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State/Territory Name: Alaska

State Plan Amendment (SPA) #: 17-0008

This file contains the following documents in the order listed:

MAY 22 2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

Jon Sherwood, Deputy Commissioner
Department of Health and Social Services
4501 Business Park Blvd., Bldg. L
Juneau, AK 99503-7167

RE: AK State Plan Amendment (SPA) Transmittal Number #17-0008 – Approval

Dear Mr. Sherwood:

We have reviewed the proposed amendment to Attachments 4.19-A, B, C and D of your Medicaid State plan submitted under transmittal number (TN) 17-0008. This SPA extends the elimination of inflation rate increases for multiple services into a third state fiscal year (2018), and implements targeted rate cuts for selected services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 17-0008 is approved effective as of July 1, 2017. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan pages.

If you have any questions concerning this state plan amendment, please contact Tom Couch, CMS' RO NIRT Representative at 208-861-9838 or Thomas.Couch@cms.hhs.gov .

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 17-0008

2. STATE: AK

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2017

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.201; 42 CFR 447.302

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2018~~ 2017 ($9,220,680) ~~$ (28,400,000)~~ (P&I)
b. FFY ~~2019~~ 2018 ($31,140,871) ~~$ (21,000,000)~~ (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment to 4.19-A -- p. 4, p. 6, p. 7;
Attachment to 4.19-B -- p.1, p.1.1, p.2a, p.2b, p.4, p.5a, p.5b, p.6, p. 7, p.11a, p.12;
Attachment to 4.19-C -- p. 2a;
Attachment to 4.19-D -- p. 4, p. 7.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment to 4.19-A -- p. 4, p. 6, p. 7;
Attachment to 4.19-B -- p.1, p.1.1, p.2a, p.2b, p.4, p.5a, p.5b, p. 6, p. 7, p.11a, p.12;
Attachment to 4.19-C -- p. 2a,
Attachment to 4.19-D -- p. 4, p. 7.

10. SUBJECT OF AMENDMENT:
Annual rate adjustment - inclusive of cost containment measures.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment on the amendment.

[redacted]

13. TYPED NAME: Jon Sherwood

14. TITLE: Deputy Commissioner, State of Alaska - DHSS

15. DATE SUBMITTED: September 22, 2017

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/22/17

18. DATE APPROVED: MAY 22 2018

PLAN APPROVED -- ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2017

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FNS

23. REMARKS:

12/1/17- State authorized P&I change to block 7

FORM HCFA-179 (07-92)

IV. Determination of Prospective Payment Rates:

The prospective payment rate for inpatient hospital services rendered to Medicaid recipients is a per-day rate reflecting costs related to patient care and attributable to the Medicaid program. Prospective payment rates will be determined under one of three methodologies – Basic, Optional, and New Facilities.

a. Basic Prospective Payment Rate Methodology

The prospective payment rate consists of four components – costs excluding capital for routine cost centers, capital costs for routine cost centers, capital costs for ancillary cost centers, and costs excluding capital for ancillary cost centers. The prospective payment rates will be annual rates based on the facility's fiscal year. Except for facilities electing to be reimbursed under the optional payment rate methodology detailed in Subsection IV-b, re-basing will occur for all facilities no less than every four years.

For state fiscal year 2018, rebasing of prospective payment rates using more current cost data will not occur. For facilities that will be getting their first cost-based rate, the freeze on rebasing in state fiscal year 2018 will not occur. Facilities that currently are receiving exceptional relief and are scheduled to be rebased in state fiscal year 2018 will not be affected by the rebasing freeze in state fiscal year 2018.

The prospective per-day rates for inpatient acute care, specialty, and psychiatric hospitals are computed as follows:

1. Total allowable base year costs excluding capital costs for each routine cost center are divided by the total inpatient days in that cost center and the resulting per-day cost is multiplied by allowable paid Medicaid days in that cost center to arrive at Medicaid allowable base year routine costs for that cost center. The sum of the Medicaid allowable base year costs for all routine cost centers are divided by the sum of the allowable paid Medicaid inpatient days for all routine cost centers resulting in the facility's base year Medicaid specific non-capital routine cost per-day.

