Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Alaska Comprehensive Program Integrity Review

January 2024

Final Report

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I. EXECUTIVE SUMMARY

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a Comprehensive Program Integrity Review of Alaska's Medicaid program to assess the state's overall program integrity efforts for the Fiscal Years (FY) 2019-2021. This review assessed the state's compliance with CMS regulatory requirements for program integrity oversight in states with a Medicaid fee-for-service (FFS) model. Under a Medicaid FFS model, the state pays providers directly for each covered service received by a Medicaid beneficiary and assumes the responsibility for program integrity oversight. Regulations for the administration of Medicaid program integrity programs are found at 42 CFR Part 455. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity practices and outcomes in its Medicaid programs.

To meet the objectives of this focused review, CMS reviewed information and documents provided by the state and conducted in-depth interviews with the State Medicaid agency (SMA). This report includes CMS' findings, as well as two related observations identified during the comprehensive review.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid program. CMS identified **one** observation related to Alaska's program integrity activities. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

State Investigations of Fraud, Waste and Abuse

> **Observation #1:** CMS encourages Alaska to improve its case tracking system to optimize the efficiency of state efforts to combat fraud, waste, and abuse.

II. BACKGROUND

Comprehensive Program Integrity Reviews

In the most recent Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

strategies that meet federal standards.

As a part of these efforts, CMS routinely conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. CMS conducts Comprehensive Program Integrity Reviews to assess state performance across multiple areas. In addition, CMS conducts Focused Program Integrity Reviews on specific high-risk areas in the Medicaid program, including, but not limited to managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These program integrity reviews (comprehensive and focused), and desk reviews help to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also solicits each state's effective practices and provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Overview of the Alaska Medicaid Program and the Comprehensive Program Integrity Review

The Department of Health and Social Services (DHSS) is responsible for the administration of the Alaska Medicaid program. Within the DHSS, the Medicaid Program Integrity Unit (PIU) is the organizational unit tasked with oversight of program integrity-related functions for the Medicaid program. In addition, as of July 1, 2020, Alaska's behavioral health services are provided through a contract with an Administrative Services Organization, Optum. DHSS served approximately 260,687 beneficiaries as of January 1, 2022. Appendix C provides detailed enrollment and expenditure data for all years within the review period.

In September 2022, CMS conducted a virtual comprehensive program integrity review of Alaska's Medicaid program. This review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 455, as well as key corresponding provisions outlined in 42 CFR Parts 431, 447, and 456, for the review period of FY 2019 through FY 2021. CMS interviewed key staff and reviewed information provided by the state and evaluated the status of Alaska's previous corrective action plan that was developed in response to a previous comprehensive program integrity review of Alaska's Medicaid program conducted by CMS in 2013, the results of which can be found in Appendix A.

During this review, CMS identified a total of **one** observation. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B.

This review assessed state regulatory performance in the following areas:

A. State Investigations of Fraud, Waste, and Abuse
B. Payment Suspensions Based on Credible Allegations of Fraud
C. Surveillance and Utilization Control
D. Claims Data Review
E. Interagency Program Integrity Coordination

III. RESULTS OF THE REVIEW

A. State Investigations of Fraud, Waste, and Abuse

Federal regulations at § 455.1 set forth requirements for a state fraud detection and investigation program. In Alaska, these requirements are implemented by DHSS. At the time of this review, the Medicaid PIU had six full-time employees (FTEs), including two auditors, three investigators/data analysts, and one office assistant. The PIU performs regular preliminary investigations of providers, pre-payment review, post-payment review, provider education, provider terminations and exclusions, provider case referrals to the Medicaid Fraud Control Unit (MFCU), and payment suspensions and provider overpayment identification and recovery. In addition, the state indicated it is using Microsoft Access and Excel to track suspected provider fraud cases, but that these methods are time consuming and do not produce accurate reporting metrics to assist the program integrity activities.

Federal regulations at § 455.13 require that all state Medicaid programs have in place methods and criteria for identifying, investigating, and reporting suspected fraud cases. The PIU is responsible for the investigation of both potential beneficiary and provider fraud, waste, and abuse. The state reported that PIU staff identify possible targets for review through information received from a variety of referral sources. These sources include: calls from a state-maintained toll-free fraud and abuse hotline, issues identified through data mining efforts, and feedback received from the state's beneficiary verification of services methods.

