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State/Territory Name: Alaska

State Plan Amendment (SPA) #: 19-0006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group/ Division of Reimbursement Review

February 27, 2020

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

RE: TN AK-19-0006

Dear Mr. Crum:

We have reviewed the proposed amendment to Attachment 4.19-B of your Medicaid State plan submitted under transmittal number (TN) AK-19-0006. The proposed amendment is to implement cost containment via rate reduction for Non-Facility services.

Based upon the information provided by the State, we have approved the amendment for incorporation into the official Alaska State Plan with an effective date of July 1, 2019. A copy of the CMS-179 and the approve plan page(s) are enclosed with this letter.

If you have any questions, please call DRR Analyst Frederick Sebree at (217) 492-4122 or by email at fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Acting 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: 19-0006

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, 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 2019 (5,639,313) ~~$ (4,782,106)~~ (P&I)
b. FFY 2020 (16,917,939) ~~$ (14,346,317)~~ (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B pages 1, 1.1, 1.2, 1b, 3, 3a, 4, 5a, 5a.1, 5b, 6, 7, 8, 8a, 9, 9a, 11, 11a, 11a.2, 11b, 12

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B pages 1, 1.1, 1.2, 1b, 3, 3a, 4, 5a, 5b, 6, 7, 8, 8a, 9, 11, 11a, 11a.2, 11b, 12

10. SUBJECT OF AMENDMENT:
Cost Containment via rate reduction and inflation freeze; NON-FACILITY

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:
[redacted]

13. TYPED NAME: Albert E. Wall

14. TITLE: Deputy Commissioner, Alaska DHSS

15. DATE SUBMITTED: September 27, 2019

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/27/2019

18. DATE APPROVED: 2/27/2020

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/19

20. SI[redacted]

21. TYPED NAME: Todd McMillion

22. TITLE: Acting Director

23. REMARKS:

12/9/19: State authorized P&I change to block 7

FORM HCFA-179 (07-92)

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

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. The fee schedule is published at
http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp.

For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the payment rates for SFY19.

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/Pages/Resources/Medicaidrelated.aspx .

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 factors 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

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

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

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

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. For SFY20, July 1, 2019 through June 30, 2020, the payment rate will be 95% of the rate that would have been effective July 1, 2019.

Licensed Behavior Analysts

The state Medicaid program reimburses for behavior analysis services through the supervising health care provider - who is a licensed behavior analyst operating within their scope of practice.

All covered services are paid at the lesser of the provider's billed charges, or the state maximum allowable for the procedures. State developed fee schedule rates are the same for both governmental and private providers of behavior analysis services. Tribal behavioral health clinic encounter rates do not apply to services in this section.

The fee schedule and its effective date are published at http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx .

In SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the SFY19 rates.

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

Dental Services for Recipients Age 21 or Older:

Payment is made at the lesser of billed charges, the Medicare Resource Based Relative Value Scale Methodology used for physicians in those instances where Medicare sets an RVU for the billed dental service, the provider's lowest charge, or the statewide fee schedule up to an annual limit of $1150 per Medicaid recipient age 21 or older.

Except as otherwise noted in the plan, state developed rates are the same for both public and private providers of dental services. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp. This fee schedule includes dental procedures whose payments are limited by the physician payment amount for dental procedures.

Dentures:

For recipients age 21 and older, dentures and the authorized services to prepare for them, are paid up to an annual limit of $1150 per recipient. When upper and lower dentures are necessary and the annual limit is not adequate to cover the cost of the dental claim, twice the annual limit may be authorized by the Department. When authorizing twice the annual limit for dentures, the maximum amount authorized is the remaining amount from the current fiscal year and the entire amount allotted for the succeeding fiscal year. The recipient is not allowed a new or additional annual limit for the succeeding year beyond that already paid for the dentures.

Except as otherwise noted in the plan, state developed rates are the same for both public and private providers of dentures. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are included in the fee schedule for dental services published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp.

Home Health Services
Payment is made at 80 percent of billed charges.

Hospice Care Services
Payment is set and adjusted according to the yearly releases from the Centers for Medicare & Medicaid Services (CMS). Alaska's Medicaid program adjusts the rates by the start of the CY (January 1) immediately after the release of the updated rates by CMS, and these rates are retroactive to the effective date of the CMS material released (usually, October 1 of each year).

Laboratory Services
Payment for laboratory services provided by independent laboratories, physicians in private practice, and hospital laboratories acting as independent laboratories is made at the lesser of billed charges or the Medicare fee schedule. For SFY20, July 1, 2019 through June 30, 2020, the payment rates for laboratory services not provided by independent laboratories will be 95% of what the payment would have been July 1, 2019. The state Medicaid program recognizes the Medicare fee schedule in place as of June 1 for the annual update of these rates that occurs at the beginning of the next SFY (on July 1). Unlisted procedures are paid at 80 percent of the amount billed to the general public.

