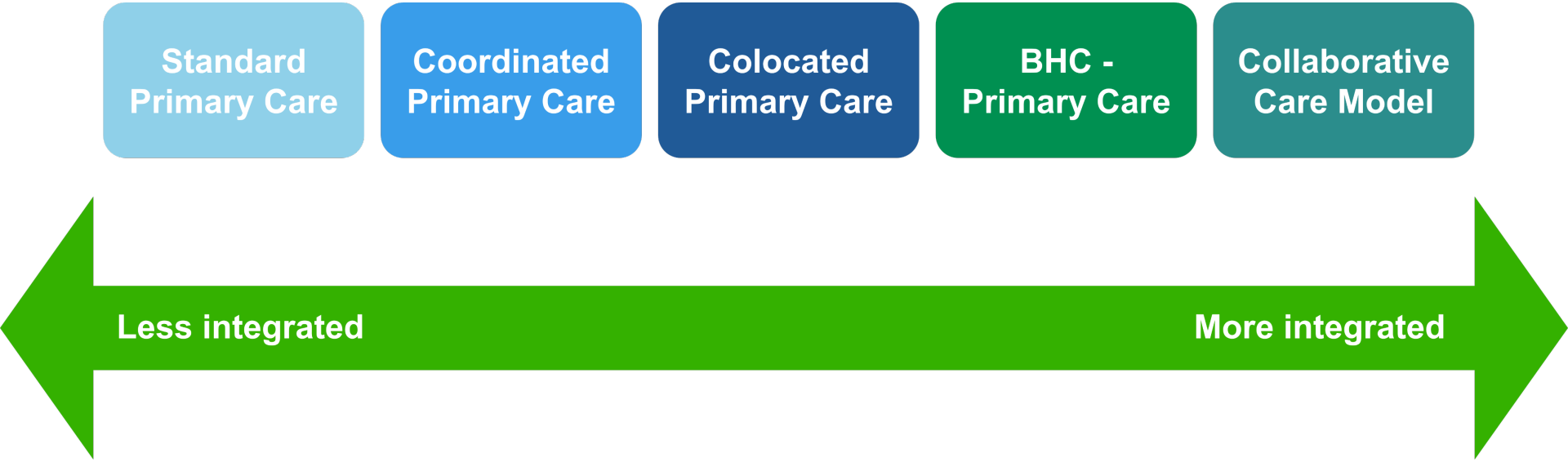
How can Behavioral Health care be enhanced within Primary Care?

Behavioral Health Integration

How can Behavioral Health care be enhanced within Primary Care?

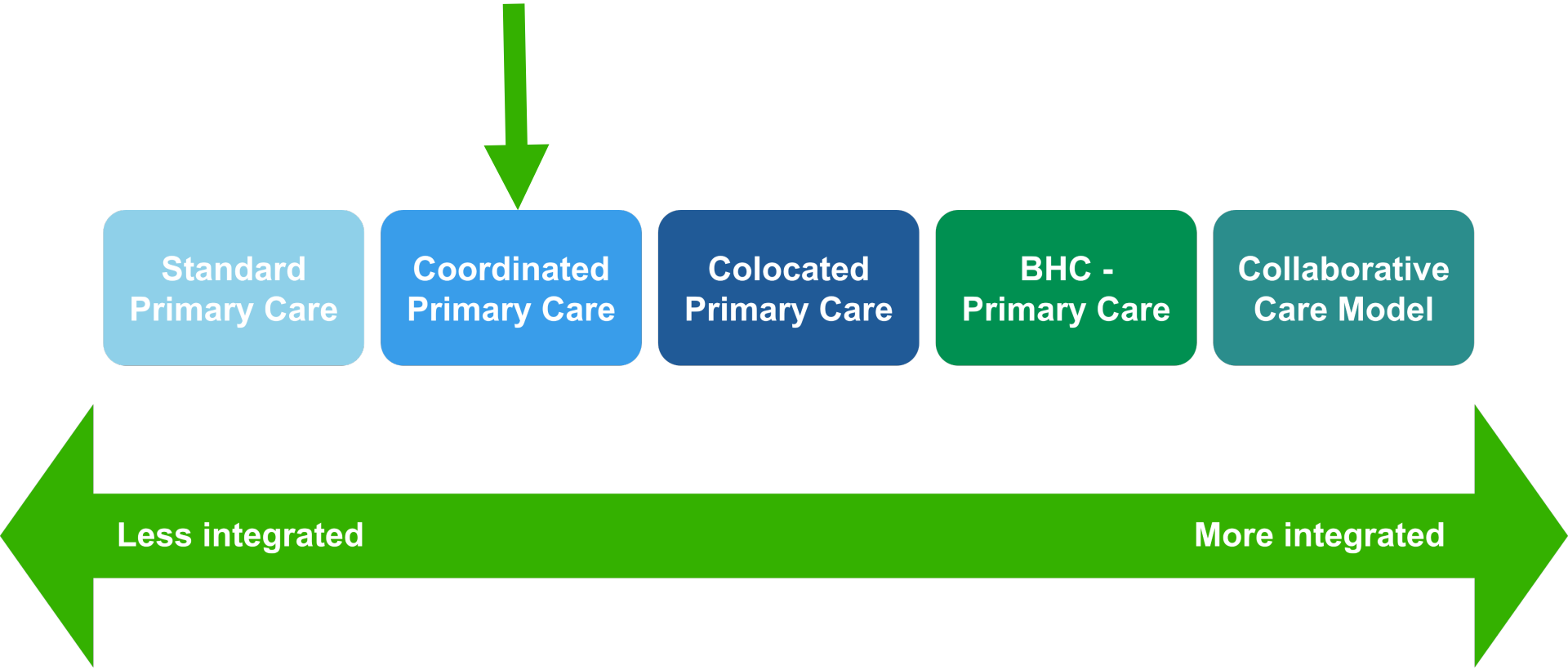
In comparison to standard primary care:
How does model work?
What clinical support is required?
How are services reimbursed?
What is the value added by model?

Continuum of BH Integration



BHC: Behavioral Health Consultant

Continuum of BH Integration

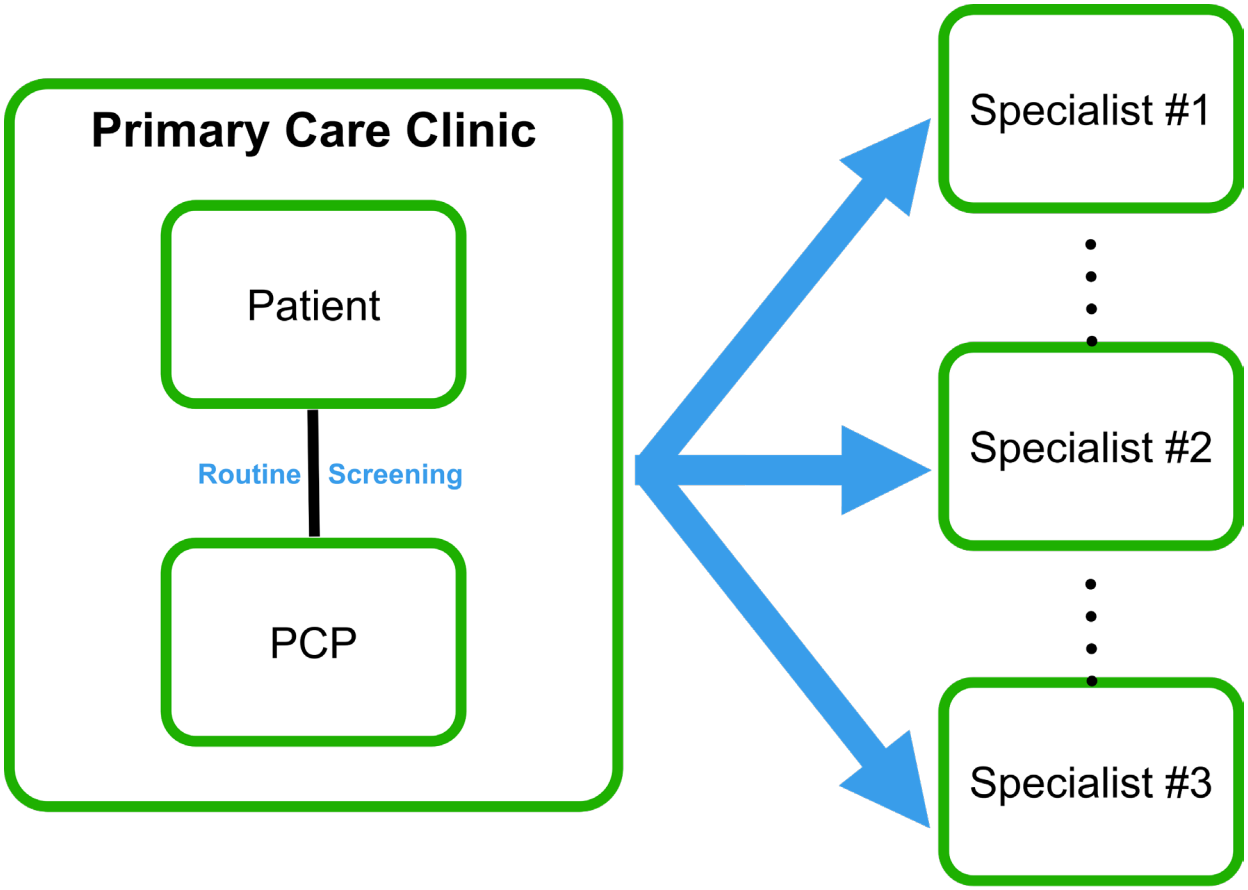


BHC: Behavioral Health Consultant

Coordinated Primary Care

In comparison to standard primary care:	Coordinated Primary Care
How does the model work?	• Routinely screen for common conditions • Refer to appropriate specialist when needed
What clinical support is required?	• Administer screenings • Manage clinical documentation, referrals
How are services reimbursed?	• Fee-for-service billing
What is the value added by this model?	• Proactive detection and treatment of common conditions

Coordinated Primary Care



What are John and Dr. Smith's experiences in coordinated primary care?

John’s Story

John is a 26-year-old single man who injured his back 6 weeks ago at work



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Treatment Plan



Coordinated Primary Care Visit #1

- John sees Dr. Smith, 15 minute appointment
- Dr. Smith educates about back pain
- Shared medical decision making
  - PT referral
  - Follow-up in 2-3 month
- Medical assistant (MA) administers BH screens
- Results of BH screens
  - Positive BH findings and unmet social needs
- MA confers with Dr. Smith
  - John scheduled for return visit in 2-4 weeks
  - Referral social work at local hospital

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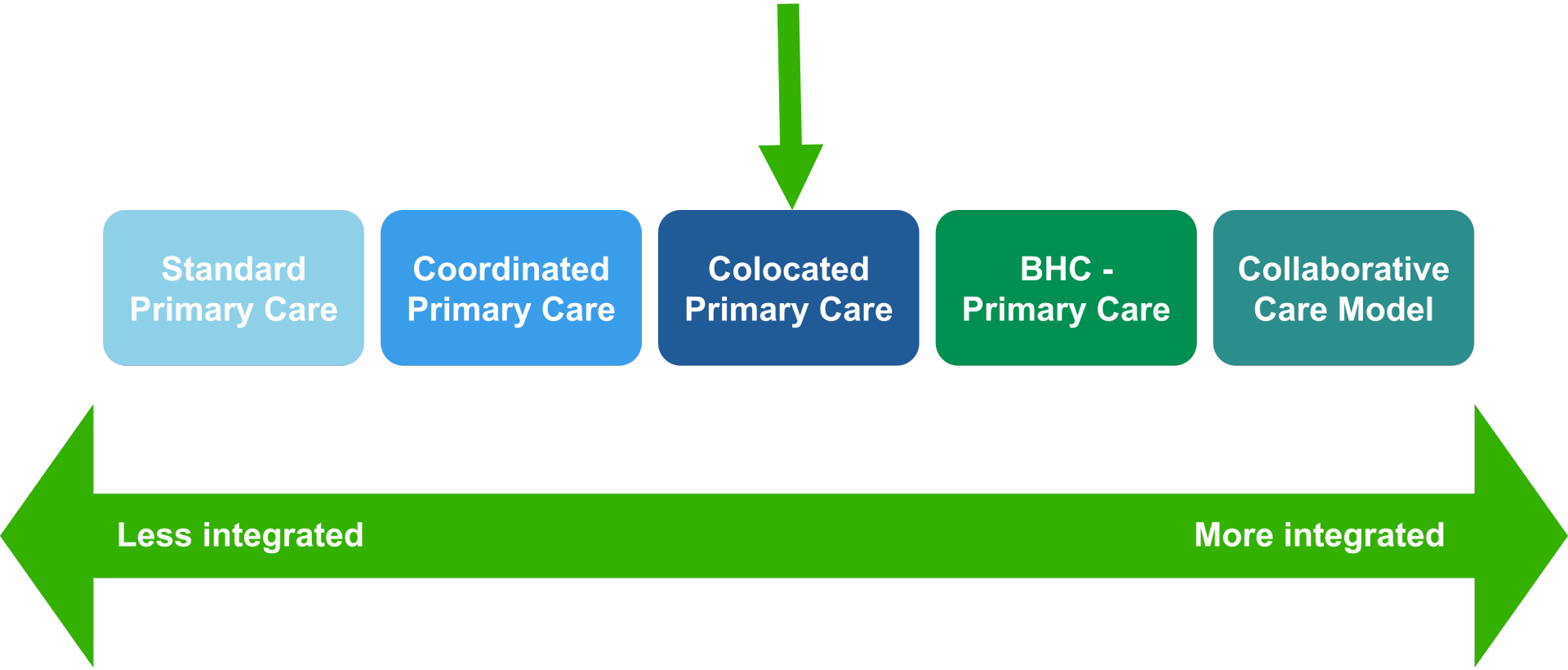
Treatment Plan

Coordinated Primary Care Visit #2

- John returns in 3 weeks, 20 minute appointment
- Urine tox screen positive for opioids
- Gather interval history
  - Pain pill and alcohol misuse
- Motivational interviewing, counseling, and psychoeducation
- Shared medical decision making
  - BH goals set
  - Low dose mirtazapine started
  - Referral to psychiatric provider
  - Increased PT frequency
  - Follow-up in 2-3 months
- Care coordination
  - Referral to psychiatric prescriber
  - Clinic note sent to PT

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Continuum of BH Integration

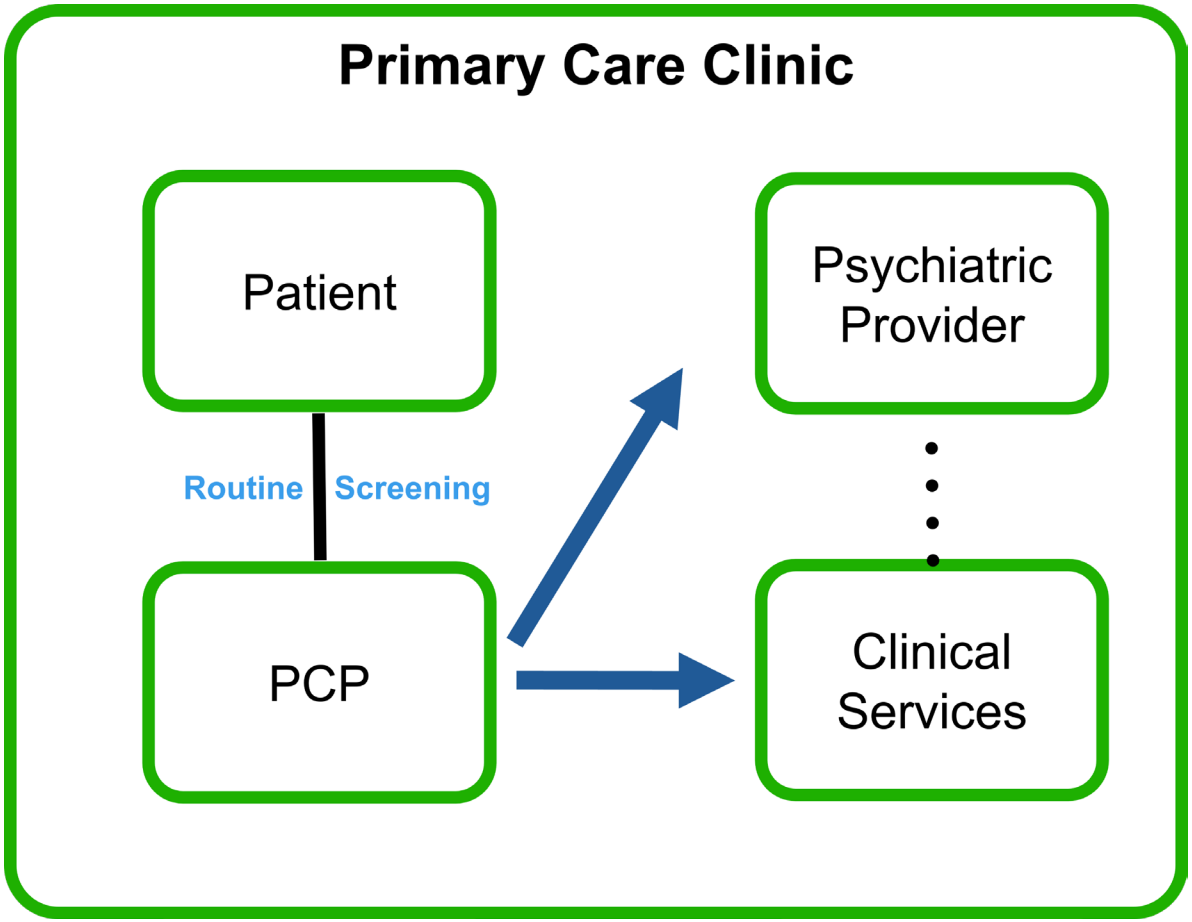


BHC: Behavioral Health Consultant

Colocated Primary Care

In comparison to standard primary care:	Colocated Primary Care
How does the model work?	• Routinely screen for common conditions • Specialists and/or other clinical services in same facility • Warm handoff when possible
What clinical support is required?	• Administer screenings • IT Support/Greater EHR capabilities
How are services reimbursed?	• Fee-for-service billing • Screening and brief interventions may be reimbursable
What is the value added by this model?	• Proximity facilitates referrals

Colocated Primary Care



What are John and Dr. Smith's experiences in colocated primary care?