2. Total allowable base year capital costs for each routine cost center are divided by the total inpatient days in that cost center and the resulting per-day cost is multiplied by allowable paid Medicaid days in that cost center to arrive at Medicaid allowable base year routine capital costs for that cost center. The sum of the Medicaid

Prospective payment rates for facilities that are calculated and paid on a per-day basis as discussed in this Section will be no greater than the per-day rates proposed in the certificate of need application and other information provided as a basis for approval of the certificate of need for the first year during which the following are available for use and for two years immediately following the first year:

(1) opening of a new or modified health care facility;
(2) alteration of bed capacity; or
(3) the implementation date of a change in offered categories of health service or bed capacity.

If a facility is granted a certificate of need for additional beds, the additional capital payment add-on to the per-day rate will include the base year's inpatient days plus additional days associated with the additional beds. The additional days are calculated as the base year's occupancy percentage multiplied by 80 percent and then multiplied by the additional beds approved in the certificate of need. The resulting figure is further multiplied by 365.

Except for critical access hospitals, costs are the lower of costs or charges in the aggregate to the general public.

For state fiscal year 2018, the payment rate will be 95% of the payment rate in state fiscal year 2017.

b. Optional Prospective Payment Rate Methodology and Criteria for Small Facilities

A facility that had 4,000 or fewer total inpatient hospital days as an acute care, specialty or psychiatric hospital, or as a combined hospital-nursing facility during the facility's fiscal year that ended 12 months before the beginning of its prospective payment rate year during calendar year 2001 may elect to be reimbursed for inpatient hospital services under provisions of this Subsection. If a facility that meets this criterion does not elect to participate during its first fiscal year after December 31, 2000, the facility may not elect to participate under the provisions of this Subsection until after a re-basing occurs under the provisions of Subsection IVa.

If a facility that elected to be reimbursed under the prior Optional Payment Rate Methodology for Small Hospitals for its payment years beginning in calendar year 1998 until the last day of its fiscal year ending during the period of July 1, 2001 through June 30, 2002, does not elect to participate after its agreement expires or does not terminate the agreement for its first fiscal year beginning after December 31, 2000, the facility may not elect to participate under the provisions of this Subsection until after a re-basing occurs under the provisions of Subsection IVa.

Its prospective payment rate will be determined pursuant to Subsection IVa until a rebasing has been executed.

A facility electing to be reimbursed under this Subsection must have an agreement with the department that will not expire, lapse, or be revoked before four facility fiscal years have lapsed. The agreement may be renewed after it expires if the facility still qualifies for reimbursement under this Subsection. A re-basing of the prospective payment rate for the renewed agreement will occur in accordance with Subsection IV.

For a facility that was not reimbursed under the Optional Payment Rate Methodology for Small Hospitals prior to its first fiscal year beginning after December 31, 2000, that elects to be reimbursed under this Subsection rather than Subsection IVa, its prospective payment rate will be based on its 1999 established rate or the rate calculated under Subsection IVa at the election of the facility. If the facility elects its 1999 payment rate, its initial year prospective payment rate during calendar year 2001 will be determined as follows:

The prospective payment rate will be expressed as a per-day rate, composed of separate capital and non-capital components.

1. The capital component is calculated by dividing the facility's Medicaid capital per adjusted admission reflected in its 1999 payment rate by the average Medicaid length of stay and adjusted for inflation by 1.1 percent per year for each fiscal year after the first year of election and ends at the expiration of its agreement.
2. The non-capital component is calculated by dividing the facility's allowable Medicaid costs per adjusted admission by the facility's average Medicaid length of stay, and subtracting the capital component from the quotient. The resulting amount is adjusted for inflation at three percent per year for each fiscal year after the first year of election and ends at the expiration of the agreement.

For state fiscal year 2016, 2017, and 2018, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

For a facility that was not reimbursed under the Optional Payment Rate Methodology for Small Hospitals prior to its first fiscal year beginning after December 31, 2000, that elects to be reimbursed under this Subsection under the provisions of Subsection IVa, its prospective payment rate for the first year beginning in calendar year 2001 and each year thereafter until the facility's agreement expires will be determined pursuant to Subsection IVa except that the non-capital and capital components of the payment rate will be adjusted annually for inflation, except when the state implements cost containment, after the first year by 3 percent and 1.1 percent respectively. For state fiscal year 2016, 2017, and 2018, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Advanced Nurse Practitioners

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Laboratory services are reimbursed at the lesser of billed charges or the Medicare fee schedule. Except as otherwise noted in the plan, state developed fees schedule rates are the same for both governmental and private providers. The fee schedule and its effective date are published at
http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2017.

Ambulatory Surgical Clinic Services

Payment is made to ambulatory (outpatient) surgical clinics on a prospectively determined rate. Payment covers all operative functions attendant to medically necessary surgery performed at the clinic by a private physician or dentist, including admitting and laboratory tests, patient history and examination, operating room staffing and attendants, recovery room care, and discharge. It includes all supplies related to the surgical care of the beneficiary while in the clinic. The payment excludes the physician, radiologist, and anesthesiologist fee. State developed fee schedule rates are the same for both public and private providers and the fee schedule is published at
http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2017.

Behavior Rehabilitation Services

Payment for Behavior Rehabilitation Services is a fee-for-service basis, with one day being the unit of service. Rates are based upon a periodic rate study using a prospective staffing based rate model that uses data gathered by the State Department of Labor reporting the prevailing wages in the State of Alaska. Specific position classifications were selected to reflect the comparable staffing requirements needed to provide quality rehabilitative services to the identified population. A factor is used to compensate for employee benefits and facility operating costs and supplies. Board and room are not included in the Behavioral Rehabilitative Service rate paid to the provider. These rates are periodically adjusted based on appropriate cost-of-living adjustments and other market indicators and program standards. Rates and rate methodology are found in Residential Behavioral Health Service handbook 2013 at
http://dhss.alaska.gov/dbh/Documents/TreatmentRecovery/RBRS%20Documents/BRS%20Handbook%2010-28-13.pdf

Certified Nurse Anesthetist

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment rates are set using the Medicare Physician RBRVS payment rates and Alaska's state-specific conversion factor and inflation adjustments. The Medicare Physician RBRVS payment rates are published in the federal register as described under the Physician reimbursement section of this attachment (4.19B). Alaska's state-specific conversion factor and inflation adjustments are published in the Alaska Administrative Code. Changes to the Medicaid rates will only occur when Medicare updates the RBRVS payment rates each year and the department incorporates those changes with its Alaska-specific conversion factor and inflation adjustments the following July 1.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Chiropractic Services

Payment for manual manipulation to correct subluxation of the spine and x-rays is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an RVU. State developed fee schedule rates are the same for both public and private providers. The fee schedule and its effective dates are published at
http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2017.

Dental Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and is effective dates are published at
http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2017.

Direct Entry Midwife Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale (RBRVS) methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at
http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated to be effective for services on or after 7/1/2017.

EPSDT Screening Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology for physicians or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers, Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated to be effective for services on or after 7/1/2017.

Freestanding Birthing Center Services

Facility rates for freestanding birthing centers are based on 75 percent of the weighted average of the Medicaid hospital inpatient rates paid to the general acute care hospitals in Anchorage, Fairbanks, Juneau, Palmer, and Soldotna with a one day length of stay designated by a primary diagnosis code of 080 as described in the *International Classification of Diseases – 10th Revision, Clinical Modification* (ICD-10-CM, adopted by reference in 7 AAC 160.900; this amount is calculated each state fiscal year using the units of services from the most recent 12 month period starting at the beginning of the state fiscal year's fourth quarter and for which timely filing has already passed and the Medicaid hospital inpatient rates for each facility that are in effect at the start of the fourth quarter of the state fiscal year preceding the July 1 effective date.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Federally Qualified Health Center Services

Payment for Federally Qualified Health Center Services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

Prospective Payment System

All Federally Qualified Health Centers (FQHCs) are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the center's reasonable costs for the center's fiscal years 1999 and 2000.These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is adjusted to take into account any increase or decrease on the scope of services. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each center fiscal year thereafter, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the center. The center must supply documentation to justify scope of service adjustments. For state fiscal year 2016, 2017, and 2018, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year with no increase by the percentage increase in the Medicare Economic Index (MEI) for primary care services, but adjusted to take into account any increase (or decrease) in the scope of services furnished by the center.

For newly qualified FQHCs after State fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers, and adjustments for increases or decreases on the scope of service furnished by the Center during that fiscal year. For state fiscal year 2016, 2017, and 2018, after the initial year for a center, the center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year with no increase by the percentage increase on the Medicare Economic Index (MEI) for primary care services, but adjusted to take into account any increase (or decrease) in the scope of services furnished by the center.