Mammograms

Payment is made at the lesser of the billed charges or the Resource Based Relative Value Scale methodology used for physicians.

Durable Medical Equipment, Medical Supplies, and Prosthetic and Orthotic Devices

Reimbursement for durable medical equipment and supplies dispensed by enrolled durable medical equipment (DME) and prosthetic and orthotic (P&O) providers to recipients physically located in the state is made at the lesser of the amount billed, the Medicare rate current at the time of dispensing, or the state maximum allowable posted on the fee schedule.

Reimbursement for dispensed medical supplies and prosthetic and orthotic devices identified as billable only by an enrolled certified P&O provider occurs at the lesser of the amount billed, the Medicare rate current at the time of dispensing multiplied by 1.2, or the state maximum allowable posted on the fee schedule.

Effective June 2, 2019 for prosthetic and orthotic supplies, and July 2, 2019 for durable medical equipment, that do not have an established Medicare rate or established state maximum allowable rate at the time of dispensing, the agency sets rates based on a methodology set in regulation and publishes the rate on the agency's fee schedule site (http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp).

For a covered, non-priced, non-miscellaneous Healthcare Common Procedure Coding System (HCPCS) code, the rate is based on the submitted unaltered final purchase invoice price plus 35 percent for claims submitted on or after June 2, 2019, and before the date the rate is established, until CMS or the department sets a rate:

(1) if the median unaltered final purchase invoice price of the non-miscellaneous HCPCS item for the first 10 claims is less than $5,000, the final rate will be set at
    (A) the median submitted unaltered final purchase invoice price of the first 10 claims plus 35 percent if the first 10 claims were paid to at least two different enrolled providers; or
    (B) the median submitted unaltered final purchase invoice price of the number of claims paid, plus 35 percent after 15 claims are paid but have not been paid to at least two different enrolled providers;

(2) if the median unaltered final purchase invoice price of the non-miscellaneous HCPCS item for the first ten claims is $5,000 or more, the final rate will be set at
   (A) the median submitted unaltered final purchase invoice price plus 30 percent if the first ten claims were paid to at least two different enrolled providers; or
   (B) the median submitted unaltered final purchase invoice price of the number of claims paid, plus 30 percent after 15 claims are paid but have not been paid to at least two different enrolled providers;

Reimbursement rates for covered items submitted using an HCPCS code, for which CMS or the department has not issued a rate, will be reimbursed at the unaltered final purchase invoice price plus 20 percent.

Used or refurbished durable medical equipment will be reimbursed at no more than 75 percent of the allowed rate for the specific HCPCS code.

Rental rates are set at 10 percent of the total allowed price of the item.

Reimbursement rates for items and services provided to recipients when the recipient is physically located outside of this state will be based on 100 percent of the current quarter's Medicare DMEPOS Fee Schedule established by CMS for these items and services in the state where the item or service was provided.

Reimbursement for unusual or custom equipment may be authorized on a case-by-case basis and may not exceed the authorized amount.

Due to the unique remote geography of Alaska, payment for the reasonable and necessary direct costs of delivery or shipping using the most cost-effective method may be authorized if:

- the recipient resides outside the municipality where the enrolled provider is physically located, and the item or service is unavailable from an enrolled provider in the municipality where the recipient resides;
- the item is durable medical equipment or replacement parts that are specialized or unique to a recipient's equipment, is shipping from the manufacturer, and the cost of the item exceeds $250; or
- the item is a home infusion therapy product, and the cost of shipping exceeds 40 percent of the sum of the per diem rate for the number of days of therapy represented in the shipment.

For certain durable medical equipment (DME) that are also covered by Medicare, the state will reimburse at no more than Medicare rates current at the time of dispensing. As such, the aggregate amount expended by the state Medicaid program for DME should compare as equal to or less than the aggregate amount which would be paid for such items on a fee-for-service basis under Medicare Part B, including as applicable, under section 1847 of the Act. If payments for DME items subject to statute exceed the FFP limit outlined in section 1903(i)(27) of the Act, the overpayment shall be returned to CMS.

For SFY20, July 1, 2019 through June 30, 2020, products and services with rates set under this section will be paid at 95% of these rates when rendered incident to a professional service by exempt provider types not listed in this section but outlined in 42 CFR 424.57 (physicians, authorized non-physician practitioners, PT, OT).

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 physician) 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 and effective date is published at http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx. For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95 percent of the rates that were effective 1/1/2019.

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 and effective date is published at http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx. For SFY20, July 1, 2019 through June 30, 2020,the payment rates will be 95 percent of the rates that were effective 1/1/2019.

