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State/Territory Name: AK

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



Financial Management Group

December 12, 2018

Adam Crum, Commissioner
Department of Health and Social Services
3601 C Street, Suite 902
Anchorage, AK 99503-5923

RE: AK State Plan Amendment (SPA) Transmittal Number #18-0004 – Approval

Dear Mr. Crum:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 18-0004. This SPA adds the definition of a new provider to the new facility prospective payment rate methodology for inpatient hospital 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 18-0004 is approved effective as of October 1, 2018. 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,

A solid black rectangular box used to redact the signature of Kristin Fan.

Kristin Fan
Director

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

1. TRANSMITTAL NUMBER:
18-0004

2. STATE
AK

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

4. PROPOSED EFFECTIVE DATE
October 1, 2018

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:

7. FEDERAL BUDGET IMPACT:

a. FFY 19 \$0

b. FFY 20 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A pages 8 & 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-A pages 8 & 9

10. SUBJECT OF AMENDMENT:

Adds definition of "new provider" to new facility prospective payment rate methodology.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Jon Sherwood

14. TITLE: Deputy Commissioner, DHSS

15. DATE SUBMITTED: November 8, 2018

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
11/8/2018

18. DATE APPROVED: DEC 12 2018

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVAL: DEC 10 2018

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

12/11/18-State authorized a P&I change to block #4.

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 before the increase in prospective payment rate that reflects the allowance for the new assets.

The administrative appeals process provided under subsection VIII is not available and the facility will use the "exceptional relief" process pursuant to subsection XII except in the case that the facility disputes an action or decision of the department that relates to the following:

- 1) The facility's eligibility to elect rate setting under the 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 and a related approved certificate of need.

c. New Facility Prospective Payment Rate Methodology

Under this subsection –

A new facility is described as a facility that has not, within the previous 36 months, provided the same or similar level of Medicaid certified patient services within 25 miles of the facility either through present or previous ownership

A new provider means an actively enrolled Medicaid facility that is currently receiving reimbursement for Medicaid services outside of the state prospective payment system and elects to enter the state prospective payment system.

If a new facility, new provider, or a new psychiatric unit in an acute care hospital is licensed, the rates will be calculated as follows:

For acute care and specialty hospitals, or separately licensed or certified psychiatric units in acute care hospitals, the inpatient per-day rate will be established at the statewide weighted average of inpatient per-day rates and of acute and specialty hospitals in accordance with this section for the most recent 12 months of permanent rates. Patient rates are the statewide weighted average using the base year's patient days.

For inpatient psychiatric hospitals or new separately licensed or certified psychiatric units in acute care hospitals, the inpatient prospective payment rate will be established at the statewide weighted average of inpatient per-day rates of psychiatric hospitals for the most recent 12 months of permanent rates; rates are the statewide weighted average using the base year's patient days.

Prospective payment rates for new facilities and new providers will be established under the provisions of section IV after two full years of cost data is reported.

V. (Reserved)