Alternative Prospective Payment System

Beginning with the Federally Qualified Health Center's fiscal year 2003 (FY03), qualifying centers may agree to have their payment rates set using an alternative prospective payment methodology outlined below. The alternative payment methodology agreement between the State and the Federally Qualified Heath Center results in payment to the FQHC of an amount at least equal to the Prospective Payment System payment rate. The State annually evaluates the Medicare Economic Index for primary care services to insure the alternative rate is at least equal to or greater than the PPS rate.

Base rates are calculated prospectively on a per visit basis equal to 100 percent of the inflated average, as explained below, of the allowable and reasonable costs of services furnished during the center's fiscal years 1999 and 2000. The base year costs for FY99 are inflated using the number set out in the first quarter 1999 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket, inflated to 2002.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

The center's allowable and reasonable costs for fiscal year 2000 are inflated by the number set out in the first quarter 2000 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket, inflated to 2002. The cost per visit is then adjusted for any increase or decrease in the scope of services, based on documentation supplied by the center to justify such an adjustment. For each subsequent fiscal year, the payment rate is increased using the first quarter publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket, then adjusted for any increase or decrease in the scope of services. At least every four years, the department will change the base year to reflect more current cost data for establishing rates. For state fiscal year 2018, rebasing using more current cost data will not occur. For facilities that will be getting their first cost-based rate, the freeze on rebasing in state fiscal year 2018 will not occur. For the state fiscal years 2016, 2017, and 2018, if the center's base year is not changing, then the center's payment rate is not increased using the first quarter publication of Global Insight's *Health Care Cost Review,* Skilled Nursing facility Total market Basket, but is adjusted for any increase or decrease in the scope of services.

Prescription drugs and hospital deliveries are excluded from this payment system because they are subject to different methodologies per state regulation.

If the rate established using the alternative prospective payment, methodology does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the center may apply to the deputy commissioner for consideration of exceptional relief from the rate-setting methodology. The application must include the estimated amount necessary to allow reasonable access to quality care, reasons for the relief requested, management actions taken to respond to the situation, corresponding audited financial statements, descriptions of efforts to offset the deficiencies, an analysis of community needs for the services and how Medicaid patients will lose access available to the general public in the same geographic location without this relief, and any other information requested by the deputy commissioner to evaluate the request.

The alternative payment methodology agreement between the State and the federally Qualified Health Center will result in payment to the FQHC of an amount that is equal to the Prospective Payment System payment rate. The State will annually evaluate the alternative payment rate to ensure that the alternative rate is at least equal to or greater than the PPS rate and that it does not exceed the payment limit set under 42 CFR 447.300 through 447.371.

Initial payments for FQHCs becoming qualified after State FY00 are established by computing a statewide weighted average payment to other centers or by cost reporting methods if a minimum of six months of cost data for years 1999 and 2000 is submitted. For each subsequent year, the center will be paid the rate it was entitled to the previous clinic fiscal year plus the percentage increase in the Skilled Nursing Facility Total Market Basket and adjusted for increases or decreases in the scope of service furnished by the Center during that center's fiscal year. For state fiscal year 2016, 2017, and 2018, if it is a center's subsequent year, the center will be paid the rate it was entitled to the previous fiscal year with no percentage increase in the Skilled Nursing Facility Total market Basket, but adjusted for increases or decreases in the scope of services furnished by the center during that center's fiscal year.

Methods and Standards for Establishing
Payment Rates: Other Types of Care

Mental Health Clinic Services

Mental health clinic services provided by a community mental health clinic, state operated mental health clinic, or mental health physician clinic (which is a group of psychiatrists or other mental health professionals working under the supervision of a psychiatrist) are reimbursed at the lesser of the amount billed the general public or the state maximum allowable. Community mental health clinics bill the Division of Behavioral Health under a separate reimbursement schedule for performing pre-admission screening and annual resident reviews (PASARR) of mentally ill persons seeking admission to or residing in long-term care facilities. The State assures that the requirements of 42 CFR 447.321 regarding upper limits of payment will be met. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of mental health clinic services. The agency's fee schedule, updated to reflect an effective date of 5/21/2017, is published at http://dhss.alaska.gov/dbh/Documents/Medicaid%20Related/CBHS%20Provider%20Rates%20Effective%20Date%20052117.pdf .

Mental Health Rehabilitation Services

Mental health rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable. Except as otherwise noted in the plan state developed fee schedule rates are the same for both governmental and private providers of mental health rehabilitation services. The agency's fee schedule, updated to reflect an effective date of 5/21/2017, is published at http://dhss.alaska.gov/dbh/Documents/Medicaid%20Related/CBHS%20Provider%20Rates%20Effective%20Date%20052117.pdf .

Nurse-Midwife Services

Payment is made at the lesser of billed charges, 85% of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Laboratory services are reimbursed at the lesser of the amount billed the general public or at the Medicare fee schedule. Drugs are covered at 95 percent of the AWP but without a dispensing fee. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of nurse-midwife services. The fee schedule was last updated, to be effective for services on or after 7/1/2017 and is available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

(Outpatient Hospital Services, continued)

6) advertising cost is allowable only to the extent that the advertising is directly related to patient care.

The reasonable cost of the following types of advertising and marketing is allowable:
- announcing the opening of or change of name of a facility.
- recruiting for personnel.
- advertising for the procurement or sale of items.
- obtaining bids for construction or renovation.
- advertising for a bond issue.
- informational listing of the provider in a telephone directory.
- listing a facility's hours of operation.
- advertising specifically required as a part of a facility's accreditation process.

7) advocacy and lobbying expenses, along with any costs related to these activities, are not allowable.

8) costs for facility-initiated court or administrative proceedings are non-allowable except when the facility prevails on the issue and the judgment doesn't include an award of fees and costs. Any allowable costs are limited to expenses incurred in the base year.

Allowable patient related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state, and federal income taxes; and interest expense. Facilities may claim a maximum of 75% of dues, meetings, conference fees, and memberships in trade organizations and associations. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non-allowed costs are bad debts, charity, contractual adjustments, and discounts taken by payers. When regulatory changes in allowable costs become effective after the last adjustment for inflation, base year costs and rate calculations may be adjusted and new rates applied to claims with dates of service after the effective date for such regulatory changes.

Prospective payment rates for outpatient hospital services are a percentage of charges except outpatient clinical laboratory services and provider based clinic services. Except as stated in this Subsection, the prospective payment rate for outpatient clinical laboratory services will be a per-procedure rate based on reasonable costs as determined by the Medicare fee schedule.

The prospective percentage of charges payment rate for acute hospital outpatient services is determined by applying the outpatient cost to charge ratio for each outpatient cost center from the Medicare Cost Report to the cost center's Medicaid outpatient charges. Laboratory and clinic cost centers are not included in the calculation. The sum of the Medicaid outpatient costs for all outpatient cost centers will then be divided by total Medicaid outpatient charges. The resulting cost to charge percentage, not to exceed 100 percent, will be the prospective outpatient payment rate effective for the fiscal year. Facilities choosing reimbursement under the Optional Prospective Payment Rate Methodology for Small Facilities described in Attachment 4.19A will have their outpatient clinical laboratory services reimbursed at their prospective outpatient percentage of charges payment rate for the term of their agreement. Rebasing will occur for all facilities no less than every four years. For state fiscal year 2018, rebasing of prospective payment rates using more current cost data will not occur. For facilities that will be getting their first cost-based rate, the freeze on rebasing in state fiscal year 2018 will not occur. Facilities that currently are receiving exceptional relief and are scheduled to be rebased in state fiscal year 2018 will not be affected by the rebasing freeze in state fiscal year 2018. For state fiscal year 2018, the payment rate will be 95% of the payment rate in state fiscal year 2017.

Method and Standards for
Establishing Payment

(Outpatient Hospital Services, continued)

Facilities may choose to be reimbursed under an Optional Prospective Payment Rate Methodology for Small Facilities. A small acute care hospital facility is defined as one that had 4,000 or fewer total inpatient hospital days as an acute care, specialty, or psychiatric hospital or at a combined hospital-nursing facility during the facility's fiscal year that ended 12 months before the beginning of its prospective payment rate year.

A small acute care hospital may elect a new four-year rate agreement if the facility becomes a combined acute care hospital-nursing facility and meets the qualifications described in this section. The facility may choose this option within 30 days after the two facilities combine. The outpatient percentage rate is calculated as the statewide average of the outpatient payment rates in effect for all qualified acute care hospital small facilities as of the date the facilities combine.

For a new facility, the outpatient prospective payment rate percentage is established at the statewide weighted average outpatient payment percentages of acute care and specialty hospitals, in accordance with this section for the most recent 12 months of permanent rates. The outpatient percentages are the statewide weighted average using the base year's outpatient charges. To determine this weighted average, Medicaid charges for the most recent 12 months from each facility are multiplied by the facility's respective rate to get the payment. The sum of facilities' payments is then divided by the sum of their charges to calculate a weighted average outpatient payment percentage.

Personal Care Services

Services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable.

Except as otherwise noted in the plan, payment for these services is based on state developed fee schedule rates, which are the same for both governmental and private providers of personal care services. The agency's rate for personal care services updated on 7/1/2016, are effective for services rendered on or after 07/01/16. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are included in the fee schedule for personal care services published at http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx

Physical and Occupational Therapy Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for the physicians, the provider's lowest charge, or the maximum allowable for procedures that do not have an established RVU.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of physical and occupational therapy services. The fee schedule was last updated, to be effective for services on or after 7/1/2017 and is available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Physician Assistants

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the maximum allowable for procedures that do not have an established RVU. State developed fee schedules are the same for both public and private providers. The fee schedule and its effective date are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Physician Services:

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established Relative Value Unit (RVU). The Resource Based Relative Value Scale methodology is that described in 42 CFR 414 except that increases and reductions to the average payment made for an individual procedure billed at least ten times during the previous fiscal year will be phased in until the year 2000. The relative value units used are the most current version published in the Federal register. Non-routine office supplies are reimbursed at the lesser of billed charges or the state maximum allowable.

Surgical reimbursement is in accordance with the Resource Based Value Scale methodology except that multiple surgeries performed on the same day are reimbursed at 100 percent for each additional surgery; bilateral surgeries are reimbursed at 150 percent of the RBRVS rate; co-surgeons are reimbursed by increasing the RBRVS rate by 25 percent and splitting the payment between the two surgeons; and supplies associated with surgical procedures performed in a physician's office are reimbursed at the lesser of billed charges or the state maximum allowable. Payment is made to surgical assistants at the lesser of billed charges or 25 percent of the Resource Based Relative Value Scale methodology.

Payment to physicians for in-office laboratory services are reimbursed at the lesser of the amount billed the general public or the Medicare fee schedule.

Payment is made to independently enrolled hospital-based physician for certain services at the lesser of the amount billed the general public or 100 percent of the Resource Based Relative Value Scale methodology.

Anesthesia services are reimbursed using the base units and time units and a state determined conversion factor.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule was last updated, to be effective for services on or after 7/1/2017 and is available at:

http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Methods and Standards for
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Podiatry Services

Payment is at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule was last updated, to be effective for services on or after 7/1/2017, and is available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Prescribed Drugs

- The Department will use the National Average Drug Acquisition Cost (NADAC), as calculated and supplied by the Centers for Medicare and Medicaid Services, as the state maximum allowable cost for both brand and generic drugs.
- When considering the amount billed by the provider, the lowest of the following will be the amount billed: gross amount due, usual and customary pricing, and submitted ingredient cost plus the professional dispensing fee.

(A) Drugs acquired outside of 340B or FSS, including 340B covered entities that purchase drugs outside of the 340B program and contract pharmacies under contract with a 340B covered entity described in section 1927(a)(5)(B) of the Act -
- Reimbursement for drugs will be the lowest of the amount billed, WAC + 1% plus professional dispensing fee, state maximum allowable cost (SMAC) plus professional dispensing fee, or the federal upper limit (FUL) plus the professional dispensing fee.

(B) Specialty Drugs that are not distributed by a retail community pharmacy and distributed primarily through the mail -
- Reimbursement for drugs will be the lowest of the amount billed, WAC + 1% plus professional dispensing fee, SMAC plus professional dispensing fee, or the FUL plus the professional dispensing fee.

(C) Drugs not distributed by a retail community pharmacy, such as in or for a long-term care facility -
- Reimbursement for drugs will be the lowest of the amount billed, WAC + 1% plus professional dispensing fee, SMAC plus professional dispensing fee, or the FUL plus the professional dispensing fee.

(D) Indian Health Service, tribal, and urban Indian facilities (pharmacies, dispensing providers) purchasing drugs through the Federal Supply Schedule (FSS) -
- Reimbursement for drugs provided by a facility purchasing drugs through the Federal Supply Schedule or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program, will not exceed the acquisition cost, as outlined in regulation for such facilities, plus the professional dispensing fee.

(E) 340B purchased covered outpatient drugs

Targeted Case Management

For care coordination services see Substance Abuse Rehabilitation Services.

For family and client support services see Mental Health Rehabilitation Services.