Treatment Plan

Colocated Primary Care Visit #1



- John sees Dr. Smith for 15 minutes
- Dr. Smith educates about back pain
- Shared medical decision making
  - PT referral
  - Follow-up in 2-3 months
- MA administers BH screens
  - Positive findings
- MA confers with Dr. Smith
  - John asked to return to PCP in 2-4 weeks
  - Referral to psychiatric prescriber in clinic
  - Referral social work in clinic

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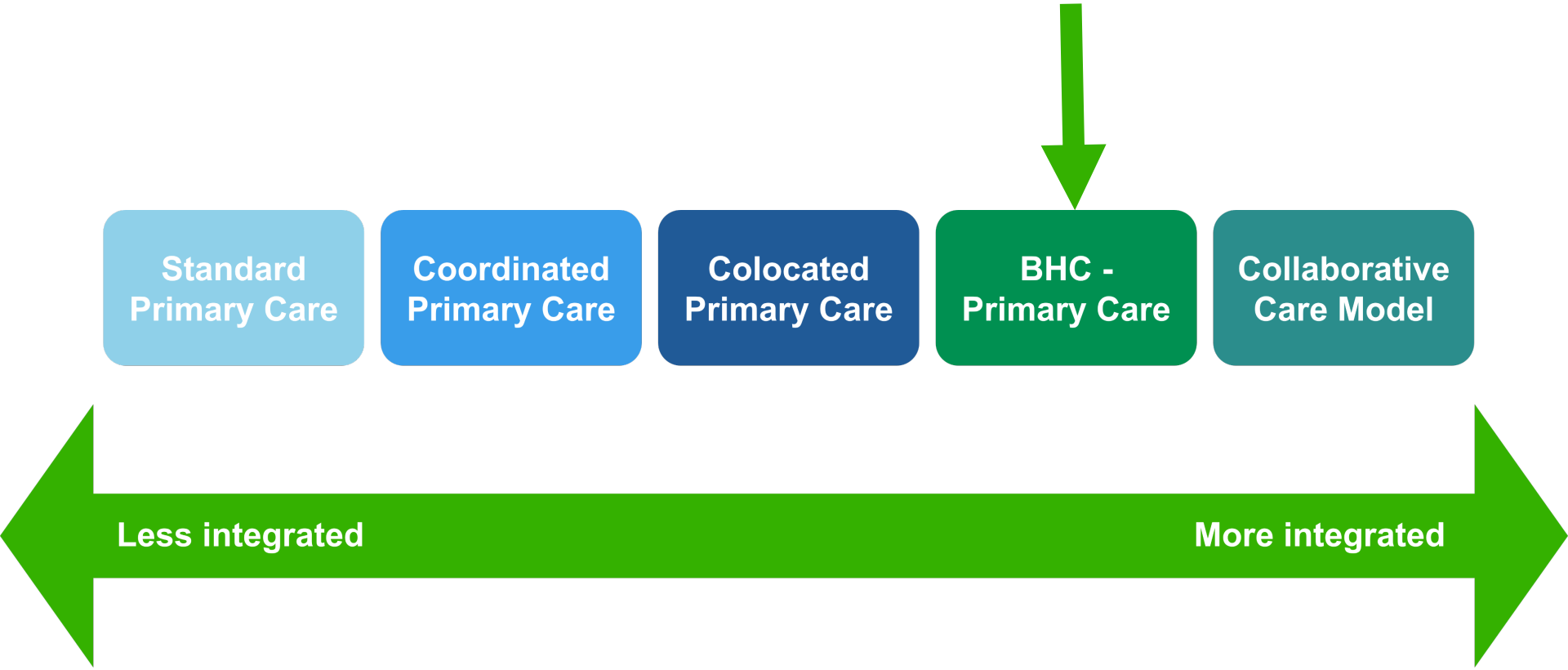
Treatment Plan

Colocated Primary Care Visit #2

- John returns in 3 weeks, 20 minute appointment
- Urine tox screen positive for opioids
- Gather interval history
  - Pain pill and alcohol misuse
- Motivational interviewing, counseling, and psychoeducation
- Shared medical decision making
  - BH goals set
  - Low dose mirtazapine started
  - Referral to psychiatric provider in clinic
  - Increased PT frequency
  - Follow-up in 2-3 months
- Care coordination
  - Dr. Smith quickly signs out case to psychiatrist, Dr. Patel
    - Patient offered opening in his schedule in 2 weeks
  - Clinic note sent to PT

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Continuum of BH Integration



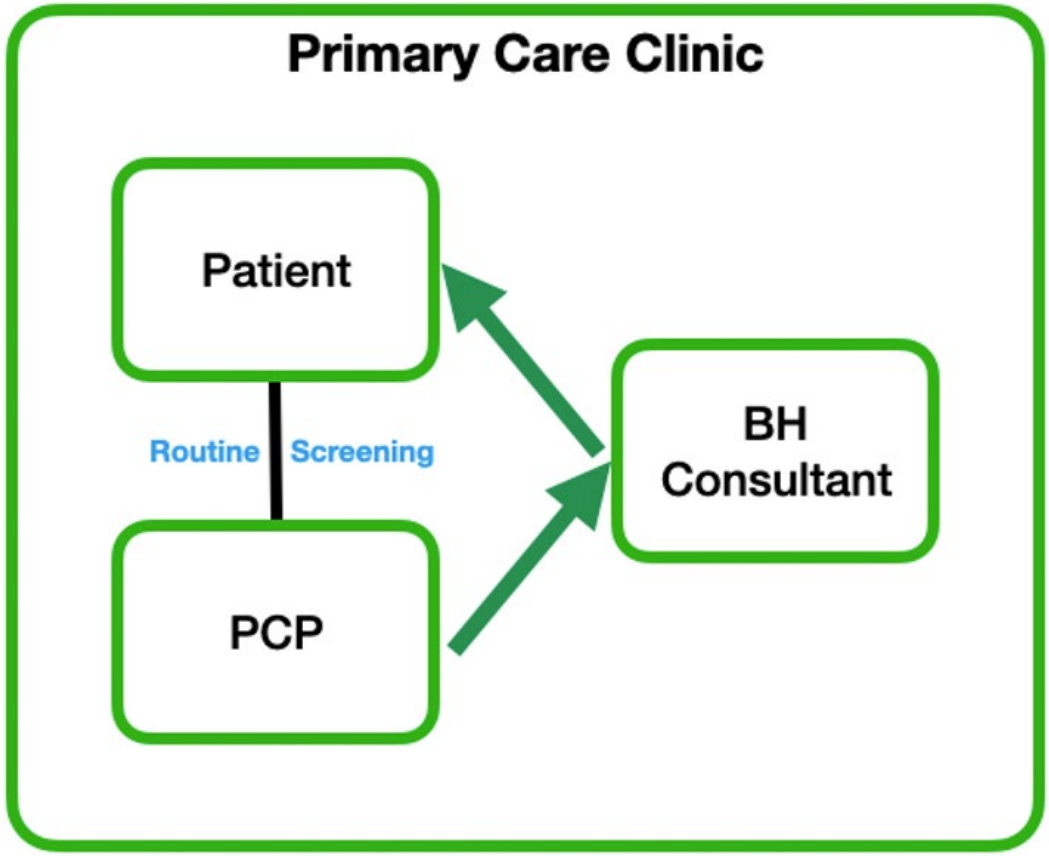
BHC: Behavioral Health Consultant

BHC - Primary Care

In comparison to standard primary care:	BHC - Primary Care
How does the model work?	• Routinely screen for common conditions • BHCs in primary care
What clinical support is required?	• Administer screenings • IT Support/Greater EHR capabilities
How are services reimbursed?	• Fee-for-service billing
What is the value added by this model?	• Proximity facilitates referrals, communication, and provider comfort • PCPs focus efforts on non-BH needs

BHC: Behavioral Health Consultant

BHC - Primary Care



What are John and Dr. Smith's experiences in BHC – primary care?

Treatment Plan

BHC - Primary Care Visit #1



- MA administers BH screens
  - Debriefs Dr. Smith of findings
- John sees Dr. Smith for 15 minute visit
- Education about back pain
- Shared medical decision making
  - John agrees to see BHC
  - Low dose mirtazapine started
  - PT referral
  - Follow-up in 6-8 weeks

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Treatment Plan

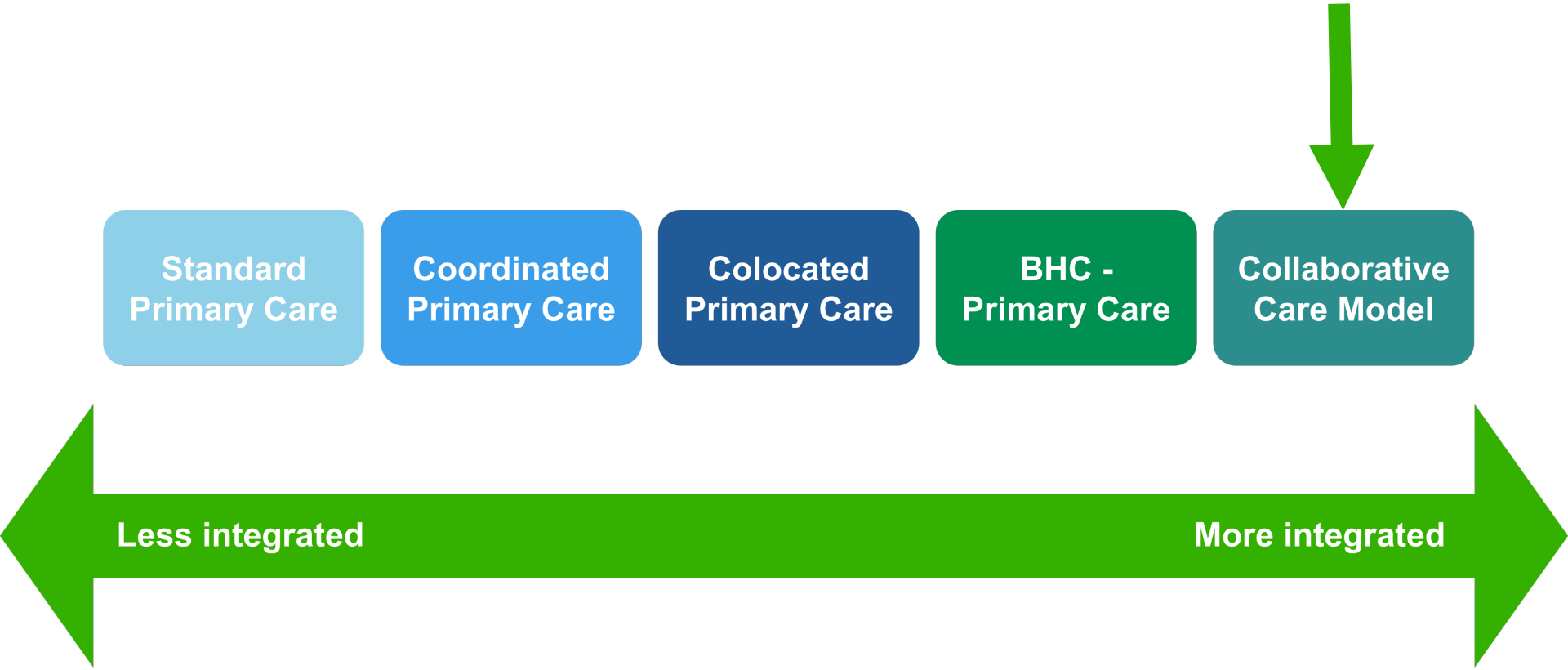
BHC - Primary Care: Visit 1



- Care coordination
  - Dr. Smith signs out case to BHC, Jill
  - Jill introduces herself to John
    - Visit scheduled in 3 days, for 45 minutes
  - Clinic note
    - Jill CC'ed in EHR
    - Sent to PT

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Continuum of BH Integration



BHC: Behavioral Health Consultant

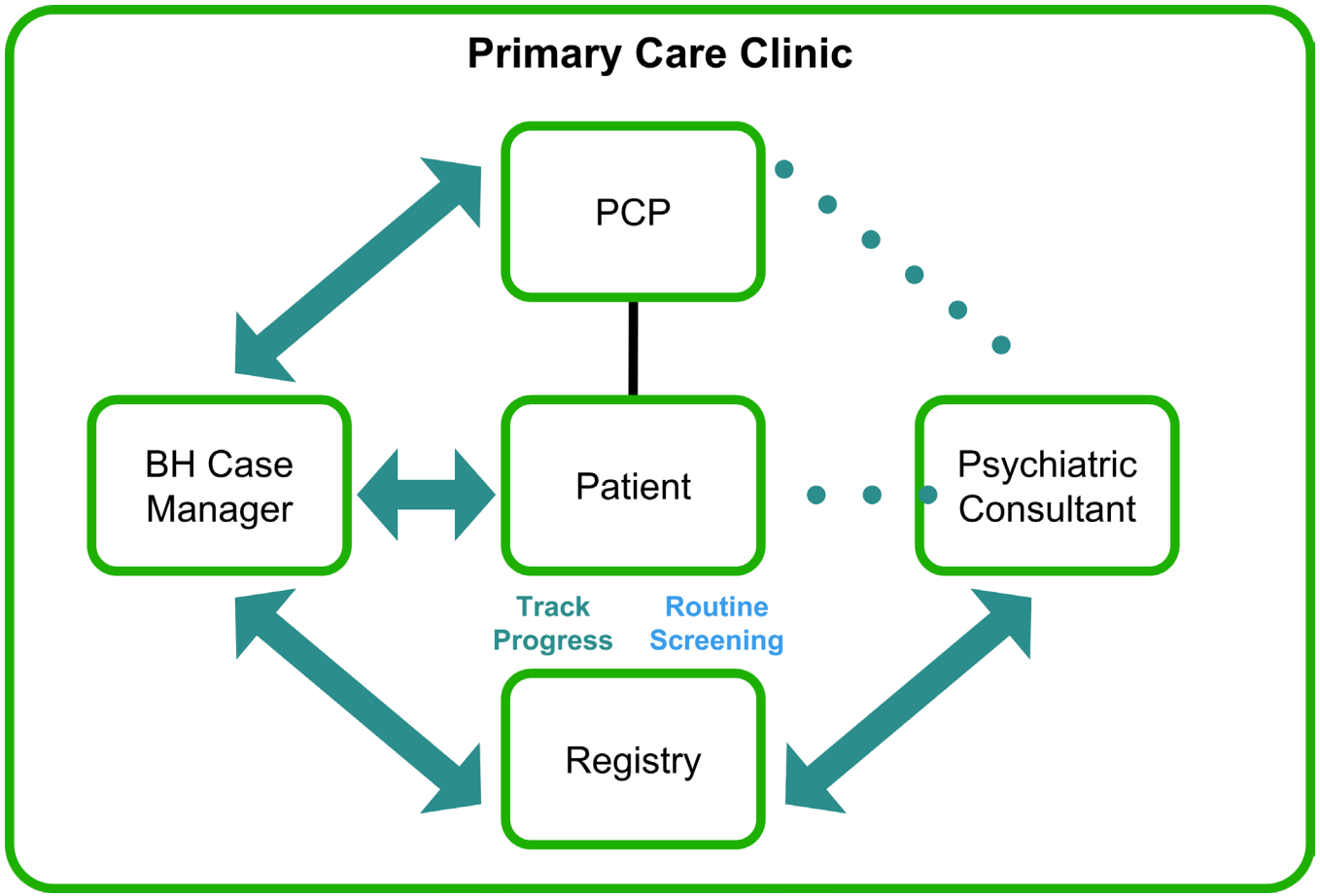
Collaborative Care Model

In comparison to standard primary care:	Collaborative Care Model
How does the model work?	• Routinely screen for common conditions • PCP and BH case manager in same facility • Psychiatric prescriber off-site

What clinical support is required?	• Administer screenings
	• Telehealth capabilities
	• IT Support/Greater EHR capabilities
	• Population health data analytics
	  ◦ Creation of registry
	  ◦ Data input
	  ◦ Track metrics over time

How are services reimbursed?	• Psychiatric collaborative care management services ◦ Special funding may be needed
What is the value added by this model?	• Proactive and timely • Longitudinal, dynamic care • Better patient outcomes • Less referrals to BH specialists

Collabotive Care Model



Treatment Plan

Collaborative Care Visit #1



- MA administers routine BH screens
  - Positive findings added to registry
  - BH Case Manager, Greg, receives alert

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Treatment Plan

Collaborative Care Visit #1



- John sees Dr. Smith for 15 minutes
- Shared medical decision making
  - Education about back pain
  - PT referral
  - Follow-up in 6-8 weeks
- Greg briefly introduces himself to John
  - Visit scheduled in 3 days, 45 minutes

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Treatment Plan

Collaborative Care Visit #1



Care coordination

- Clinic note
  - Note sent to PT
- Greg discusses John's care with Psychiatric NP, Heather, during regular staffing
  - NP Heather suggests Dr. Smith start mirtazapine

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Treatment Plan

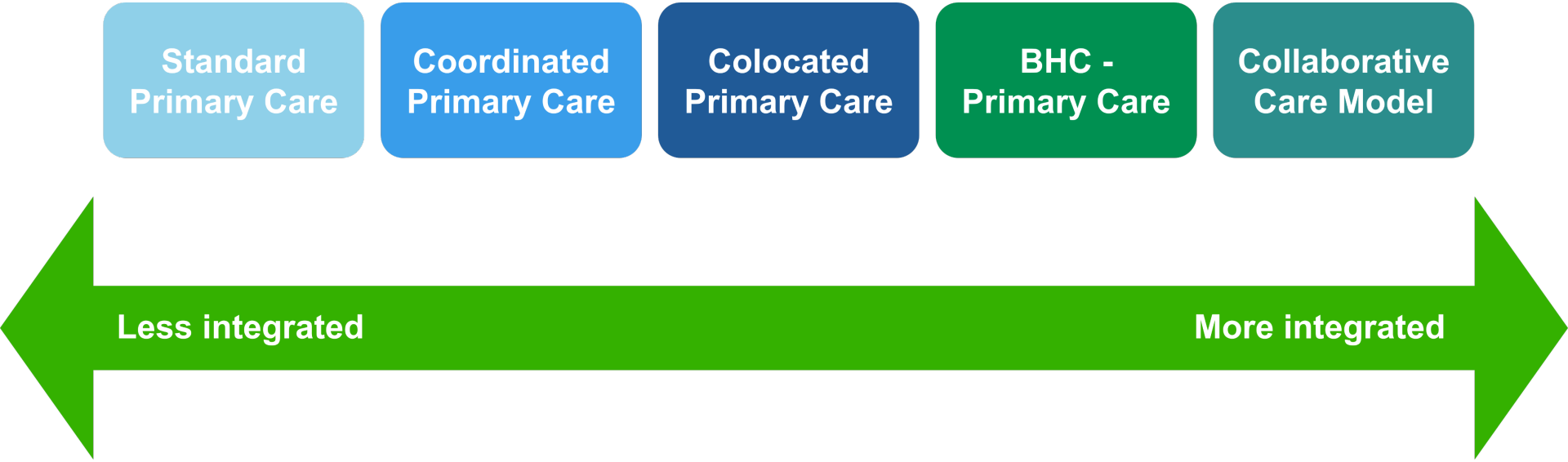
Collaborative Care Visit #1

Greg meets with John

- Intake completed
- Motivation Interviewing
- Behavioral goals set
- Recommends visit with Dr. Smith to discuss medications that might help
- Return visit with Greg in 1 week, 45 minutes
- Greg makes visit with Dr. Smith in 2 weeks, 15 minutes

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Continuum of BH Integration



BHC: Behavioral Health Consultant

Final Thought



Thank you! Questions?

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TEFRA and SDS Programs

Grace Ingrim RN, BSN, CCM

Manager AMCCI, TEFRA and Waiver Programs, Comagine Health

Comagine Health

Tax Equity Fiscal Responsibility Act (TEFRA)

Presented by

Grace Ingrim RN BSN CCM, Manager AMCCI, TEFRA and Waiver Programs

May 2025 Comagine Health Educational Sessions

Topics for Discussion

- The “Who, What, and Why” of TEFRA
  - Agencies involved
  - Eligibility requirements
- The “How” of TEFRA and role of Care Coordinator
  - DPA application and process
- FAQs
- Contact Information

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TEFRA

(Tax Equity Fiscal Responsibility Act)

- The term “TEFRA” comes from the Tax Equity and Fiscal Responsibility Act of 1982 that authorized this Medicaid category.
- Also known as Katie Beckett named after child stuck in hospital; Ronald Reagan approved 1981 and states followed
- Medicaid program for disabled children (under 19)living at home with significant medical/psych/developmental needs allowing some who would not typically qualify for Medicaid because of family income to receive Medicaid benefits
- Comagine Health contracted with Division of Public Assistance (DPA) to perform LOC reviews
- Comagine Health also supports care coordinators, families and state agencies to complete the application process within specified timeframes

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TEFRA Eligibility Requirements

1. Financial eligibility (DPA) based on the child's income and resources; parents' income and resources are not counted

- Be under 19 years of age
- Live in parental home / guardian
- Monthly income requirements
- Have resources $2000.00 or less.

2. Must have medical / psych/ development condition that meets Social Security Disability definition of child disability according to the Disability Determination Services Unit (State DDU Unit)

- Child must have a physical or mental condition that very seriously limits his or her activities; and the condition must have lasted, or be expected to last at least 1 year or result in death
- SSI and Medicaid use the book Disability Evaluation Under Social Security (also known as the Blue Book) to determine if a child meets the definition of child disability.
- This book lists childhood impairments (conditions) that qualify. It is available on the Internet at http://www.ssa.gov/disability/ professionals/bluebook/ChildhoodListings.htm

3.Meet Level-of Care per State criteria (Comagine Health)

- Nursing Facility (NF)- medical
- Inpatient Psychiatric Hospital (IPH)- psych
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) *(DSDS)

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MAGI Standards

Alaska Department of Health
Division of Public Assistance

MAGI MEDICAID INCOME ELIGIBILITY STANDARDS – FPL BASED Effective 4/01/2025				
Household Size	Pregnant Women	Children-Under age 19 With Insurance	Children-Under age 19 Without Insurance	Expansion Group
	225% of FPL	177% of FPL	203% of FPL	133% of FPL
1	n/a	2,884	3,308	2,167
2	4,956	3,899	4,472	2,930
3	6,246	4,914	5,635	3,692
4	7,536	5,929	6,799	4,455
5	8,826	6,943	7,963	5,217
6	10,116	7,958	9,127	5,980
7	11,406	8,973	10,291	6,742
8	12,696	9,988	11,455	7,505
9	13,986	11,003	12,619	8,268
10	15,276	12,018	13,783	9,031
Each Additional	1,290	1,015	1,164	763

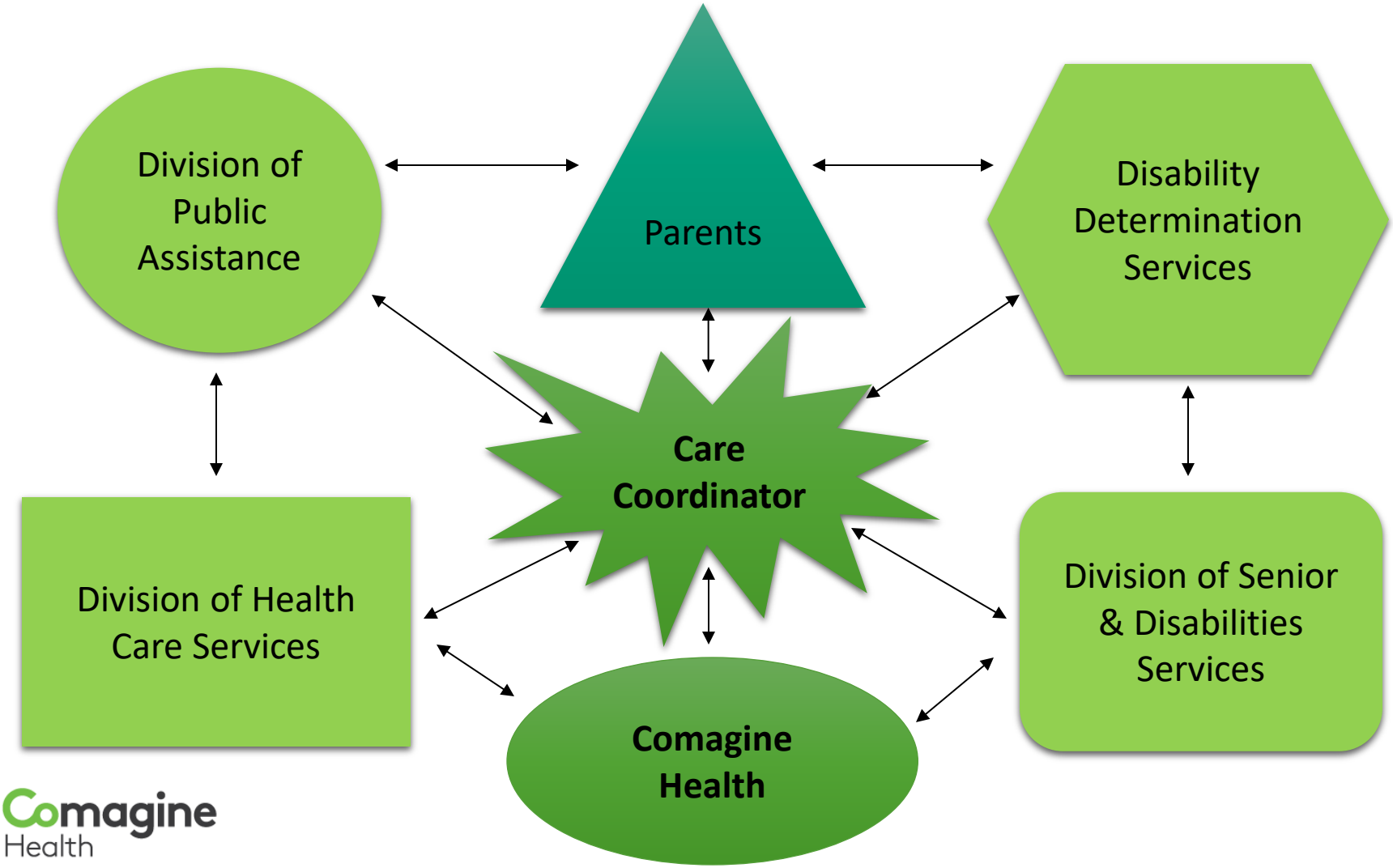
TEFRA Eligibility Requirements, cont.

- The purpose of the TEFRA Medicaid category is to allow children needing a high level of care to live at home rather than in a medical institution
- The child also must need a high level of care that would be provided in one of the following types of facilities:
  - Skilled or intermediate nursing facility
  - Inpatient psychiatric hospital
  - Intermediate care facility for the intellectually and developmentally disabled
- Live in the home of the parent/guardian
- Must meet all financial / social security disability and level of care criteria

Final eligibility is determined by DPA

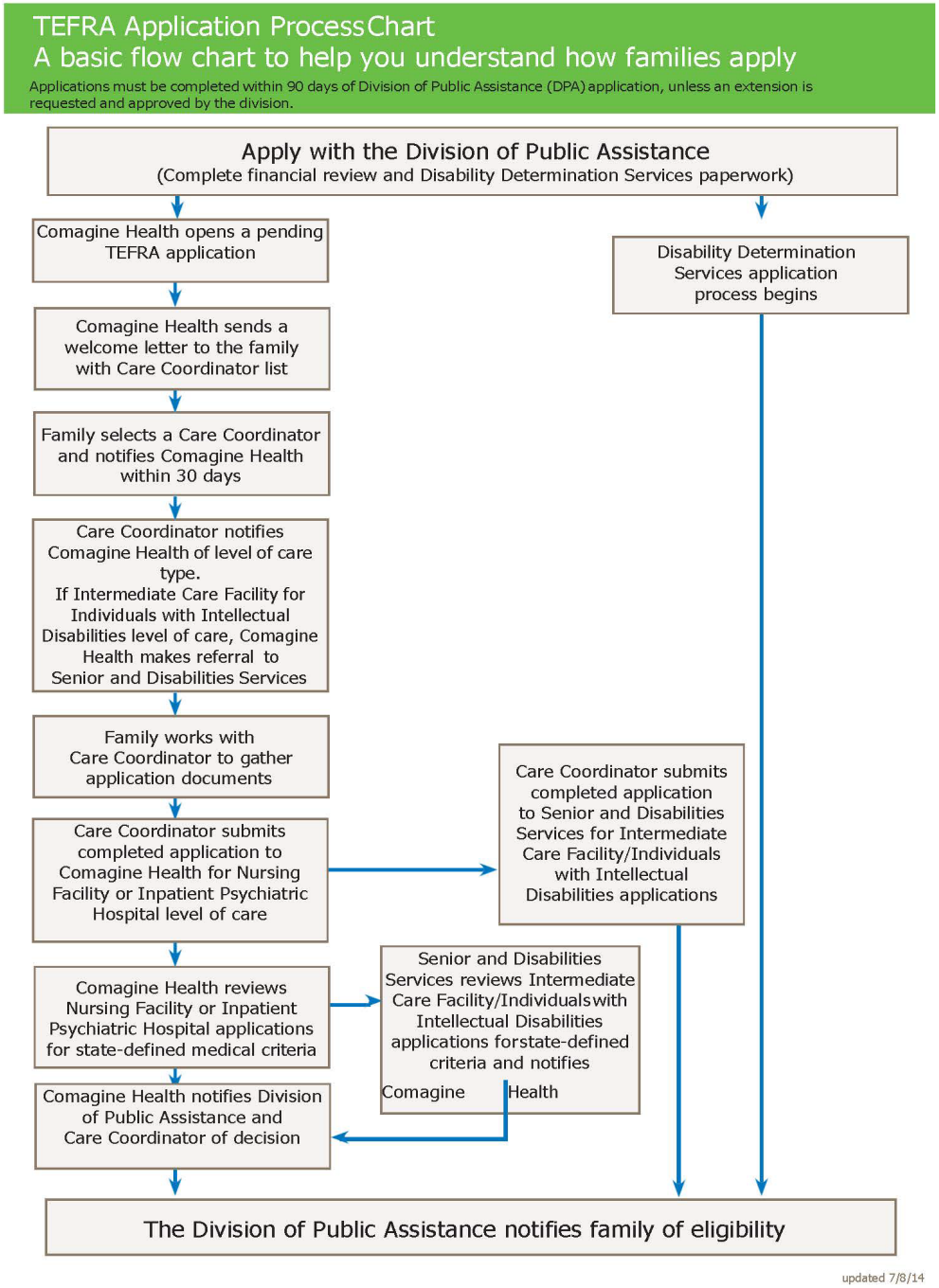
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Who's Involved in TEFRA?



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TEFRA Application Process Flow



Does TEFRA Medicaid Offer Additional Coverage?

- No. TEFRA Medicaid provides the same coverage as Denali KidCare, MAGI Medicaid, or as a child receiving SSI-related Medicaid
- No additional services are paid for by TEFRA Medicaid
- Check the DPA website: for additional information and resources on programs and services such as food stamps, heating assistance, childcare, senior benefits and more

https://health.Alaska.gov/en/services/division-of-public-assistance-dpa-services/

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TEFRA vs Waivers

Similarities

- Each client works with certified Care Coordinator
- Must have approved LOC / POC / COC
- TEFRA ICF /IDD decision determined by SDS is same criteria as Waiver IDD or ISW

Differences

- TEFRA NF LOC determined by Comagine Health uses different criteria than Waiver
- TEFRA IPH unique to TEFRA with no comparable Waiver and is determined by Comagine Health
- TEFRA and Waiver have different income / resource limits
- TEFRA provides basic Medicaid coverage, Waiver provides additional supports for child and family beyond basis Medicaid coverage.

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Comagine Health Role

- Link for families, care coordinators, and state agencies to:
  - Provide administrative management and oversight throughout the application and renewal processes
  - Tracking timeframe processes
  - Maintain TEFRA website
- Review documentation for:
  - NF/IPH- LOC, POC, COC
  - ICF/IID- POC, COC
- Physician consultation
- Support hearing processes



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Determining Level of Care (LOC) for NF or IPH Application / Renewal

- What are the care needs?
  - Substantial needs
  - **Not** cost or diagnosis driven

- Chronic Conditions
  - Mild
  - Moderate
  - Profound
  - Severe

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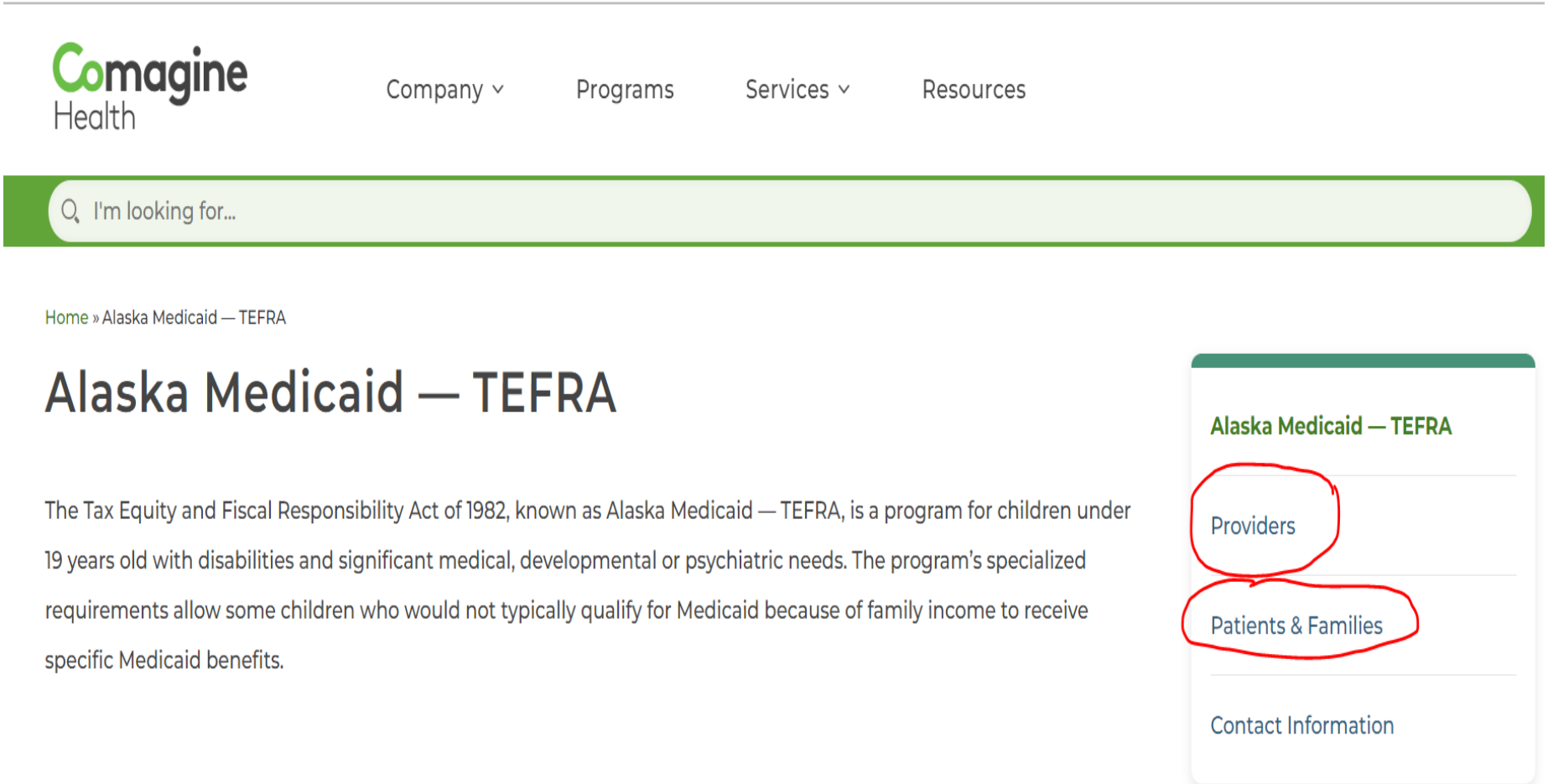
Determining LOC for NF / IPH Application / Renewal (cont.)