When a provider-related referral is received through any of these sources, the PIU assigns an investigator to perform a preliminary investigation, in accordance with § 455.14. A preliminary investigation entails a review of claims records, as well as other investigative steps, such as interviews with beneficiaries, if needed. Preliminary investigations result in a dismissal of the referral or the establishment of a credible allegation of fraud. Under § 455.2, allegations are considered to be credible when they have indicia of reliability, and the SMA has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. The SMA has formalized standards on what constitutes a credible allegation of fraud, which can be found in the Alaska Administrative Code (AAC) at 7 ACC 160.110. If the investigator establishes a credible allegation of fraud, the case is escalated for a full investigation, including referral to the MFCU. In addition, the PIU prepares a work order for processing through the Division of Health Care Services (DHCS) to place the referred providers on a payment suspension for the duration of the investigation, in accordance with § 455.23 unless a good cause exception is requested by law enforcement officials.

The state reported that the procedures for referral to the MFCU and other law enforcement entities were developed in cooperation with State legal authorities. The MFCU reported satisfaction with the referrals provided by the SMA. After a case is referred to law enforcement, the SMA continues to communicate and meet with law enforcement concerning the investigation, as well as continuing to provide any required additional information, as it becomes available. If the MFCU declines to investigate further, the MFCU will notify the SMA of the referral declination in writing, which allows the SMA to independently seek resolution on all

declined law enforcement or MFCU credible allegation of fraud referrals. This can include, but is not limited to, disciplinary action, training, or suspension/termination from the program. Details on number of cases referred by the SMA to the MFCU for each year within the review period can be found in Table 3 in Appendix C.

In Alaska, the oversight and monitoring requirements found at §§ 455.1 - 455.23 are met. However, CMS observed inconsistent program integrity practices being performed by the state that could allude to a lack of oversight activities being performed.

> **Observation #1:** CMS encourages Alaska to improve its case tracking system to optimize the efficiency of state efforts to combat fraud, waste, and abuse.

Overpayments

Based on data provided by the state, Alaska's program integrity activities resulted in the identification and recovery of overpayments for all three years in the review period. Detailed information on overpayments identified and recovered each year can be found in Table C-4 of Appendix C.

The overpayment estimation methodology that Alaska utilizes is a difference estimate. The state uses the greater of actual overpayments or the lower bound of a 90% confidence interval. The DHSS negotiates settlement of the state's share of overpayments during the appeal process. Settlements are occasionally reached in conjunction with the Department of Law.

CMS did not identify any findings or observations relating to overpayments.

Beneficiary Restriction Program

In accordance with §431.54(e), if a Medicaid agency finds that a beneficiary has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the state, the agency may restrict that beneficiary for a reasonable period of time to obtain Medicaid services from designated providers only. Beneficiary restrictions are subject to certain conditions ensuring reasonable access to services.

The SMA reported that Alaska does operate a restriction program under §431.54(e). Provision for this program is made under 7 AAC 105.600, *Restriction of recipient's choice of providers*. Alaska's beneficiary restriction program is called the Care Management Program (CMP). Prior to January 1, 2021, the standard CMP/lock-in placement was 12 months. The SMA implemented regulation changes on January 1, 2021, that transitioned to 24 months for a first placement, and 36 months for any subsequent placement. Alaska reported that this program has shown measurable results in reducing beneficiary fraud. Detailed information on Restriction Program Enrollment and Cost Savings can be found in Table C-5 of Appendix C.

CMS did not identify any findings or observations relating to these requirements.

Beneficiary Verification of Services

In accordance with § 455.20, the state must have in place a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

CMS determined that Alaska met this requirement for the review period. The SMA uses a member portal with Explanation of Benefit (EOB) functionality for the full Medicaid beneficiary population. The SMA also mails EOB letters to a random sample of beneficiaries; the state reported that approximately 500 are sent out each month. If the beneficiary identifies a billing aberrancy, they are able to alert the SMA within the portal. These reports are reviewed by the DHCS Quality Assurance-Surveillance and Utilization Review (SUR) for investigation/analysis.

CMS did not identify any findings related to these requirements.

False Claims Act Information

In accordance with 42 U.S.C. §1396a(a)(68), the state plan to provide medical assistance, must contain provisions to ensure that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, has in place written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers. The state is compliant with this requirement.

A review of Alaska's policy found that the state has included policies for all employees, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

CMS did not identify any findings or observations related to these requirements.

B. Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 455.23, states must suspend all Medicaid payments to a provider after the SMA determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity, unless the agency has good cause to not suspend payments or to suspend payment only in part. Further information on payment suspensions and good cause exceptions can be found in Table 6 in Appendix C.

CMS determined that Alaska is in compliance with this requirement; 7 AAC 105.480 permits the suspension of providers upon escalation of a case from a preliminary to full investigation, barring a good cause exception. This occurs simultaneously with referral of a case to the MFCU. During the review period, the MFCU requested a good cause exception for two cases. Upon implementation of a payment suspension, the state notifies providers of suspension within five

days and allows the provider to request additional administrative review, if desired. CMS determined that state policy ensures that provider suspension notices contain all appropriate elements, as detailed in § 455.23(b)(2). The state reported that providers are typically placed on suspension until the culmination of the investigation, when administrative action is taken, or the case is otherwise closed.

The state provides administrative review to the provider for suspending the provider's payments. Providers are offered due process rights and may appeal the payment suspension through the Office of Administrative Hearings. All payment suspensions are temporary and will be discontinued when the prosecution of the case has been resolved. The length of the payment suspension varies based on provider. The state will discontinue the suspension if the MFCU or other law enforcement agency declines a referral. The state delivers written notices, including documentation of termination, through the Office of Administrative Hearings.

CMS did not identify any findings or observations related to these requirements.

C. Claims Payment Review

Federal regulations found at § 456.22 require that the SMA have procedures in place for the on-going evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services. The SMA reported that this requirement is met through 7 AAC 160.140, which establishes a quality assurance program to ensure provider compliance with applicable program integrity requirements through reviews of medical care, services delivery, and claims payment information to verify the accuracy of paid claims. The Surveillance and Utilization Review Subsystem (SURS) unit within the DHSS is responsible for the administration of the Quality Assurance Program. If state determines adverse action is necessary as a result of a review, the state will issue a written report of the findings to the provider. The state is also entitled to suspend the provider from program participation, enact sanctions, require a corrective action plan be developed, or enforce other administrative actions, as determined necessary. Details of these processes are included in the Quality Assurance - SURS Case Selection and Review Procedures.

The State of Alaska Medicaid Program and IBM-Watson (Truven) JSURS have a contractual obligation to create and review control files for every active provider type with claims activity each state fiscal year. Additionally, SURS reviews the control files created by IBM-Watson (Truven) and select cases for initiation based on the state fiscal year. Providers are identified by utilizing paid and denied claims data to identify outliers. Ranking reports are evaluated by the staff to select cases for review. The state uses a provider type-based risk level to determine how far into an exception ranking report their analyst will make in case selection, in accordance with § 455.450.

In addition, 7 AAC 160.115 requires all Medicaid providers to conduct a self-audit once every two years, draft a report of the self-audit, sign and submit the self-audit attestation form, and to repay all identified overpayments. The PIU suggests the use of RAT-STATS for provider self-auditing purposes. The state may sample beneficiaries, services, and claims for review in addition to this self-audit process.

Sampling and extrapolation processes in Alaska are guided by 7 AAC 160.120, which directs the DHSS or provider conducting the review or audit to use statistically valid sampling methodologies to select claims and to calculate overpayment amounts.

CMS determined that the payment review processes in place in Alaska satisfies the requirements at § 456.22. CMS did not identify any findings or observations related to these requirements.

Medicaid Management Information System

Medicaid Management Information Systems (MMIS) are an integrated group of procedures and computer subsystems designed to provide "systems mechanization" and "mechanized claims processing and information retrieval systems" is identified in section 1903(a)(3) of the Social Security Act and defined in regulation at § 433.111. Specifically, an MMIS is used to process claims for Medicaid payment from providers of medical care and services furnished to beneficiaries and to perform other functions necessary for economic and efficient operations, management, monitoring, and administration of the Medicaid program. States may receive 90 percent Federal Financial Participation (FFP) for the design, development, or installation, and 75 percent FFP for the operation of state mechanized claims processing and information retrieval systems, if the MMIS meets certain regulatory criteria, as outlined in § 433.12.

Regulations found at § 456 regarding control of the utilization of Medicaid services also require SMAs to include SURS in the MMIS to safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments; assesses the quality of those services; and provides for the control of the utilization of all services provided. Unlike claims-processing subsystems that process one claim at a time, SURS can be used to analyze post-payment data for multiple claims at a time to identify suspicious provider billing patterns.

In Alaska, this requirement is met through 7 AAC 160.100 (1), which creates provision for the operation of a surveillance, utilization, and review subsystem to manage Medicaid information. Supporting policies and procedures provided by the state during the review affirmed that DHSS SUR unit has a post-payment review process in place. The SUR unit, in conjunction with their contractor Truven, monitors the delivery and receipt of medical services and selects cases based on paid claims information, exception processing, and information from other various sources. The SUR unit may also, at their discretion, select cases for review based on referrals or problem focused issues. At the culmination of a SUR review, the unit staff will make a recommendation that may include case closure or written referral to an external agency (MFCU, Program Integrity, Drug Enforcement Agency, Alaska State Troopers, local Police Departments), as deemed necessary.

Additionally, regulations found at § 433.116 (h) require that, if the State has a MFCU, the SMA must have procedures to assure that information on probable fraud or abuse that is obtained from, or developed by, the MMIS system is made available to that unit. CMS determined this requirement was met through 7 AAC 160.100 (4), which states that the state provide for and operate program integrity activities in, "…coordination with the Department of Law, the United States Department of Justice, and the United States Office of Inspector General."

The DHSS reported that the PIU does not consult the Fraud Investigation Database (FID) as part of its regular activities. Programs that are paid outside the MMIS includes: case management services (Comagine), mental health service providers (Optum), Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Non-Emergency Medical Assistance Transportation, and Health Insurance Premium Payment.

CMS did not identify any findings or observations related to these requirements.

Pre-Payment Review

In accordance with § 447.45(f)(1), the SMA must conduct prepayment claims review for all claims validating: beneficiary and provider eligibility to receive and provide services; consistency of services provided with beneficiary characteristics and circumstances, such as type of illness, age, sex, and service location; that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed; that the payment does not exceed any reimbursement rates or limits in the state plan; and checks for third-party liability.
In Alaska, this requirement is met. DHSS demonstrated that it has systems in place to perform the requirements of timely claims payment set forth in § 447.45(f)(1). Regulations found at 7 AAC 145.005 (a) (1-3) state that the SMA will pay a provider for a covered service if, "… [a] claim is submitted by a provider who is enrolled with the department; services were rendered to an individual who was eligible under 7 AAC 100 at the time the service was rendered; and the department gave prior authorization for the service if required." Information reported by the state during the review confirmed that the SMA has system edits in place that identify claims prior to payment that do not meet the criteria outlined in § 447.45(f)(1). Claims identified by these systems edits are denied payment.

The state reported that providers are typically selected for manual prepayment review following an identification of heightened risk associated with the provider. Prepayment review is identified as an official case recommendation under DHCS QA/SURs case dispositions. Prepayment review is also recommended through Division of Behavioral Health and Division of Senior and Disability Services (DSDS) compliance investigations. Additionally, prepayment review is identified through ongoing PI functions, and from referrals via outside agencies and the Medicaid fraud and abuse hotline. The state reported that it does not track savings attributed to prepayment denials.

Cases identified for investigation through the pre-payment review process are subject to the same outcome standards as all other cases, including withholding payment, program exclusion, and recoupment of previously paid funds. During the three FY review, zero cases were identified through pre-payment claim review that resulted in a referral to MFCU.

CMS did not identify any findings or observations related to these requirements.

Encounter Data Edits

While not a federal requirement, regularly analyzing encounter data allows states to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for

non-covered services, and fraudulent billing. One valuable method states employ to garner insights from encounter data are prepayment edits in the MMIS. Prepayment edits are designed to prevent payment for noncovered and/or not medically necessary services, and are established, modified, and evaluated for effectiveness on an ongoing basis. States generally apply edits to claims after they are submitted, but before they are paid.

The state reported that Medicaid National Correct Coding Initiative edits are utilized through the Regional Information Sharing System (RISS). In addition, the PIU provides input for the edits used in the MMIS. Edits currently include, but are not limited to, indicators or modifiers, duplicate claims, contraindications, limits on the number of services, prior approval, 30-day supply of drug, brand name vs. generic name, and services after date of death.

CMS did not identify any findings or observations relating to encounter data edits.

Post-Payment Review

In accordance with § 456.23, the SMA must have a post-payment review process in place that allows State personnel to develop and review recipient utilization profiles, provider service profiles and exceptions criteria. This process should identify exceptions so that the agency can correct misutilization practices of recipients and providers. This requirement is supported by § 447.45(f)(2).

In Alaska, these requirements are met. DHSS demonstrated that it has systems in place to perform the requirements of post-payment review processes set forth in § 456.23. The state includes medical necessity assessments, conducted by Auditors and Medicaid Program Specialists, in the post-payment review process.

The state performs post-payment reviews through desk and field audits. For FY 2019, the state conducted 42 desk audits and 13 field audits. For FY 2020, the state conducted 46 desk audits, and 14 field audits. For FY 2021, the state conducted 66 desk audits and 1 field audit.

CMS did not identify any findings or observations related to these requirements.

D. Interagency Program Integrity Coordination

Within a Medicaid program, coordination between the various internal units within the SMA, other relevant agencies and the state MFCU is essential in facilitating program integrity efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. The state has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Additionally, the state meets with the MFCU regularly to discuss case referrals. The fraud task force meets monthly which includes the

state, MFCU, Office of Inspector General and other investigative task forces with the Federal Bureau of Investigation. In addition, the state and MFCU investigators meet weekly in a one-on-one setting.

The state reported that the MOU is reviewed once a year; however, CMS noted that the current MOU was developed in 2013.

CMS did not identify any findings or observations related to these requirements.

IV. CONCLUSION

CMS supports Alaska's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' comprehensive review identified one observation that requires the state's attention.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with Alaska to build an effective and strengthened program integrity function.

V. APPENDICES

Appendix A: Status of Prior Review

Alaska's last CMS program integrity review was conducted in December 2012, and the report for that review was issued in January 2014. The report contained two risk areas with recommendations. The findings from the 2014 Alaska PI review report have all been satisfied by the state.

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Summary Data

Table 1 and Table 2 below provide enrollment and expenditure data

Table C-1. Summary Data for Alaska's Medicaid Program*

	Alaska Medicaid
Beneficiary enrollment total	247,468
Provider enrollment total	24,276
Size and composition of Program Integrity Unit (FTEs)	6

**As of Jan 1, 2021*

Table C-2. Annual Medicaid Expenditure Data for Alaska

State	FY 2019	FY 2020	FY 2021
Alaska	$2,233,293,510	$2,164,387,012	$2,213,738,880

Table C-3. Number of State Investigations Referred to the MFCU by Alaska

State	FY 2019	FY 2020	FY 2021
Alaska	9	7	4

Table C-4. Alaska's Overpayment Recoveries from Program Integrity Investigations*

FY	Preliminary Investigations	Full Investigations**	Total Overpayments Identified	Total Overpayments Recovered
2019	48	1	$933,488	$352,855
2020	42	0	$1,501,771	$1,163,670
2021	16	0	$5,602,694	$2,240,936

Table C-5. Restriction Program Enrollment and Cost Savings

Fiscal Year	Recipient Count**	Cost Savings*
FY 2019	427	$4,438,719.00
FY 2020	453	$4,854,978.00
FY 2021	562	$5,942,654.00

**Cost Savings are calculated using pre/post intervention methodology. The state utilizes a members start date as the catalyst/triggering event and calculate the claims cost for 365 days before/after the start date.*
*** Contains duplication*

Table C-6. Number of Payment Suspensions vs. Good Cause Exceptions enacted by the State

	FY 2019	FY 2020	FY 2021
Payment Suspensions	0	0	0
Good Cause Exceptions	0	0	2

Appendix D: State PI Review Response Form

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
N/A	No recommendations are included in this report.		

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)