Payment Methodology for all types of Targeted Case Management

Payment for Infant Learning Program Targeted Case management will be based on a monthly encounter rate. The payment rate is calculated prospectively and is based on the following:

Rate Computation Methodology

The prospective rate for payment of case management services is computed annually using the following formula. The data for this computation will be taken from the base year, that is the first full year before providers billed for Targeted Case Management services under this section, and will be inflated forward using an inflation index approved by the Department. For fiscal year 2016, 2017, and 2018, the data for this computation taken from the base year will not be inflated forward.

Compute the	Annual Case Manager salary and fringe benefits
Plus	Other anticipated operating cost including travel, supplies, telephone, and occupancy cost
Plus	Direct supervisory cost
Plus	Average indirect administrative cost of provider organization
Divided by	TOTAL STATEWIDE NUMBER OF CASE MANAGERS
Equals	TOTAL STATEWIDE ANNUAL COST PER CASE MANAGER
Divided by	12
Equals	MONTHLY STATEWIDE AVERAGE COST PER CASE MANAGER
Divided by	Statewide average number of children served per month
Equals	TOTAL STATEWIDE AVERAGE MONTHLY COST PER CHILD

The total cost per case manager is the sum of the case manager's reasonable salary, direct supervisory cost, indirect administrative costs of the provider organization, and other operating costs such as travel, supplies, occupancy, and telephone. Dividing the statewide average cost per case manager by twelve (12) months yields the average statewide monthly cost per manager. Dividing the statewide monthly cost per case manager by the average monthly number of children served statewide results in the total monthly cost per child. This is the encounter rate to be used by the provider for billing whenever a Medicaid eligible client receives a TCM service during the month. Providers may only bill the encounter rate once per child per month and must keep documentation to verify this practice.

Payment Methodology for Under 21 Targeted Case Management

Rate Determination: The monthly rate for case management services is based on the total average monthly cost per client served by the provider. The monthly rate is limited to the provider's direct service and administrative costs associated with case management service delivery. The rate is computed by taking the provider's monthly case management cost divided by the monthly number of clients that are provided case management services.

The rate is established prospectively. In the first year, the rate is based on estimates of cost and the number of clients to be served. For subsequent years, the rate is based on actual case management costs for previous years. A cost statement is completed at the end of each state fiscal year once the actual costs incurred have been determined.

Payment Methodology: Payment will be made through MMIS. The provider will bill at the full monthly rate for each client provided case management services during that month. An encounter is a case management activity performed on the client's behalf. Each encounter will be documented to support the billing. Encounters include but are not limited to in-person, phone, mail, email, and other means.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Telemedicine Applications

Payment for services delivered via telemedicine is made according to the Medicaid payment methodology for the service and provider type. Reimbursement is made for a telemedicine application if the service is:

1. An initial visit;
2. A follow-up visit;
3. A consultation made to confirm a diagnosis;
4. A diagnosis, therapeutic referrals/orders, or interpretive service;
5. A psychiatric or substance abuse assessment; or
6. Psychotherapy or pharmacological management services on an individual recipient basis.

Separate reimbursement is not made for the use of technological equipment and systems associated with a telemedicine application to render the service.

Vision Care Services

Reimbursement is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that to not have an established RVU. The state awards a competitive-bid contract for eyeglasses.

Optometry Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology used for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of 7/1/2017 and are effective for dates of services on or after that date. The fee schedule and its effective dates are published at http//manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE AND TRIBAL FACILITIES – CONTINUED

Other Physician Services:

At the option of Tribal outpatient hospitals certified or deemed to meet Medicare Conditions of Participation by the State Survey Agency or a national accreditation organization under a program approved by the Centers for Medicare and Medicaid Services:

1. Outpatient hospital services are reimbursed at the all-inclusive rate published by the Indian Health Service (IHS), reduced by the average amount for the services of any or all of the practitioner types listed in (2) below for whose professional services the tribal outpatient hospital elects to be separately reimbursed; and
2. Covered services rendered to Medicaid recipients in the outpatient hospital setting by the following practitioner types and whose costs are excluded from the all-inclusive rate as described under (1) above, are also paid a fee for service practitioner payment according to the methodology for their services described in Attachment 4.19-B:
   Physicians
   Physician Assistants
   Advance Nurse Practitioners
   Nurse Midwives
   Certified Registered Nurse Anesthetists
   Speech-Language Pathologists
   Audiologists
   Physical Therapists
   Podiatrists

The Indian Health Service will provide the State with the revised outpatient hospital service rates, reduced by the average amount for the services of any or all of the practitioner types listed in this section.