Services performed at home that would typically be rendered in a facility setting such as:

- Hospital
- Residential Psychiatric Treatment Center (RPTC)
- Nursing Home
- Other institutional settings (ICF/IDD)

Online Resource Comagine Health

https://comagine.org/program/alaska-medicaid-tefra



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Waiver / 3rd Party Reviews

Presented by

Grace Ingrim RN BSN CCM, Manager AMCCI, TEFRA and Waiver Programs

May 2025 Comagine Health Educational Sessions

Medicaid Waivers

- Senior and Disabilities Services (SDS) programs/policies/authorizations for services
- Offers choice between home and community-based services verses institutional care for those meeting criteria
- Waiver programs cover seniors, adults and children
- Provides Medicaid services plus additional add on services



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Waiver Programs

- Waiver Programs
  - Adults Living Independently (ALI-21 yrs and older)
  - Adults with Physical Disabilities (APDD-21 yrs and older with physical and developmental disabilities)
  - Children with Complex Medical Conditions (CCMC-children and young adult under age 22)
  - Intellectual & Developmental Disabilities (I/DD)
  - The Individualized Supports Waiver (ISW)

Waiver Services

- Environmental Modifications
- Respite care
- Residential Supported Living
- Specialized Medical Equipment
- Care Coordination
- Other

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Waiver Resources











Division of Senior & Disabilities Services | State of Alaska | Department of Health

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3rd Party Review Denied Reassessments

- Additional contract 3rd Party Review of Denied Reassessments
- Initial & second review of denial by the State; Comagine Health review of denial using State criteria



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Comagine Health Role

- Independent 3rd Party Review Denied Reassessments
- Support with physician and QIDP (Qualified Intellectual Disability Professional)
- Make recommendations to support or overturn denial based on state criteria
- Provide support for Fair Hearing
- Administrative support

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Comagine Health Contact Information



Case Management/TEFRA

- Toll-free phone (888) 578-2547
- 907-550-7600
- Fax referral form to (877) 265-9549
- Grace Ingrim

  907-205-9590 gingrim@comagine.org

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TEFRA/Waiver Services - Questions



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Quyanaq



Thank you for the services you provide to Alaska Medicaid recipients, and for your continued efforts on their behalf.

Comagine Health

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Lunch Break

Please return by 12:40 AKT

Comagine Health

Alaska Medicaid Arranging Patient Travel

Carrie Silvers, RHIT

Medicaid Program Specialist IV, Division of Health Care Services



AK Medicaid Arranging Patient Travel

May 2025 Comagine Spring Provider Outreach

Discussion Topics

Basic Principles

5 key components of travel coverage

New Resources

Transportation SA Quick Reference Guide and COMN

Resource Review

Arranging Member Travel webpage

Travel SA Flow

Flow of travel SA process; Top reasons Travel SAs are RTPed and how to avoid

Travel SA Statistics

Travel SA requests received, approved and denied

Guidehouse

Rate review contractor and process

Gainwell Technologies Proprietary and Confidential

100

AK Medicaid Coverage Basic Principles



What is the Assurance of Transportation?

The assurance of transportation requires states to ensure that Medicaid enrollees without other transportation means have transportation – including both NEMT and emergency medical transportation – when necessary to access covered services. These services can be provided through multiple modes in recognition of varied individual needs and geography/terrain across states.



Assuring Access to Necessary Transportation

- States can set limitations when implementing the assurance of transportation, but they must:
  - Be reasonable in meeting enrollees' needs
  - Not conflict with the state's responsibility to assure transportation so that an enrollee can access necessary, covered medical services



Emergency Medical Transportation

- The assurance of transportation applies to emergency medical transportation as well as NEMT.
- There is not a federal requirement that emergency transportation must be to a hospital emergency department, and alternative emergency locations might include urgent care, group practices, crisis centers, and community clinics.

Source: "SMD# 23-006 RE: Assurance of Transportation: A Medicaid Transportation Coverage Guide." Centers for Medicare & Medicaid Services, September 28, 2023. https://www.medicaid.gov/sites/default/files/2023-12/smd23006.pdf.

Five Key Components for Coverage

There are five key components that must be established for travel to be covered. Healthcare providers must provide supporting information for all 5 components. Typically, verbal and written information is accepted, however there are some scenarios in which the department will require written information.

Medicaid Benefit Status: The member must be eligible for Alaska Medicaid on the date the service is requested with a benefit plan that includes travel.

Provider Enrollment: Both the referring and receiving healthcare provider must be enrolled with Alaska Medicaid. Exceptions include military and VA facilities as well as emergency situations where the member was traveled to the closest acute care hospital that could meet their needs.

Covered Service: The service the travel is needed for must be an Alaska Medicaid covered service.

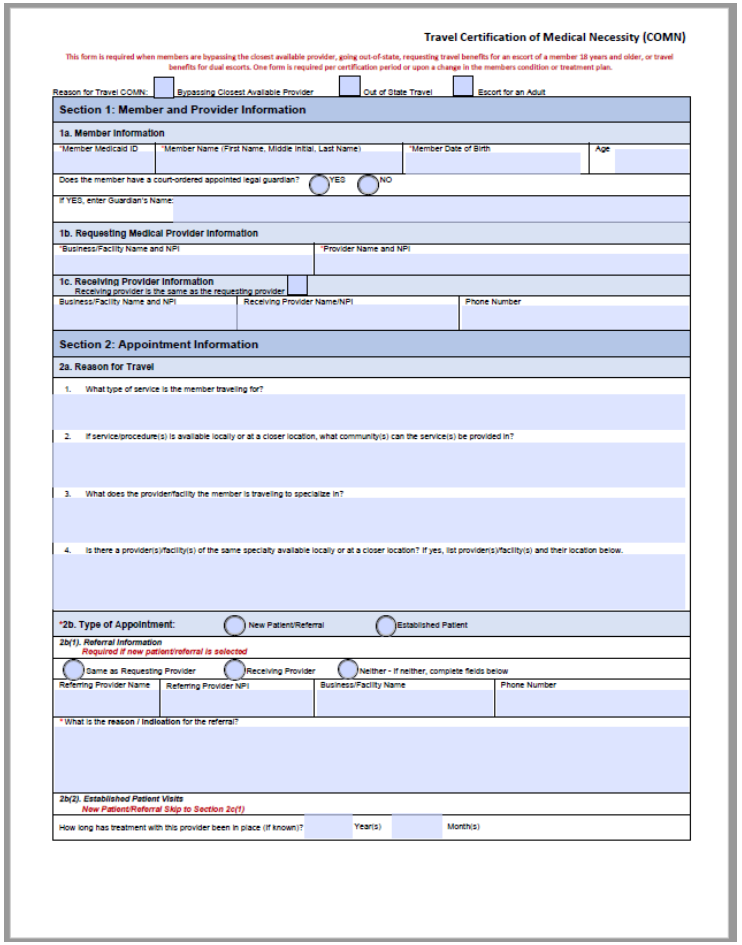
Closest, Most Appropriate Provider: Transportation must be to the closest most appropriate healthcare provider that can meet the member's needs. However, Alaska Natives may be approved for traveling to the nearest tribal health facility. Does not apply to travel services in a member's home community.

Medical Necessity: The healthcare service(s) must be reasonable, necessary, and appropriate, based on evidence-based clinical standards of care. Medical necessity also applies to products used to treat or prevent diseases and disorders. Alaska Medicaid uses criteria established by the Department of Health or by standards of practice applicable to the ordering or referring healthcare provider's license or certification.

New Resources



New Travel COMN



Travel Certification of Medical Necessity (COMN)

This form is required when members are bypassing the closest available provider, going out-of-state, requesting travel benefits for an escort of a member 18 years and older, or travel benefits for dual escorts. One form is required per certification period or upon a change in the members condition or treatment plan.

Reason for Travel COMN: ☐ Bypassing Closest Available Provider ☐ Out of State Travel ☐ Escort for an Adult

Section 1: Member and Provider Information

1a. Member Information

*Member Medicaid ID	*Member Name (First Name, Middle Initial, Last Name)	*Member Date of Birth	Age

Does the member have a court-ordered appointed legal guardian? ◯ YES ◯ NO

If YES, enter Guardian's Name:

1b. Requesting Medical Provider Information

*Business/Facility Name and NPI	*Provider Name and NPI

1c. Receiving Provider Information

Receiving provider is the same as the requesting provider ☐

Business/Facility Name and NPI	Receiving Provider Name/NPI	Phone Number

Section 2: Appointment Information

2a. Reason for Travel

1. What type of service is the member traveling for?
2. If service/procedure(s) is available locally or at a closer location, what community(s) can the service(s) be provided in?
3. What does the provider/facility the member is traveling to specialize in?
4. Is there a provider(s)/facility(s) of the same specialty available locally or at a closer location? If yes, list provider(s)/facility(s) and their location below.

***2b. Type of Appointment:** ◯ New Patient/Referral ◯ Established Patient

2b(1). Referral Information

Required if new patient/referral is selected

◯ Same as Requesting Provider ◯ Receiving Provider ◯ Neither - If neither, complete fields below

Referring Provider Name	Referring Provider NPI	Business/Facility Name	Phone Number

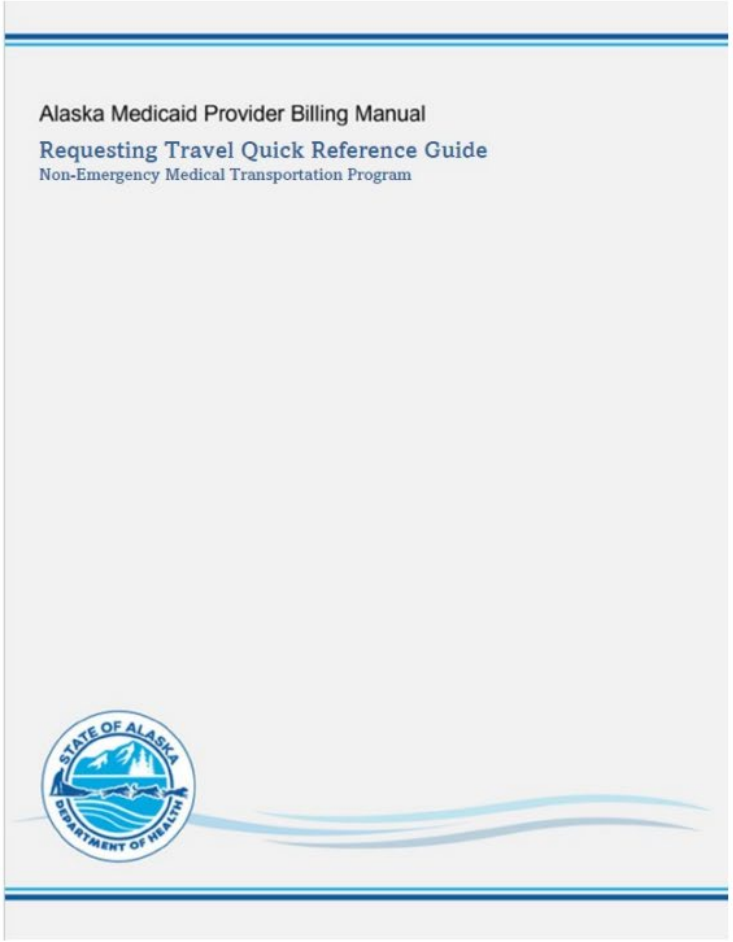
* What is the reason / indication for the referral?

2b(2). Established Patient Visits

New Patient/Referral Skip to Section 2c(1)

How long has treatment with this provider been in place (if known)? Year(s) Month(s)

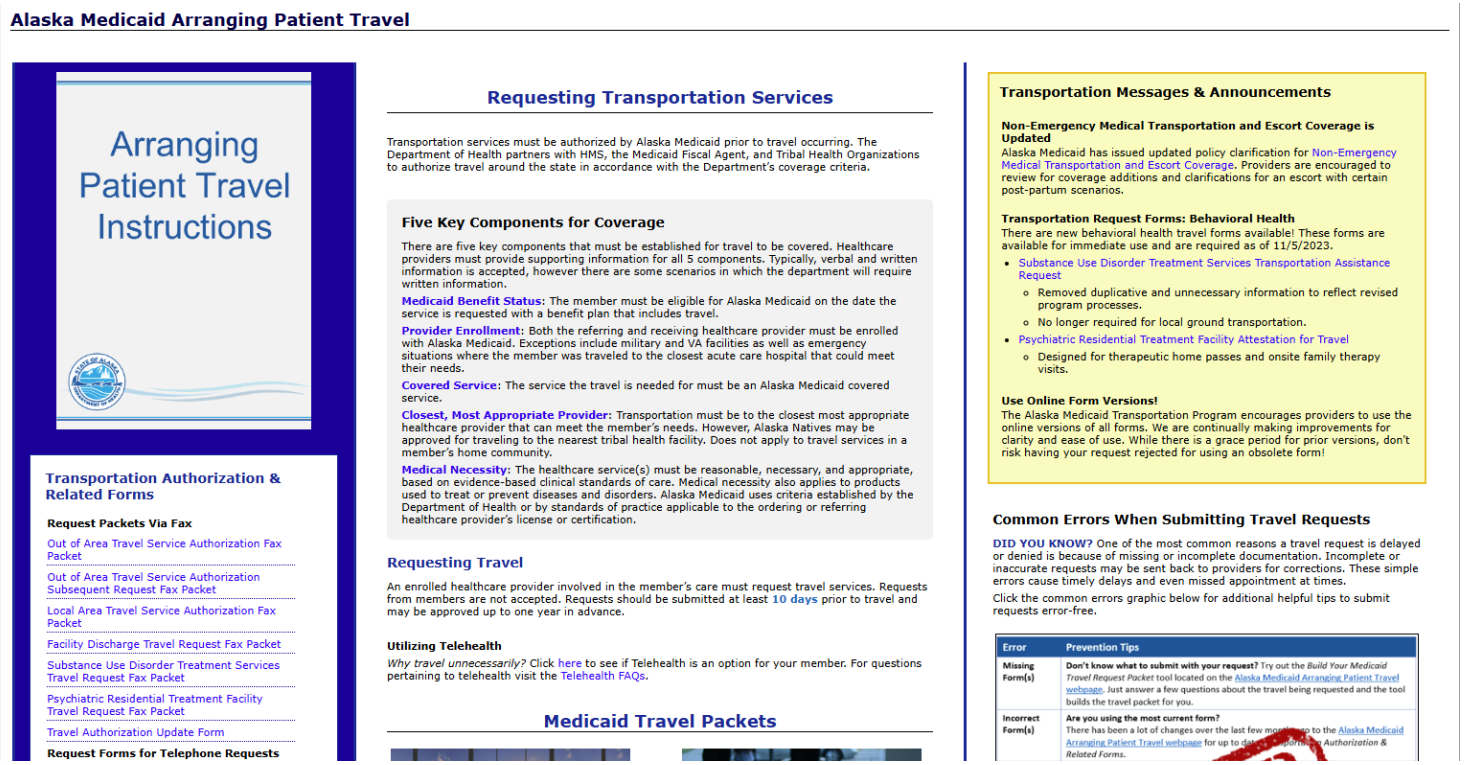
Travel SA Quick Reference Guide



Existing Resources

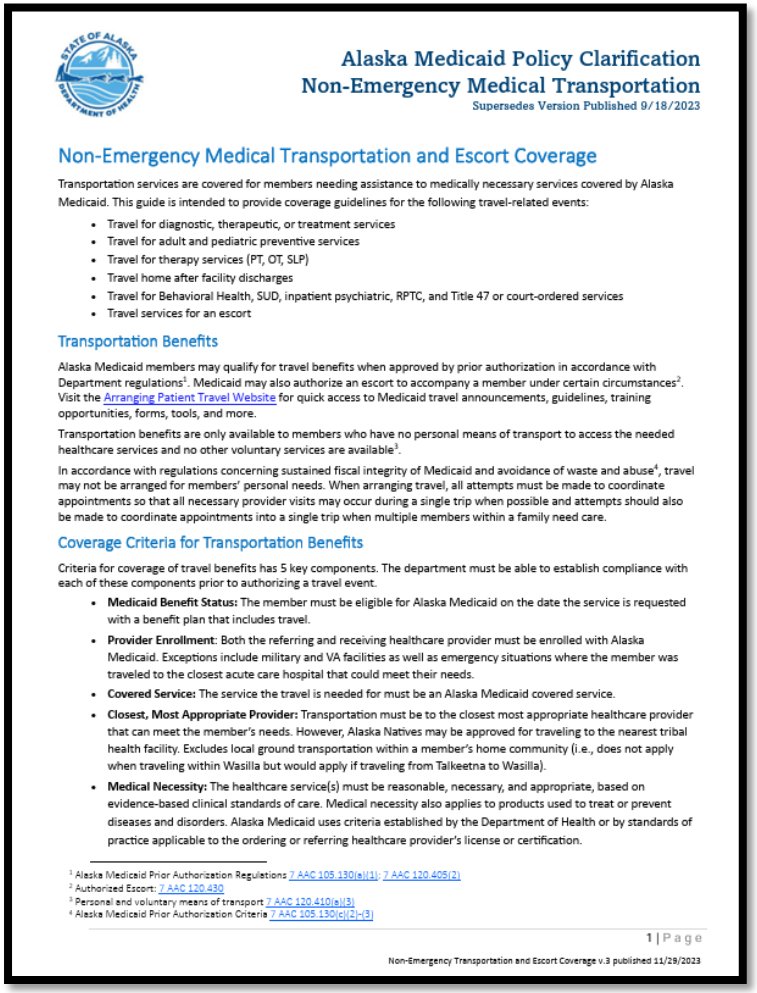


Arranging Member Travel Webpage



https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Sites/Arranging_Patient_Travel.html

https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Updates/NEMT_Escort_Coverage_Flyer_20231129.pdf



Alaska Medicaid Policy Clarification
Non-Emergency Medical Transportation

Supersedes Version Published 9/18/2023

Non-Emergency Medical Transportation and Escort Coverage

Transportation services are covered for members needing assistance to medically necessary services covered by Alaska Medicaid. This guide is intended to provide coverage guidelines for the following travel-related events:

- Travel for diagnostic, therapeutic, or treatment services
- Travel for adult and pediatric preventive services
- Travel for therapy services (PT, OT, SLP)
- Travel home after facility discharges
- Travel for Behavioral Health, SUD, inpatient psychiatric, RPTC, and Title 47 or court-ordered services
- Travel services for an escort

Transportation Benefits

Alaska Medicaid members may qualify for travel benefits when approved by prior authorization in accordance with Department regulations[1]. Medicaid may also authorize an escort to accompany a member under certain circumstances[2]. Visit the Arranging Patient Travel Website for quick access to Medicaid travel announcements, guidelines, training opportunities, forms, tools, and more.

Transportation benefits are only available to members who have no personal means of transport to access the needed healthcare services and no other voluntary services are available[3].

In accordance with regulations concerning sustained fiscal integrity of Medicaid and avoidance of waste and abuse[4], travel may not be arranged for members' personal needs. When arranging travel, all attempts must be made to coordinate appointments so that all necessary provider visits may occur during a single trip when possible and attempts should also be made to coordinate appointments into a single trip when multiple members within a family need care.

Coverage Criteria for Transportation Benefits

Criteria for coverage of travel benefits has 5 key components. The department must be able to establish compliance with each of these components prior to authorizing a travel event.

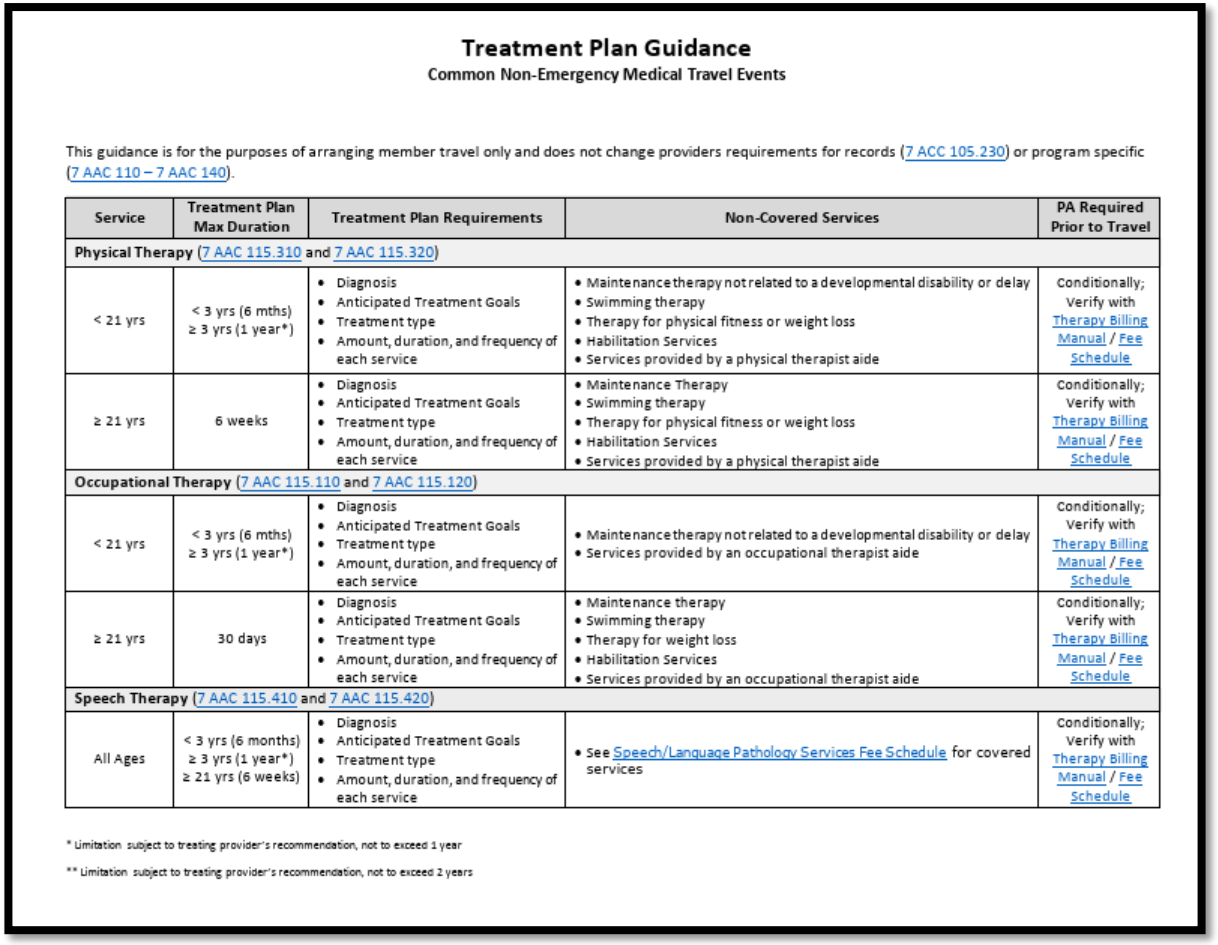
- **Medicaid Benefit Status:** The member must be eligible for Alaska Medicaid on the date the service is requested with a benefit plan that includes travel.
- **Provider Enrollment**: Both the referring and receiving healthcare provider must be enrolled with Alaska Medicaid. Exceptions include military and VA facilities as well as emergency situations where the member was traveled to the closest acute care hospital that could meet their needs.
- **Covered Service:** The service the travel is needed for must be an Alaska Medicaid covered service.
- **Closest, Most Appropriate Provider:** Transportation must be to the closest most appropriate healthcare provider that can meet the member's needs. However, Alaska Natives may be approved for traveling to the nearest tribal health facility. Excludes local ground transportation within a member's home community (i.e., does not apply when traveling within Wasilla but would apply if traveling from Talkeetna to Wasilla).
- **Medical Necessity:** The healthcare service(s) must be reasonable, necessary, and appropriate, based on evidence-based clinical standards of care. Medical necessity also applies to products used to treat or prevent diseases and disorders. Alaska Medicaid uses criteria established by the Department of Health or by standards of practice applicable to the ordering or referring healthcare provider's license or certification.

[1] Alaska Medicaid Prior Authorization Regulations 7 AAC 105.130(e)(1); 7 AAC 120.405(2)
[2] Authorized Escort: 7 AAC 120.430
[3] Personal and voluntary means of transport 7 AAC 120.410(e)(3)
[4] Alaska Medicaid Prior Authorization Criteria 7 AAC 105.130(c)(2)-(3)

1 | Page

Non-Emergency Transportation and Escort Coverage v.3 published 11/29/2023

https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Updates/POC_Requirement_Guidance.pdf



Treatment Plan Guidance

Common Non-Emergency Medical Travel Events

This guidance is for the purposes of arranging member travel only and does not change providers requirements for records (7 ACC 105.230) or program specific (7 AAC 110 – 7 AAC 140).

Service	Treatment Plan Max Duration	Treatment Plan Requirements	Non-Covered Services	PA Required Prior to Travel
Physical Therapy (7 AAC 115.310 and 7 AAC 115.320)				
< 21 yrs	< 3 yrs (6 mths) ≥ 3 yrs (1 year*)	• Diagnosis • Anticipated Treatment Goals • Treatment type • Amount, duration, and frequency of each service	• Maintenance therapy not related to a developmental disability or delay • Swimming therapy • Therapy for physical fitness or weight loss • Habilitation Services • Services provided by a physical therapist aide	Conditionally; Verify with Therapy Billing Manual / Fee Schedule
≥ 21 yrs	6 weeks	• Diagnosis • Anticipated Treatment Goals • Treatment type • Amount, duration, and frequency of each service	• Maintenance Therapy • Swimming therapy • Therapy for physical fitness or weight loss • Habilitation Services • Services provided by a physical therapist aide	Conditionally; Verify with Therapy Billing Manual / Fee Schedule
Occupational Therapy (7 AAC 115.110 and 7 AAC 115.120)				
< 21 yrs	< 3 yrs (6 mths) ≥ 3 yrs (1 year*)	• Diagnosis • Anticipated Treatment Goals • Treatment type • Amount, duration, and frequency of each service	• Maintenance therapy not related to a developmental disability or delay • Services provided by an occupational therapist aide	Conditionally; Verify with Therapy Billing Manual / Fee Schedule
≥ 21 yrs	30 days	• Diagnosis • Anticipated Treatment Goals • Treatment type • Amount, duration, and frequency of each service	• Maintenance therapy • Swimming therapy • Therapy for weight loss • Habilitation Services • Services provided by an occupational therapist aide	Conditionally; Verify with Therapy Billing Manual / Fee Schedule
Speech Therapy (7 AAC 115.410 and 7 AAC 115.420)				
All Ages	< 3 yrs (6 months) ≥ 3 yrs (1 year*) ≥ 21 yrs (6 weeks)	• Diagnosis • Anticipated Treatment Goals • Treatment type • Amount, duration, and frequency of each service	• See Speech/Language Pathology Services Fee Schedule for covered services	Conditionally; Verify with Therapy Billing Manual / Fee Schedule

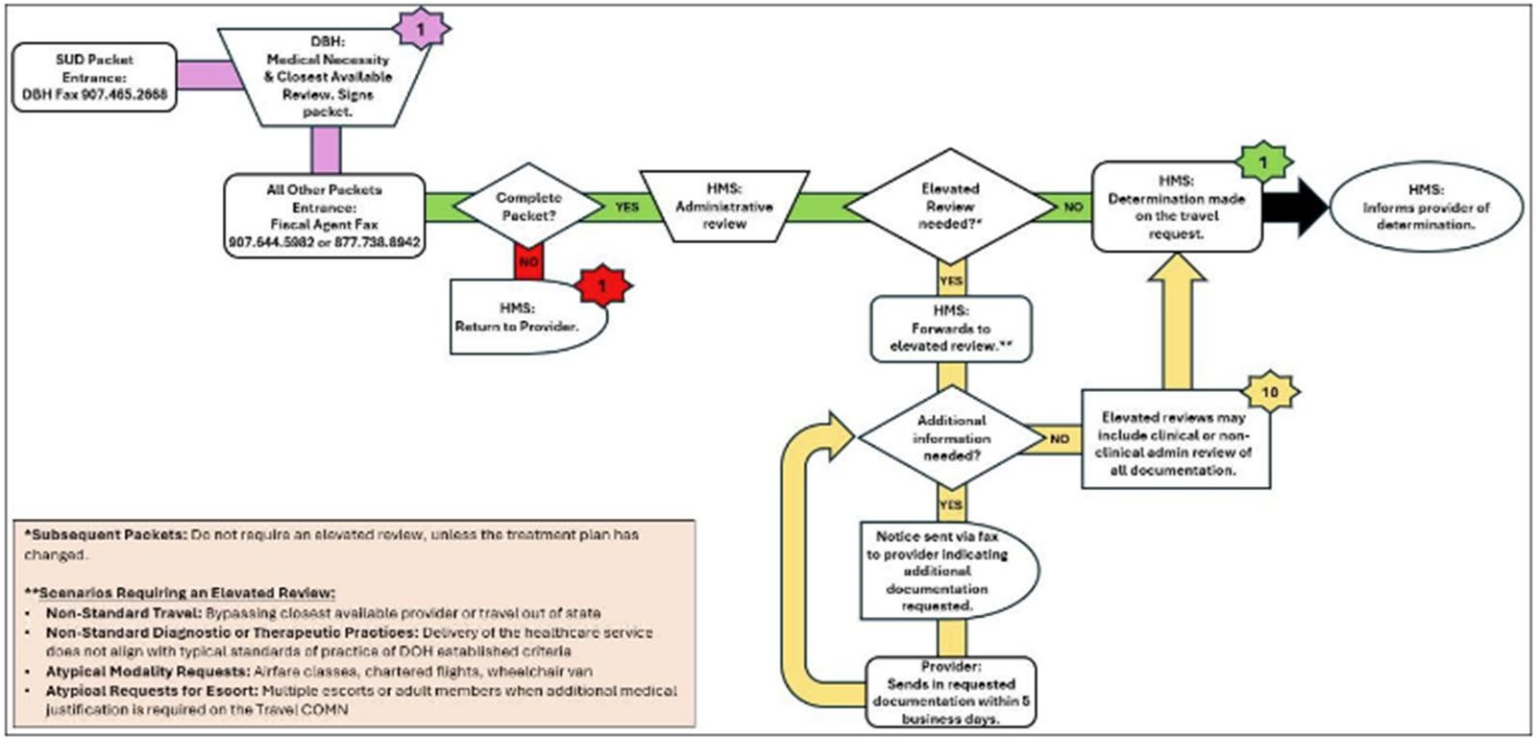
* Limitation subject to treating provider's recommendation, not to exceed 1 year

** Limitation subject to treating provider's recommendation, not to exceed 2 years

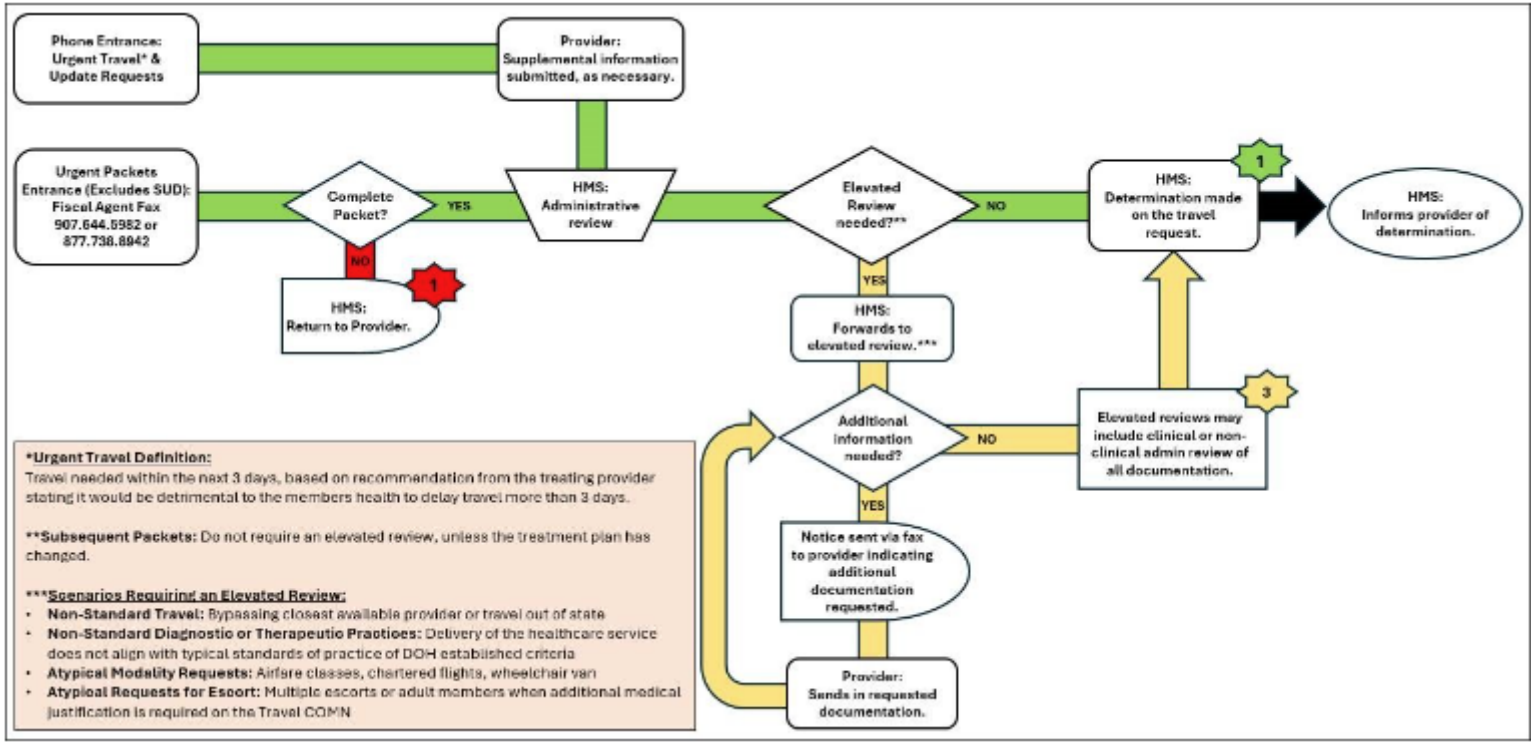
Travel SA Flow



Non-Urgent Travel



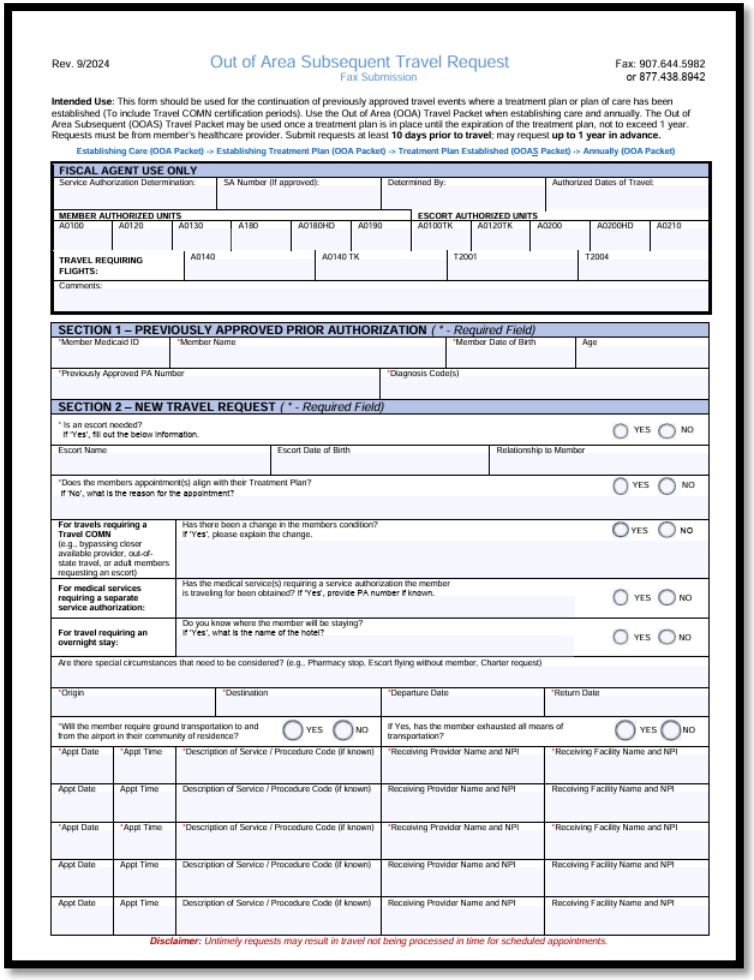
Urgent Travel



Subsequent Travel Requests

- Subsequent requests are for follow-up on travel AK Medicaid has paid for. If a member has traveled to a provider initially on their own, the first trip through Medicaid would be requested using an initial packet.
- Subsequent requests are meant to simplify the request process when the fiscal agent already has the relevant documentation on the member's travel needs.

https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Provider_Forms/OOA_Travel_Service_2nd_Request_Fax_Packet.pdf



Rev. 9/2024

Out of Area Subsequent Travel Request
Fax Submission

Fax: 907.644.5982
or 877.438.8942

Intended Use: This form should be used for the continuation of previously approved travel events where a treatment plan or plan of care has been established (To include Travel COMN certification periods). Use the Out of Area (OOA) Travel Packet when establishing care and annually. The Out of Area Subsequent (OOAS) Travel Packet may be used once a treatment plan is in place until the expiration of the treatment plan, not to exceed 1 year. Requests must be from member's healthcare provider. Submit requests at least **10 days prior to travel**; may request **up to 1 year in advance.**

Establishing Care (OOA Packet) -> Establishing Treatment Plan (OOA Packet) -> Treatment Plan Established (OOAS Packet) -> Annually (OOA Packet)

FISCAL AGENT USE ONLY

Service Authorization Determination:	SA Number (If approved):	Determined By:	Authorized Dates of Travel:

MEMBER AUTHORIZED UNITS						ESCORT AUTHORIZED UNITS				
A0100	A0120	A0130	A180	A0180HD	A0190	A0100TK	A0120TK	A0200	A0200HD	A0210

TRAVEL REQUIRING FLIGHTS:	A0140	A0140 TK	T2001	T2004

Comments:

SECTION 1 – PREVIOUSLY APPROVED PRIOR AUTHORIZATION *(* - Required Field)*

*Member Medicaid ID	*Member Name	*Member Date of Birth	Age

*Previously Approved PA Number	*Diagnosis Code(s)

SECTION 2 – NEW TRAVEL REQUEST *(* - Required Field)*

*Is an escort needed? If 'Yes', fill out the below information. YES NO

Escort Name	Escort Date of Birth	Relationship to Member

*Does the members appointment(s) align with their Treatment Plan? If 'No', what is the reason for the appointment? YES NO

For travels requiring a Travel COMN (e.g., bypassing closer available provider, out-of-state travel, or adult members requesting an escort)	Has there been a change in the members condition? If 'Yes', please explain the change.	YES NO
For medical services requiring a separate service authorization:	Has the medical service(s) requiring a service authorization the member is traveling for been obtained? If 'Yes', provide PA number if known.	YES NO
For travel requiring an overnight stay:	Do you know where the member will be staying? If 'Yes', what is the name of the hotel?	YES NO

Are there special circumstances that need to be considered? (e.g., Pharmacy stop, Escort flying without member, Charter request)

*Origin	*Destination	*Departure Date	*Return Date

*Will the member require ground transportation to and from the airport in their community of residence? YES NO

If Yes, has the member exhausted all means of transportation? YES NO

*Appt Date	*Appt Time	*Description of Service / Procedure Code (if known)	*Receiving Provider Name and NPI	*Receiving Facility Name and NPI
Appt Date	Appt Time	Description of Service / Procedure Code (if known)	Receiving Provider Name and NPI	Receiving Facility Name and NPI
*Appt Date	*Appt Time	*Description of Service / Procedure Code (if known)	*Receiving Provider Name and NPI	*Receiving Facility Name and NPI
Appt Date	Appt Time	Description of Service / Procedure Code (if known)	Receiving Provider Name and NPI	Receiving Facility Name and NPI
Appt Date	Appt Time	Description of Service / Procedure Code (if known)	Receiving Provider Name and NPI	Receiving Facility Name and NPI

Disclaimer: *Untimely requests may result in travel not being processed in time for scheduled appointments.*

Travel SA Statistics



March Travel Fax Statistics

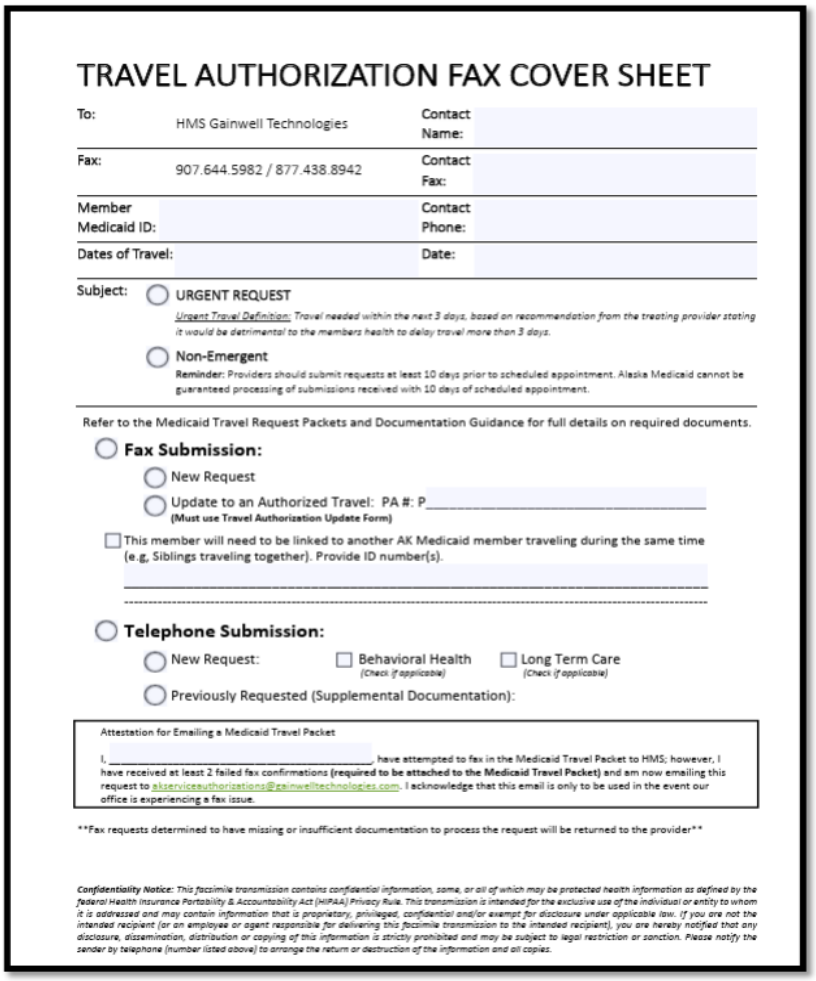
- Total travel faxes in March 2025 – 5,166
- Total RTP – 542

- RTP % is down to only 10% - Great Progress!!



Top 3 Travel SA RTP Reasons

#1 No coversheet



TRAVEL AUTHORIZATION FAX COVER SHEET

To:	HMS Gainwell Technologies	Contact Name:	
Fax:	907.644.5982 / 877.438.8942	Contact Fax:	
Member Medicaid ID:		Contact Phone:	
Dates of Travel:		Date:	

Subject:

◯ URGENT REQUEST

Urgent Travel Definition: Travel needed within the next 3 days, based on recommendation from the treating provider stating it would be detrimental to the members health to delay travel more than 3 days.

◯ Non-Emergent

Reminder: Providers should submit requests at least 10 days prior to scheduled appointment. Alaska Medicaid cannot be guaranteed processing of submissions received with 10 days of scheduled appointment.

Refer to the Medicaid Travel Request Packets and Documentation Guidance for full details on required documents.

◯ **Fax Submission:**

◯ New Request

◯ Update to an Authorized Travel: PA #: P_____

(Must use Travel Authorization Update Form)

☐ This member will need to be linked to another AK Medicaid member traveling during the same time (e.g, Siblings traveling together). Provide ID number(s).

_____

◯ **Telephone Submission:**

◯ New Request: ☐ Behavioral Health *(Check if applicable)* ☐ Long Term Care *(Check if applicable)*

◯ Previously Requested (Supplemental Documentation):

Attestation for Emailing a Medicaid Travel Packet

I, _____, have attempted to fax in the Medicaid Travel Packet to HMS; however, I have received at least 2 failed fax confirmations **(required to be attached to the Medicaid Travel Packet)** and am now emailing this request to akserviceauthorizations@gainwelltechnologies.com. I acknowledge that this email is only to be used in the event our office is experiencing a fax issue.

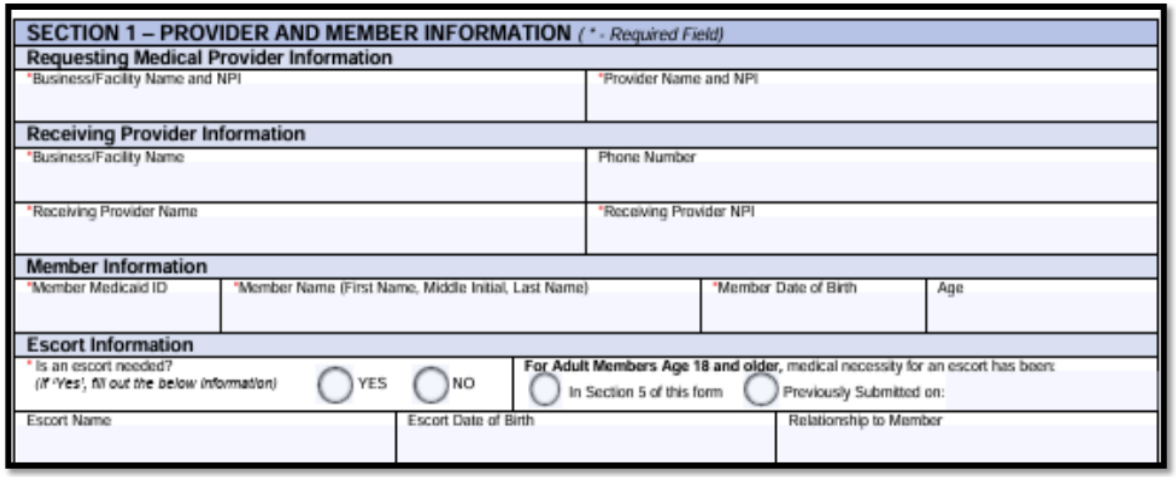
Fax requests determined to have missing or insufficient documentation to process the request will be returned to the provider

Confidentiality Notice: *This facsimile transmission contains confidential information, some, or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt for disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.*

Top 3 Travel SA RTP Reasons

2
Section 1 under Provider and Member information, Requesting Medical Provider Information not filled in completely.

Business/Facility Name and NPI need to be entered in the 1st box and the individual Provider name and NPI need to be in the 2nd box



SECTION 1 – PROVIDER AND MEMBER INFORMATION *(* - Required Field)*

Requesting Medical Provider Information

*Business/Facility Name and NPI	*Provider Name and NPI

Receiving Provider Information

*Business/Facility Name	Phone Number
*Receiving Provider Name	*Receiving Provider NPI

Member Information

*Member Medicaid ID	*Member Name (First Name, Middle Initial, Last Name)	*Member Date of Birth	Age

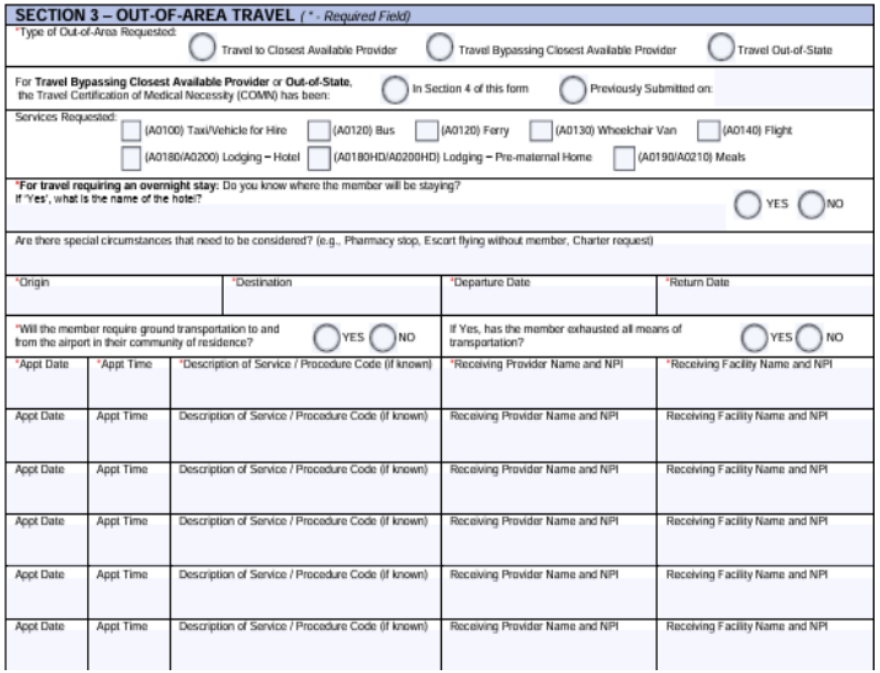
Escort Information

* Is an escort needed? *(If 'Yes', fill out the below information)* ◯ YES ◯ NO	**For Adult Members Age 18 and older,** medical necessity for an escort has been: ◯ In Section 5 of this form ◯ Previously Submitted on:

Escort Name	Escort Date of Birth	Relationship to Member

Top 3 Travel SA RTP Reasons

3
In section 3 under Out-of-Area travel, appointment detail information not filled out.



SECTION 3 – OUT-OF-AREA TRAVEL *(* - Required Field)*

*Type of Out-of-Area Requested: ◯ Travel to Closest Available Provider ◯ Travel Bypassing Closest Available Provider ◯ Travel Out-of-State

For **Travel Bypassing Closest Available Provider** or **Out-of-State**, the Travel Certification of Medical Necessity (COMN) has been: ◯ In Section 4 of this form ◯ Previously Submitted on:

Services Requested: ☐ (A0100) Taxi/Vehicle for Hire ☐ (A0120) Bus ☐ (A0120) Ferry ☐ (A0130) Wheelchair Van ☐ (A0140) Flight ☐ (A0180/A0200) Lodging – Hotel ☐ (A0180HD/A0200HD) Lodging – Pre-maternal Home ☐ (A0190/A0210) Meals

***For travel requiring an overnight stay:** Do you know where the member will be staying? If 'Yes', what is the name of the hotel? ◯ YES ◯ NO

Are there special circumstances that need to be considered? (e.g., Pharmacy stop, Escort flying without member, Charter request)

*Origin	*Destination	*Departure Date	*Return Date

*Will the member require ground transportation to and from the airport in their community of residence? ◯ YES ◯ NO

If Yes, has the member exhausted all means of transportation? ◯ YES ◯ NO

*Appt Date	*Appt Time	*Description of Service / Procedure Code (if known)	*Receiving Provider Name and NPI	*Receiving Facility Name and NPI
Appt Date	Appt Time	Description of Service / Procedure Code (if known)	Receiving Provider Name and NPI	Receiving Facility Name and NPI
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Appt Date	Appt Time	Description of Service / Procedure Code (if known)	Receiving Provider Name and NPI	Receiving Facility Name and NPI

Tips for Success

- Behavioral health providers requesting travel for their AK Medicaid member patients should list the organization as the requesting or receiving provider
- QA your forms prior to submitting them, **especially** when receiving a request from another provider
  - Feel free to add extra notes concerning your process or noting any missing information from the other provider
- Use your resources and know the policies!
- For requesting escorts, refer to the Non-Emergency Medical Transportation and Escort Coverage flyer
- No cookie cutter information! Information needs to be personalized to the member who is traveling
- Have medical necessity in mind when making your request – these are Medicaid dollars being spent and are subject to audit
- Be aware of the time that requests take to process - prevent urgent request by requesting travel as early as possible
- Consolidate trips and requests when possible



Guidehouse Process



Overview and Goals of Rate Review

- This work is part of larger rate evaluation encompassing Transportation, Behavioral Health, Long Term Services and Supports (LTSS), and Federally Qualified Health Centers (FQHCs)
- Promote access to healthcare for all Alaskans from a rate setting and policy perspective, and support service sustainability through reimbursement adequacy
- Review existing rate methodologies and comparison to other states
- Consider rate differentials informed by unique geographical and regional complexities
- Evaluate alignment with rates for similar services established across programs and divisions (as applicable)
- Conduct robust engagement with community partners including Tribal Health Organizations (THOs)
- Complete a comprehensive fiscal analysis
- Provide recommendations for implementation

Key Deliverables*

1. Project Workplan
2. Peer State Comparisons
3. Provider Survey
4. Rate Models
5. Policy and Fiscal Impact Analysis
6. Final Report with Rate and Policy Implementation Recommendations

**Note: Deliverables for implementation and post-implementation support are not included in this list and may depend on the outcomes of the rate development process.*

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Services Included in Rate and Policy Study

Air Ambulance

- Fee schedule
- Emergency call return trips both occupied and empty
- Staffing costs for associated ground transport
- Multiple patient transport

Ground Ambulance

- Fee schedule
- Emergency call return trips both occupied and empty
- Treat in place and refuse transport
- Non-emergent facility transport
- Behavioral health

Other Ground Transportation

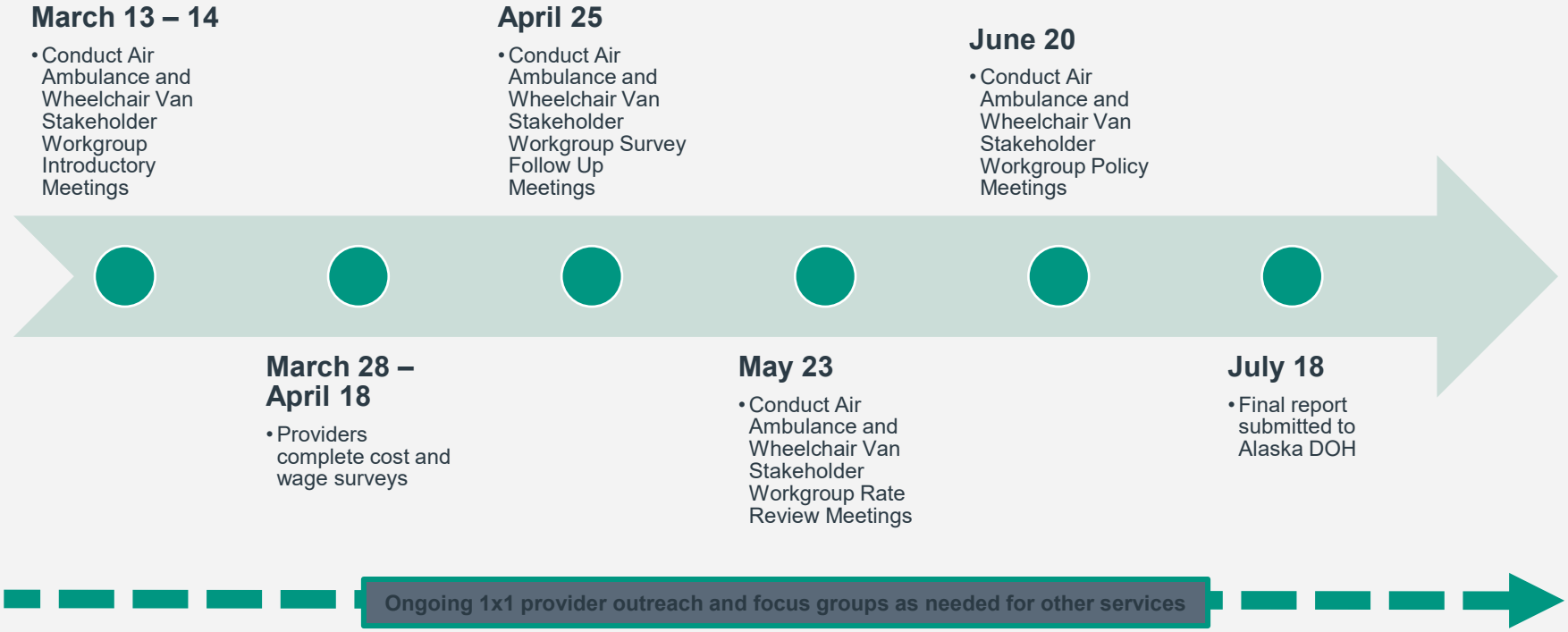
- Wheelchair Vans
- Taxi
- Ride Share
- Personal Vehicle Mileage

Lodging

- Lodging fee schedule
- Seasonality overall and specific rates
- Tribal reimbursement and policy
- Out of state rates
- Seasonal availability

© 2025 Guidehouse Inc.

Project Plan and Key Dates



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Guidehouse

For questions or comments, please reach out to:
akratestudy_transportation@guidehouse.com

Questions?

Contacts

HMS, Provider Inquiry
907.644.6800, option 1, 1 or 800.770.5650 option 1, 1

Kayla Knight
Alaska Medicaid Transportation Program Manager
Kayla.knight@alaska.gov or 907.334.2183

Comagine Health

Zero Suicide Initiatives and Updates

Amy Molloy
Senior Project Associate, Zero Suicide, Education Development Center

Mya Robinson
Zero Suicide Program Coordinator, SOA DOH Division of Behavioral Health, Section of Prevention & Early Intervention

EDC.ORG

Alaska Zero Suicide Initiative

Amy Molloy
Zero Suicide at EDC

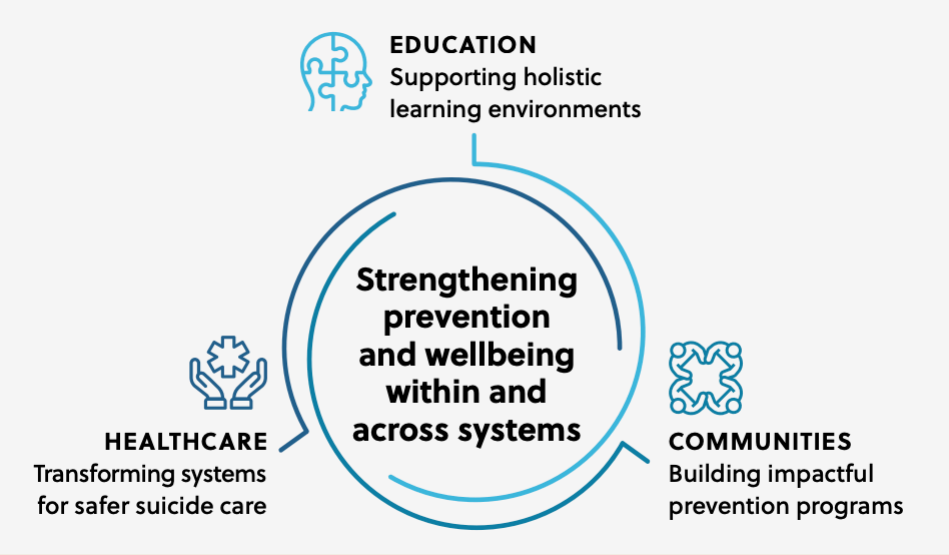
Mya Robinson, DOH
Zero Suicide Program Coordinator



May 2025

ABOUT EDC SOLUTIONS

A Better World is Possible When We *Transform Together*



EDC Solutions

EDC Solutions offers versatile consultation and training for **education**, **community**, and **healthcare** systems committed to **improving prevention and wellbeing** for their workforce and the people they serve.

Legal Disclaimer



The suicide prevention content and resources provided through the services and trainings of Education Development Center, Inc. (including Zero Suicide Institute and EDC Solutions) are intended to provide organizations with a range of best practice options and resources designed to improve suicide prevention care. Please note that the recommended options and resources are not intended to be exclusive and may not be appropriate for all patient populations in all settings. Organizational leaders and staff should review other resources, protocols, and practices to select the most appropriate and complementary options that meet their ultimate goals and needs.

Agenda



- Why Zero Suicide?
- Review of Zero Suicide elements
- Update: Zero Suicide in Alaska
- What’s next?


ZERO Suicide
JOIN THE MOVEMENT.
Commit to safer care. Aspire to zero.
ZeroSuicide.edc.org/Toolkit

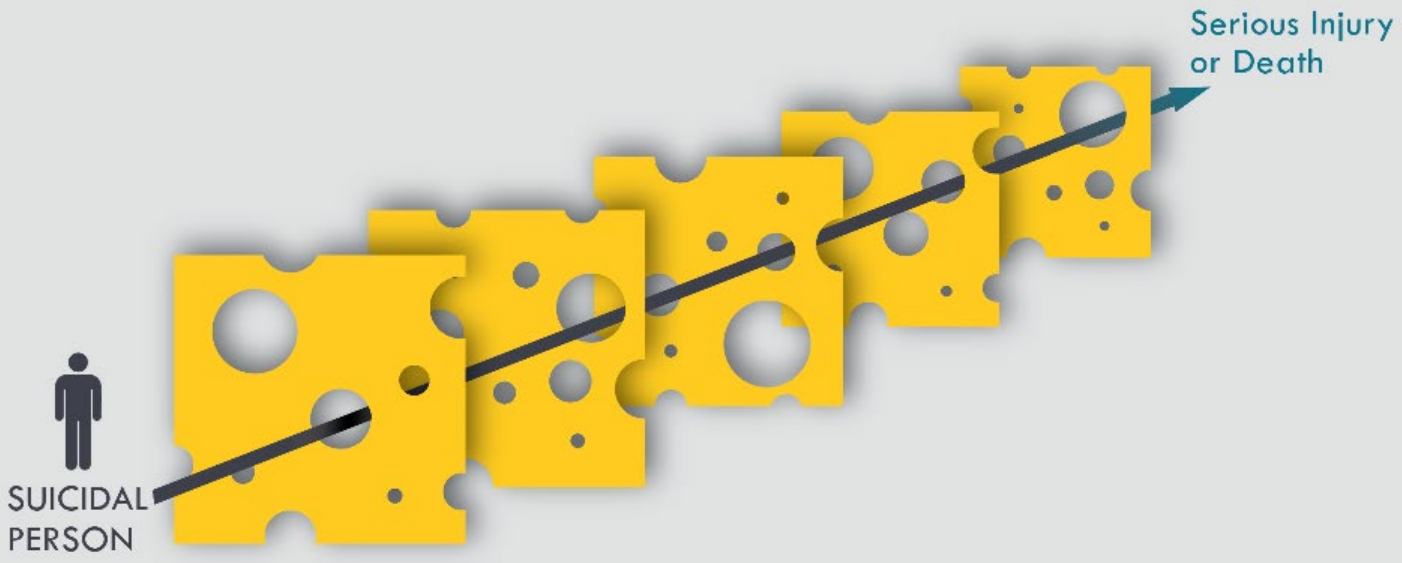
Zero Suicide Framework

Core Components of Safe Suicide Care

- Seven elements
- Systems approach
- Not linear but simultaneous



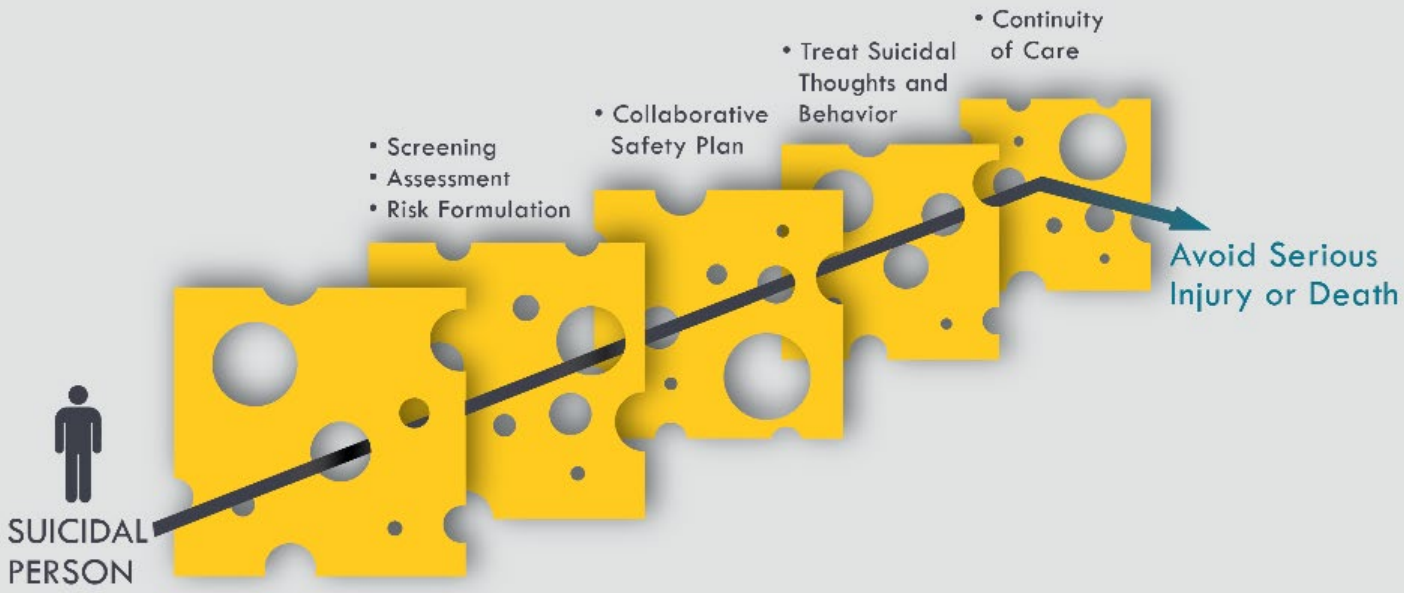
A Focus on Patient Safety and Error Reduction



Adapted from James Reason's "Swiss Cheese framework of Accidents"

© 2016 Education Development Center, Inc.

A Focus on Patient Safety and Error Reduction



Adapted from James Reason's "Swiss Cheese framework of Accidents"

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Why Zero Suicide?

Health care systems have a vital role in suicide prevention.

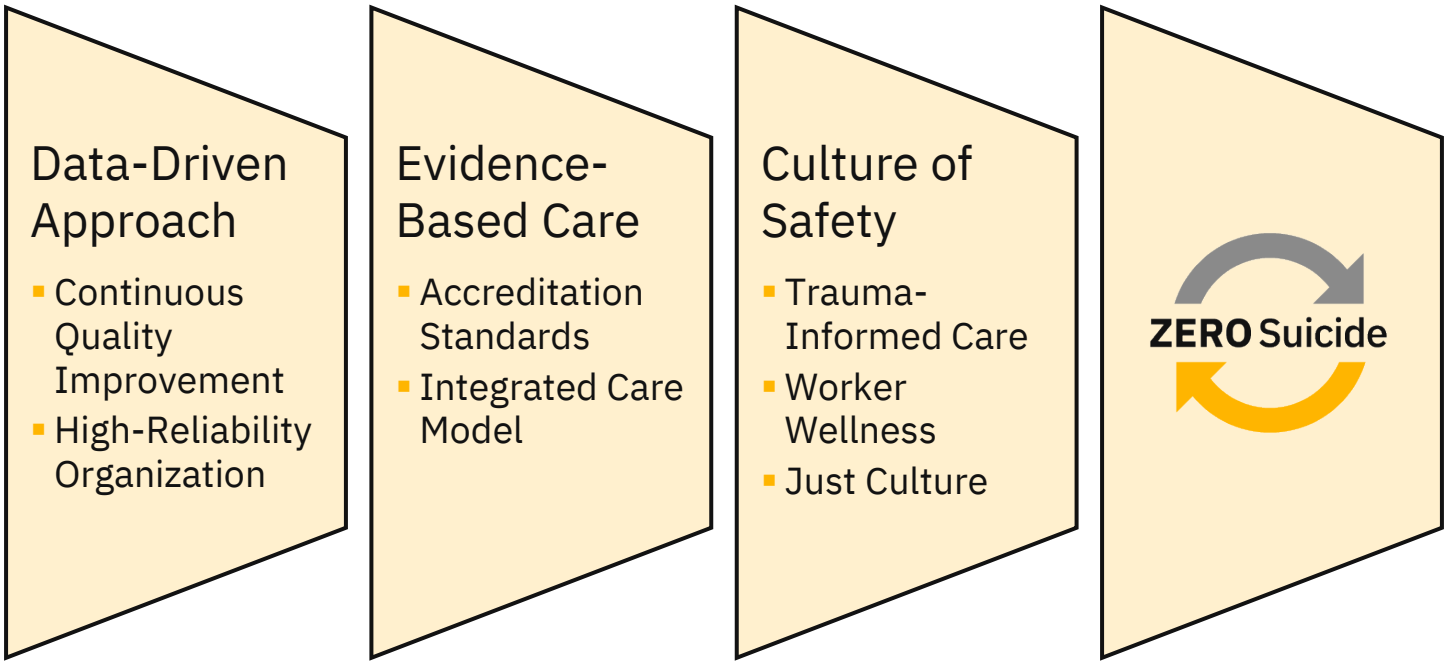
For individuals who died by suicide:

- 92% saw healthcare provider year before death
- 48% saw primary care provider 30 days before
- 25% saw mental health provider 90 days before
- Nearly 30% had healthcare visit one week before
- Over 50% had healthcare visit 30 days before

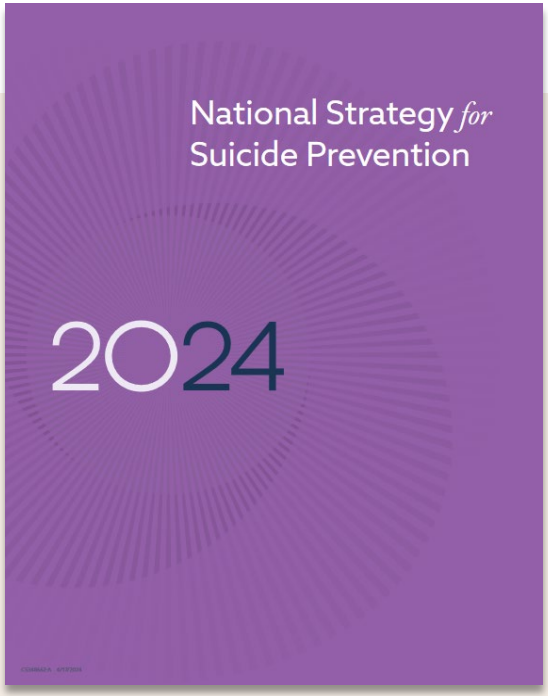


Ahmedani et al., 2019

Aligning Zero Suicide



2024 National Strategy for Suicide Prevention

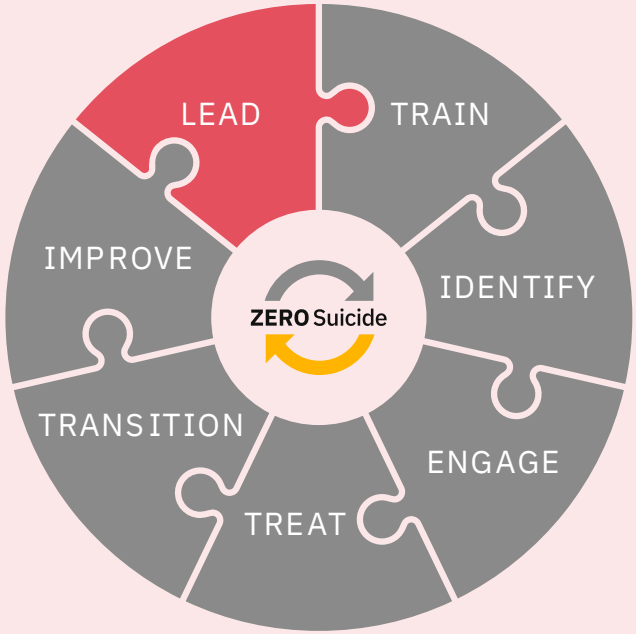


Goal 8:
Implement effective suicide prevention services as a core component of healthcare.

Goal 9:
Improve the quality and accessibility of crisis care service across all communities.

Lead

- Belief that suicide can be prevented
- Polices support a culture of safety
- Lived experience is valued and included in meaningful ways
- No-blame, just culture is rooted in leadership support
- Postvention activities promote healing and reduce risk



Improve

- Zero Suicide is a data-driven quality improvement model
- Monitoring for fidelity is on-going
- Quality/risk staff are actively engaged in implementation team
- Use EHR to collect and report on data



Train

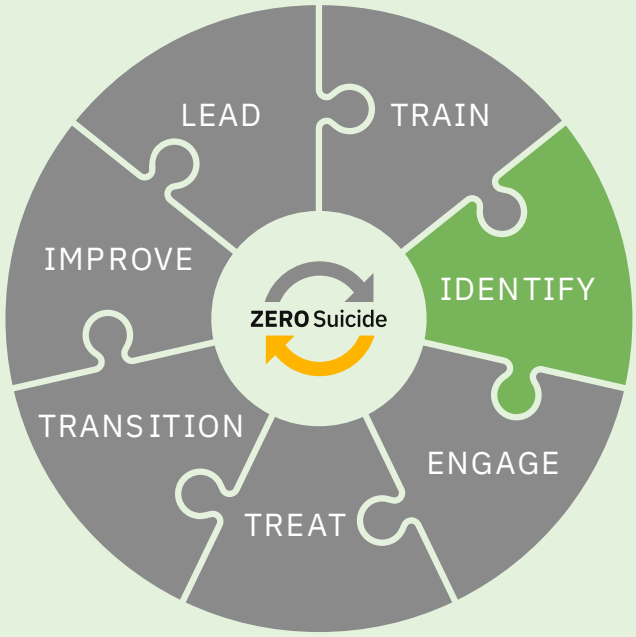
- What is Zero Suicide?
- Basic suicide awareness for all staff
- Train on interventions, policies and workflows
- Use CQI to inform training plan
- Provide initial and on-going support



IDENITFY

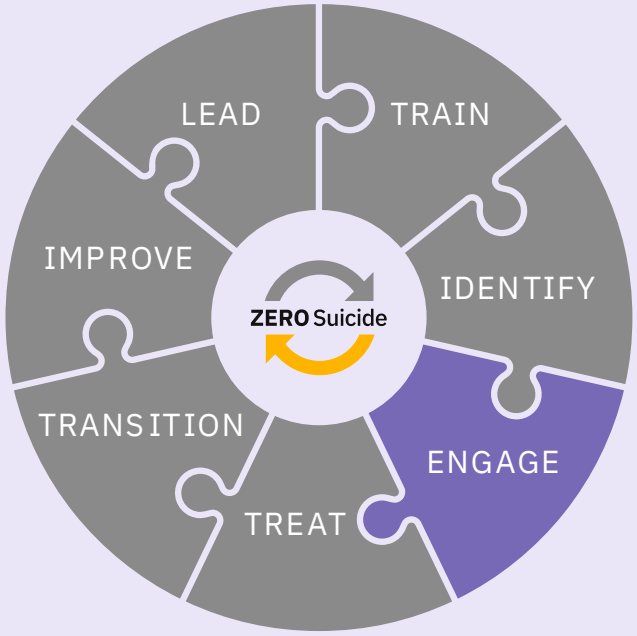
Identify

- Screening & assessment are two distinct processes
- Use evidence-based tools
- Don't ignore clinical judgement
- Outline process in workflow
- Determine risk level to inform suicide care response



Engage

- Collaborative safety planning
- Lethal means safety
- Suicide care pathway



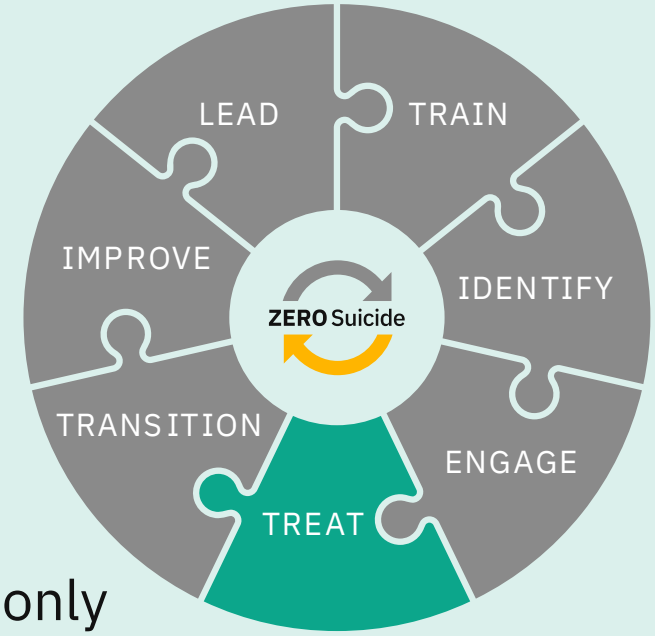
Transition

- Warm hand-off
- Appointment scheduling
- Caring Contacts
- Peer support
- Care coordination



Treat

- Directly treat suicide
- Appropriate to risk level
- Least restrictive setting
- Can be provided via telehealth
- Little to no evidence for hospital only



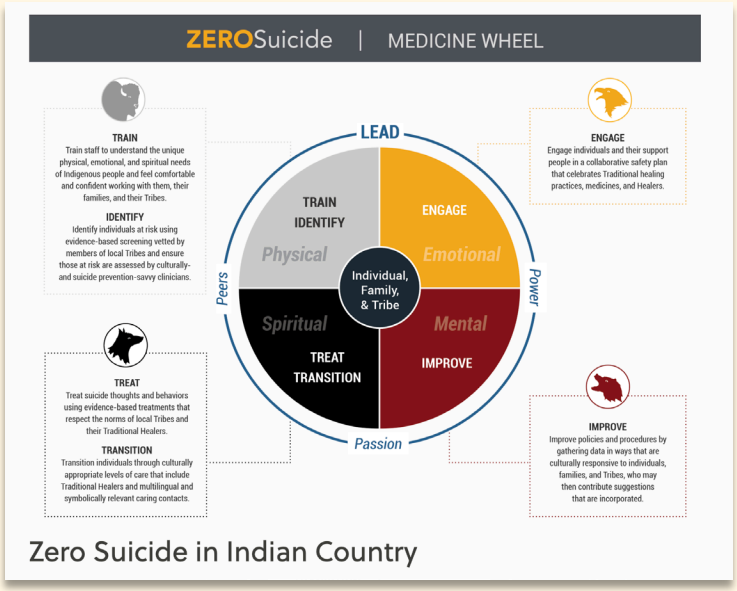
FREE Zero Suicide Resources

Zero Suicide Toolkit



Population Specific Zero Suicide Toolkits

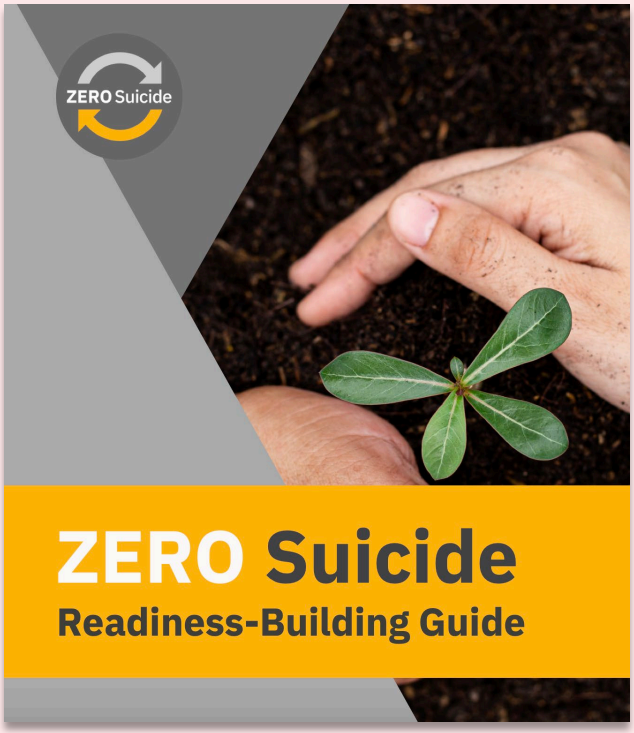




Zero Suicide in Indian Country

Staff Readiness

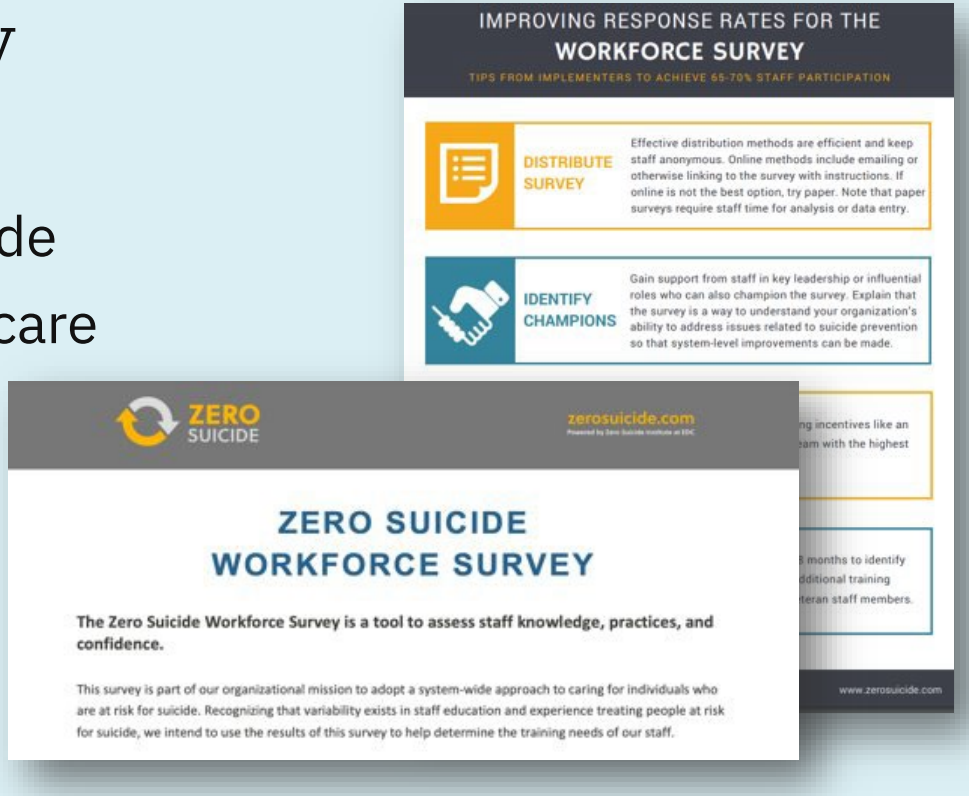
- Readiness-Building Guide
- Readiness Presentation
- Communications Planner
- Mini articles
- FAQs



Workforce Survey

Assess employee:

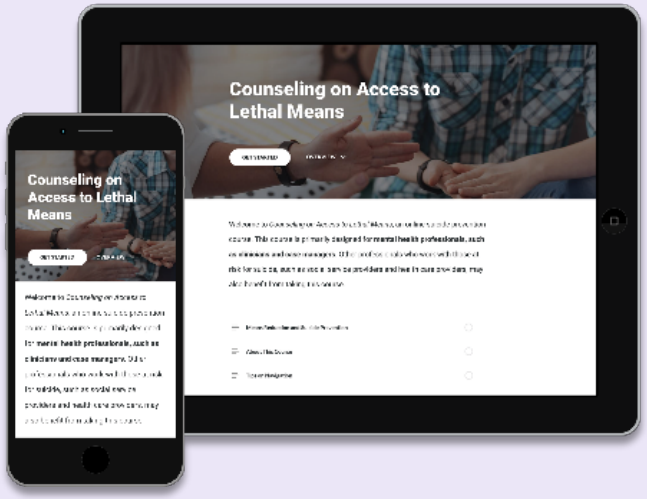
- Knowledge about suicide
- Skills for safer suicide care
- Beliefs and attitudes
- Repeat every couple years



Counseling on Access to Lethal Means

This free online course is designed to help counsel people at risk for suicide - and their families - on lethal means safety.

- Updated content
- Real-world case studies
- Mobile-friendly design



FREE Training Opportunities For Alaska

- EDC's Assisting and Managing Suicide Risk (AMSR) for direct staff providing inpatient and outpatient care.
- Lethal Means Safety: PC CARES training about hold conversations with families about lethal means reduction
- The Connect Program, NAMI New Hampshire
  - Connect Health Care online training
  - Connect Mental Health Care online training

FREE Training Opportunities For Alaska cont.

UAA Center for Human Development suicide prevention trainings:

1. Collaborative Assessment & Management of Suicidality
2. CAMS: Brief Intervention (BI)
3. CAMS4Teens
4. Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)
5. Be Sensitive, Be Brave for Suicide Prevention

Contact Information

Statewide Suicide Prevention Coordinator: Sheli.Delaney@alaska.gov

Zero Suicide Program Coordinator: Mya.Robinson@alaska.gov

988 Program Coordinator: Anneliese.Hudson@alaska.gov


Questions?



Thank you Merci Gracias شكرا

For more information, check out **zerosuicide.edc.org**

Comagine Health

Closing Remarks – Day Two

Yvette Stratton, RN, BSN, CCM
Executive Director, Care Management, Comagine Health

Please complete the survey

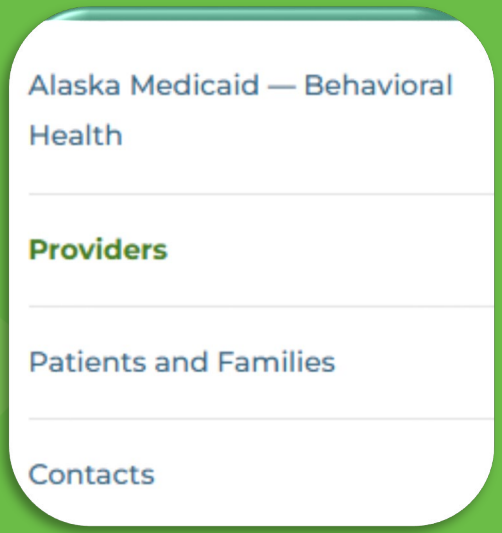
The survey only needs to be completed once.

Link:
https://uaa.co1.qualtrics.com/jfe/form/SV_0P5HWcko27RFpD8?Q_CHL=qr

QR Code:

Thank you for attending!

A recording of the presentation will be available on the Comagine Health website under Programs, Alaska Medicaid Behavioral Health, and Alaska Medicaid-Division of Health Care Services. Click on the Provider link for Provider Resources.





Comagine Health