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 and effective date 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. For state fiscal

year 2020, July 2, 2019 through June 30 2020, the payment rate for hospitals that are not licensed as Critical Access Hospitals will be paid at 95% of the rate that would have been effective July 1, 2019. Facilities licensed as Critical Access Hospitals through the State of Alaska, Division of Health Care Services, Health Facilities Licensing Certification List, updated February 28, 2019, will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions under this subsection.

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 7/1/2019, are effective for services rendered on or after 07/01/19. 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. For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the SFY19 rates.

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 and its effective dates 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 effective date is available 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. Effective July 1, 2019, physician services reimbursement will be set using the Medicare Relative Value Units, updated on a quarterly basis, and the most recently published Medicare Geographic Practice Cost Index for the state of Alaska. The state of Alaska applies a conversion factor of $40.974 to the formula in the calculation of an RBRVS rate. The fee schedule and effective date is available at: http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

For SFY20, July 1, 2019 through June 30, 2020, the conversion factor for provider types that are not direct entry midwife, school based services, family planning clinics, or independent laboratory, or are any provider type but have a specialty codes on the rending provider that is not general practice, family practice, gynecology, obstetrics and gynecology, pediatrics, obstetrics, adult health, nurse midwife, women's health/OB-GYN, family health, pediatric, or gerontological, will be $37.792.

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

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 and effective date 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

- Reimbursement for drugs for a covered entity described in U.S.C. 256b, that indicates it will use covered outpatient drugs purchased through the 340B pricing program to bill to Medicaid, will be the lower of the submitted actual acquisition cost plus professional dispensing fee, WAC +1% plus professional dispensing fee, the SMAC plus professional dispensing fee, or the FUL plus professional dispensing fee.

(F) Drugs acquired through the 340B program and dispensed by contract pharmacies under contract with a 340B covered entity described in section 1927 (a)(5)(B) of the Act will not be reimbursed. Compounded Drugs

1) Reimbursement for compounded prescriptions will be the sum of the costs of each of the ingredients as established under (A) through (E) above plus the professional dispensing fee to reimburse no more than the provider's lowest charge.
2) The professional dispensing fee for a compounded covered outpatient drug is the applicable fee listed in (K) of this subsection.

(G) Physician-administered drugs

1) Physician administered drugs including those purchased through the 340 B program are reimbursed at the lower of the billed amount or WAC + 1% without a professional dispensing fee.
2) Physician administered drugs will be reimbursed for the drug without a professional dispensing fee.
3) For SFY2020 (after a 30-day notice to providers, prescribed drugs billed under provider types other than those by a Pharmacy (pharmacy administered drugs) will be paid at 95% of these rates

(H) Clotting factor

- Reimbursement for drugs will be the lowest of the amount billed, WAC + 1% plus professional dispensing fee, SMAC plus professional dispensing fee, or the federal upper limit plus the professional dispensing fee.

(I) Drugs other than those of (A) through (H) above, and for brand names of multiple source drugs, specified by the prescriber, without a specific established limit in accordance with 42 C.F.R. 447.512, will be reimbursed the lesser of the provider's billed amount or WAC + 1%, plus the professional dispensing fee.

(J) Investigational and Experimental Drugs

1) Reimbursement will not be provided for investigational drugs.
2) Reimbursement will not be provided for experimental drugs.

(K) Professional Dispensing Fee

1) The professional dispensing fee is based on the results of the surveys of in-state pharmacies' costs of dispensing prescriptions. For each pharmacy, the professional dispensing fee will be reimbursed no more than once every 22 days per individual medication strength, and based on the following schedule:
   (a) For pharmacy located on the road system: $13.36
   (b) For a pharmacy not located on the road system: $21.28
   (c) For an out-of-state pharmacy: $10.76
   (d) For a mediset pharmacy: $16.58
2) The department will reimburse the lesser of the pharmacy's assigned professional dispensing fee based on the schedule above, or the submitted dispensing fee.
3) Professional Dispensing Fee Schedule Description
   (a) "pharmacy located on the road system" means a pharmacy in this state and is connected to

Anchorage by road;

(b) "pharmacy not located on the road system" means a pharmacy located in this state and is not connected to Anchorage by road;

(c) "out of state pharmacy" means a pharmacy that is physically located in a state other than this state;

(d) "mediset pharmacy" means a pharmacy dispensing 75% or more of the total annual Medicaid prescription for covered outpatient drugs in prescriber-ordered medisets or unit doses to a recipient living in a congregate living home, a recipient of home and community-based services, a recipient eligible for Medicaid under a category set out in 7 AAC 100.002(b) or (d) who is blind or disabled, a recipient who is an adult experiencing a severe emotional disturbance.

(L) Miscellaneous and Definitions

- Reimbursement will be made to the provider for reasonable and necessary postage or freight costs incurred in the delivery of the prescription from the dispensing pharmacy to a recipient in a rural area. Cross-town postage or delivery charges are not covered. Handling charges are included in the dispensing fee (below) and not directly reimbursed.

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 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. For SFY20, July 1, 2019 through June 30, 2020, rates will be 95% of the SFY19 rates.

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 methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. This maximum allowable payment is a single rate per procedure code. The fee schedule and effective dates are available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp.
The state assures that the requirement of 42 CFR 447.325 regarding upper limits of payment will be met.

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 hemodialysis 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. 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, 2019 and are effective for dates of service after on or after that date.

Speech, Hearing, and Language Services:
The department will pay for speech pathology/audiology services if they are identified in the *CPT Fee Schedule for Speech Pathologist table and HCPC Fee Schedule for Speech Pathologists* table.

Payment for speech-language pathology services provided by a speech pathologist or outpatient speech therapy center 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 for hearing services provided by an audiologist 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 to a hearing aid supplier is made at the lesser of billed charges or the state maximum allowable. The fee schedule and effective date is available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Substance Abuse Rehabilitation Services:
The following substance abuse rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable:

1. assessment and diagnosis services;
2. outpatient services, including individual, group, and family counseling; care coordination; and rehabilitation treatment services;
3. intensive outpatient services;
4. intermediate services; and
5. related medical services, including medical evaluation for admission into methadone treatment, intake physical for non-methadone recipients, methadone treatment plan review, medication management, medication dispensing, and urinalysis and detoxification services.

The fee schedule was last updated to be effective for services on or after 7/1/2019 and is available at http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx.

For SFY 2020, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the rates that were effective 1/1/2019.

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 years, 2016, 2017, 2018, and 2020 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.

Long Term Services and Supports (LTSS) Targeted Case Management:

Reimbursement to providers of long-term services and supports (LTSS) targeted case management services provided on or after July 1, 2019, is a monthly fee for service at rates based on:

- Salaries
- Fringe Benefits
- Allowable Indirect Costs
- Average caseload size

Payment Methodology: The Department of Health and Social Services (the department) will authorize case management as a service within the participant support plan. Payment will be made through MMIS and each encounter will be documented to support the billing. The department established regulations for the operation of long term services and supports targeted case management services in a manner that protects and promotes the health, safety, and welfare of participants. The fee schedule will be rebased at least every four years. In the years in which the fee schedule is not rebased, the payment rate will be increased using the most recent quarterly publication available 60 days before July 1 of Global Insights Health Care Cost Review, CMS Home Healthy Agency Market Basket. For SFY20, July 1, 2019 through June 30, 2020, inflation will not be granted.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both government and private providers. The fee schedule was last updated to be effective for services on or after July 1, 2019, and is available at http://www.dhss.alaska.gov/dsds/Documents/pca/Chart_LTSSTargetedCase%20Management_7-1-2019.pdf.

For SFY20, July 1, 2019 through June 30 2020, the payment rate will be set at 95% of the payment rate for SFY19.

Transportation Services

Emergency and non-emergency transportation services are paid at the lesser of the amount billed the general public or the state maximum allowable if such a maximum has been established. For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the payment rates for SFY19. If the reimbursement rate for SFY19 was billed charges, it will continue to be billed charges for SFY20. State developed fee schedule rates are the same for both public and private providers. The agency's fee schedule rates and effective dates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp.

The following types of emergency transportation services for recipients are payable at the lesser of the amount billed the public or the state maximum allowable, published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp:

- Ground ambulance service, whether within the same community or outside of it;
- Air ambulance service.

For SFY20, July 1, 2019 through June 30, 2020, the payment rate will be 95% of the payment rates for SFY19. If the reimbursement rate for SFY19 was billed charges, it will continue to be billed charges for SFY20.

The following types of non-emergency transportation services for recipients and authorized escorts are payable at the amount billed the public or the state negotiated rate, when applicable:

- Commercial airline service;
- Ferry service;
- Ground transportation.

For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the payment rates for SFY19. If the reimbursement rate for SFY19 was billed charges, it will continue to be billed charges for SFY20. The State maintains files of negotiated rates.

With the exception of government-operated accommodations, meal and lodging costs for recipients and approved escorts are reimbursed at the lesser of the amount billed the public or the state maximum allowable per day, which is the government rate established for all publicly funded travel-related room and board. For SFY20, July 1, 2019 through June 30, 2020, the payment rates will be 95% of the payment rates for SFY19. If the reimbursement rate for SFY19 was billed charges, it will continue to be billed charges for SFY20.

Costs for recipients and approved escorts utilizing government-operated accommodations are reimbursed at the federal per diem rate or the per diem rate established by the State of Alaska, whichever the provider chooses; or, if less, the amount billed to the public.

Prior authorization is required for all non-emergency transportation and all lodging and meal costs for both recipients and escorts.

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.

The fee schedule and effective date is available at
http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

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 and its effective dates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp.