Table of Contents

State/Territory Name: Alaska

State Plan Amendment (SPA) #: 19-0001

This file contains the following documents in the order listed:

1) Approval Letter
2) 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Western Division - Regional Operations Group

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

April 29, 2019

Adam Crum, Commissioner
Department of Health and Social Services
3601 C Street, Suite 902
Anchorage, AK 99503-7167

RE: Alaska State Plan Amendment (SPA) Transmittal Number 19-0001

Dear Mr. Crum:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Alaska's State Plan Amendment (SPA) Transmittal Number 19-0001. This SPA updates reimbursement methodology and rates for ESRD Services.

This SPA is approved effective March 24, 2019, as requested by the state.

If there are additional questions, please contact me or your staff may contact Frank A. Schneider at frank.schneider@cms.hhs.gov or at (206) 615-2335.

Sincerely,

[redacted]

David L. Meacham
Deputy Director

cc:
Donna Steward, DHSS

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: 19-0001

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
March 24, 2019

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 19 $ - 614,845
b. FFY 20 $ -1,223,150

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B page 9 and 9a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B page 9

10. SUBJECT OF AMENDMENT:
Revising existing ESRD reimbursement methodology and clarifies language in radiology services reimbursement.

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

GENCY OFFICIAL:
[redacted]

13. TYPED NAME: Donna Steward

14. TITLE: State of Alaska, DHSS Deputy Commissioner

15. DATE SUBMITTED: March 26, 2019

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3/28/2019

18. DATE APPROVED: 4/29/19

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 3/24/19

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]
Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, L. Meacham -S
Date: 2019.04.29 11:27:40 -07'00'

21. TYPED NAME: David L. Meacham

Deputy Director

23. REMARKS:

3/10/19-State authorized a P&I change to block number 7.

FORM HCFA-179 (07-92)

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

Private Duty Nursing for Children Under 21

Payment for private nursing is the lesser of the amount billed the general public or $80 per hour for registered nurse services and $75 per hour for licensed practical nurse services. Hours must be justified in a physician-approved plan of care, must be less than 24-hours per day, and cannot when added to the other Medicaid services used by the child, exceed the cost of institutional care.

Radiology Services

Payment for radiology services provided by independent radiology facilities 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. Rates update automatically when the RBRVS rate changes annually. This maximum allowable payment is a single rate per procedure code. The state assures that the requirement of 42 CFR § 447.325 regarding upper limits of payment will be met.

Fee schedules are located here:
http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Renal Dialysis Physician Clinics

Payment for renal dialysis clinic services will be paid at a composite, per treatment payment rate for hemodialysis and a separate composite per treatment rate for peritoneal dialysis. No more than one treatment may be billed per day, and no more than three hemodialysis treatments may be billed per week without medical justification.

The rates for end-stage renal disease facilities are all-inclusive, except that the department will pay for erythrocyte-stimulating agents and parenteral iron replacement products, which are separately reimbursable under existing prescribed drug payment methodology.

The composite, per treatment payment rates for hemodialysis and peritoneal dialysis will be adjusted annually each July 1.

The composite, per treatment payment rates for hemodialysis and peritoneal dialysis will be calculated as statewide weighted averages. The following will be used to develop the statewide weighted averages:

a. Alaska Medicaid claims information that identifies the number of hemodialyses and separately the number of peritoneal dialysis treatments delivered to Alaska Medicaid recipients during the most recent calendar year for which timely filing has passed; and
b. The average cost per treatment included on Medicare Cost Reports submitted by end-stage renal disease clinics for the calendar year aligning with a) above.

The hemodialysis cost per treatment will be taken from the Average Cost of Treatments Value entered on the Computation of Average Costs per Treatment Basic Composite Cost worksheet for maintenance hemodialysis portion of the Medicare Cost Reports submitted by end-stage renal disease clinics.

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

The cost of the peritoneal cost per treatment will be taken from the average cost of treatments value reported on the Computation of Average Costs per Treatment Basic Composite Cost worksheet for Home Program Continuous Ambulatory Peritoneal Dialysis (CAPD) and for Home Program Continuous Cycling Peritoneal Dialysis (CCDP) portion of the Medicare Cost Reports submitted by end-stage renal disease clinics.

When the average cost of treatments from the Computation of Average Costs per Treatment Basic Composite Costs are reported as weekly costs on the Medicare Cost Reports submitted by end-stage renal disease clinics, the department will divide hemodialysis values by three treatments per week and peritoneal dialysis values by seven treatments per week to arrive at the average cost per daily treatment.

Respiratory Therapy Services

Payment for respiratory therapy services is made at the lesser of the amount billed the general public or the state maximum allowable. This maximum allowable payment is a single rate per procedure code. The agency's rates for respiratory therapy services were updated on July 1, 2012 and are effective for dates of service on or after that date.