Community Health Provider Services:

Payment for covered Community Health Provider (CHP) Services is made at a single statewide CHP Encounter Rate as described below.

The CHP Encounter Rate will equal total allowable costs for all levels and practice area categories of such CHPs, divided by their total annual encounters. The rate will be calculated by the Department's Office of Rate Review as described below, in close consultation with affected tribal health organizations, adjusted annually for inflation using the Global Insight's *Health-Care Cost Review*, Skilled Nursing Facility Total Market Basket available sixty days before January 1, and rebased every four years.

For state fiscal year 2018, the annual inflation referenced in the above paragraph will not apply.

The initial rate will be calculated using costs associated with providing CHP services by an identified group of Alaska tribal health programs. The costs will be reviewed and adjusted by the department to

Prospective payment rates will be determined under one of three methodologies – Basic, Optional, and New Facilities.

a. Basic Prospective Payment Rate Methodology

The prospective payment rate consist of four components – costs excluding capital for routine cost centers, capital costs for routine cost centers, capital costs for ancillary cost centers, and costs excluding capital for ancillary cost centers. The prospective payment rates will be annual rates based on a facility's fiscal year. Except for facilities electing to be reimbursed under the optional payment rate methodology detailed in Subsection IV-b, rebasing will occur for all facilities no less than every four years. For state fiscal year 2018, rebasing of prospective payment rates using more current cost data will not occur. For facilities that will be getting their first cost-based rate, the freeze on rebasing in state fiscal year 2018 will not occur. Facilities that currently are receiving exceptional relief and are scheduled to be rebased in state fiscal year 2018 will not be affected by the rebasing freeze in state fiscal year 2018.

The prospective per-day rates for long-term care facilities are computed as follows:

1. Total allowable routine base year costs excluding routine capital costs for routine costs are divided by the total long-term care days. This gives the non-capital routine component of the rate.

2. Total allowable routine base year costs excluding routine non-capital costs are divided by the total long-term care days. This gives the routine capital component of the rate. Long-term care days are the greater of total actual long-term care patient days or 85% of licensed capacity days. Licensed capacity days are the product of the licensed long-term care beds in the base year multiplied by 365.

3. The ancillary capital component of the per-day payment rate is calculated by determining the percentage of capital cost for each ancillary cost center and multiplying the percentage by the related Medicaid long-term care ancillary costs from the base year. These amounts are totaled and divided by the sum of the Medicaid long-term care patient days from the base year

4. The non-capital ancillary Medicaid component of the rate is determined by subtracting Medicaid capital ancillary costs from facility Medicaid ancillary costs. This amount is then divided by facility Medicaid long-term care days from the base year. This becomes the non-capital ancillary component of the rate.

(2) For the first year of the agreement, the capital component is calculated as described in Subsection IVa. The resulting amount is adjusted for inflation at 1.1 percent per year for each fiscal year after the first year of election until the agreement expires.

(3) For the first year of the agreement, the non-capital component is calculated as described in Subsection IVa. The resulting amount is adjusted for inflation at three percent per year for each fiscal year after the first year of election until the agreement expires.

For state fiscal year 2016, 2017, and 2018, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

Increases in the capital component of the prospective payment rate for new assets placed in service during the period covered by the agreement will be allowed, based on the provisions in Subsection IVa, if the following conditions are met:

1) The assets placed into service have a value of at least $5,000,000;
2) The facility obtains one or more Certificates of Need for the assets placed into service; and
3) The facility provides a detailed budget that reflects the allowance for the new assets before the prospective payment rate is increased.

In most cases, a facility must use the "exceptional relief" process for appealing department decisions pursuant to Subsection XII. The administrative appeals process outlined in Subsection VIII, will be used only when an appeal relates to one of the following subjects:

1) The facility's eligibility to elect rate setting under this Subsection;
2) The violation of a term of the rate agreement between the facility and the department;
3) The denial of an increase in the capital component of the prospective payment rate for new assets related to an approved Certificate of Need.

A small facility acute care hospital may elect a new four-year rate agreement as described in this Subsection of the facility becomes a combined acute care hospital-nursing facility. The facility may choose this option within 30 days after the combination of the two facilities. The nursing facility payment rate is calculated as follows: