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State/Territory Name: Alaska

State Plan Amendment (SPA)#: 14-006

This file contains the following documents in the order listed:

1) Approval Letters

2) Additional Companion letter

3) Summary Form (with 179-like data)

4) 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, Washington 98104

Division of Medicaid & Children's Health Operations

William J. Streur, Commissioner
Department of Health and Social Services
Post Office Box 110601
Juneau, Alaska 99811-0601

OCT 2 2 2014

RE: Alaska State Plan Amendment (SPA) Transmittal Number 14-006

Dear Mr. Streur:

The Centers for Medicare & Medicaid Services (CMS) Pharmacy Team recently approved State Plan Amendment (SPA) 14-006, effective May 18, 2014, which modifies pharmacy reimbursement for covered outpatient and physician, administered drugs.

In addition, during the review Alaska SPA 14-006, CMS performed an analysis of corresponding coverage sections not originally submitted with this SPA. This analysis revealed issues that will require additional information and/or possible revision through a corrective action plan (CAP). Under separate cover, CMS is sending a companion letter detailing those issues, and provide guidance on timeframes for correction.

The state has or will receive an approval of this SPA from the CMS Pharmacy Team. The Seattle Regional Office is also providing an additional copy as we were the recipient of the original, signed amendment request, and we maintain the official State Plan.

Enclosed you will find a copy of the official CMS form 179, amended page(s), and copy of the approval letter from the Pharmacy Team for your records.

If you have any questions concerning the Seattle Regional Office role in the processing of this SPA, please contact me, or have your staff contact Maria Garza at (206) 615-2542 or via email at maria.garza@cms.hhs.gov.

Sincerely,

[redacted]

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

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

Disabled & Elderly Health Programs Group

October 22, 2014

William J. Streur, Commissioner
Department of Health and Social Services
Post Office Box 110601
Juneau, Alaska 99811-0601

Dear Mr. Streur:

We are responding to your request to approve Alaska State Plan Amendment (SPA) 14-006 received in the Seattle Regional Office on April 29, 2014. This proposed SPA is to modify the current payment for covered outpatient drugs and for practitioner administered drugs, effective May 18, 2014.

ALASKA STATE PLAN AMENDMENT PROPOSALS

Dispensing Fees

Under the current state plan, the state applies a tiered dispensing fee schedule based on annual total prescription volume. AK 14-006 will replace the dispensing fees based on volume with dispensing fees based on the pharmacy location or if medisets (unit doses) are being dispensed. For purposes of determining the dispensing fee, a pharmacy will be designated as either a pharmacy located on the road system, pharmacy not located on the road system, mediset pharmacy, or out-of-state pharmacy. The proposed dispensing fees are as follows:

- For pharmacies located on the road system, the dispensing fee will be $13.36 to be paid no more than once every 22 days per individual medication strength.
- For pharmacies not located on the road system, the dispensing fee will be $21.28, to be paid no more than once every 22 days per individual medication strength.
- For a mediset pharmacy the dispensing fee will be $16.58, to be paid no more than once every 14 days per individual medication strength.
- The dispensing fee for an out-of-state pharmacy will be $10.76, to be paid no more than once every 22 days per individual medication strength.
- A covered outpatient drug dispensed by a dispensing provider will be reimbursed for a drug without a dispensing fee.

- The state proposes to remove the compound dispensing fee. The proposed tiered dispensing fee schedule that will apply to all other outpatient prescriptions will also be applied to compounded drugs.

Reimbursement

- The SPA proposes that if (1) the Centers for Medicare and Medicaid Services (CMS) has not established a federal upper limit for the drug, (2) the drug is not purchased through the 340B program, (3) the drug is not purchased through the Federal Supply Schedule, or (4) the drug is not a brand name of a multiple source drug that is prescribed to be dispensed as written (DAW), then the pharmacy will be reimbursed the assigned dispensing fee plus the estimated acquisition cost (EAC). The EAC is to be Wholesale Acquisition Cost (WAC)+1%.

- In establishing a state maximum allowable cost the state proposes reviewing the WAC, direct price or purchase invoices.

- The state clarifies that if a provider uses medications purchased through the 340B program to bill Medicaid, the provider must submit the actual acquisition cost to Medicaid.

- Practitioner administered drugs will no longer be reimbursed at the lower of the billed amount or WAC + 8 %. They are to be reimbursed at the lower of the billed amount or WAC + 1% without a dispensing fee.

- Reimbursement will also change for pharmacists providing smoking cessation medication management to the lesser of billed charges or a tobacco cessation counseling fee of $16.00.

- The state is proposing to change the period the pharmacy may not refuse to fill an interim prescription from before the end of 28 days to before the end of 14 days for mediset pharmacies or 22 days for outpatient pharmacies.

CMS FINDINGS AND ANALYSIS

While we review proposed SPAs to ensure their consistency with the relevant provisions of the Social Security Act, we conducted our review of your submittal with particular attention to the statutory requirements at section 1902(a)(30)(A) of the Act ("Section (30)(A)"). Section (30)(A) of the Medicaid Act requires that state plans contain "methods and procedures...to assure that payment are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396(a)(30)(A). As we explain in greater detail below, we find that the state's submission is consistent with the requirements of the Act, including those set forth in Section (30)(A).

States must submit information sufficient to allow CMS to determine whether a proposed amendment to a state plan is consistent with the requirements of section 1902 of the Act. However, consistent with the statutory text, CMS does not require a state to submit any particular type of data, such as a provider cost studies, to demonstrate compliance. *See* Proposed Rule, Dep't of Health & Human Servs. Ctrs. For Medicare & Medicaid Servs., 76 Fed. Reg. 26342, 26344 (May 6, 2011). Rather, as explained in more detail in the May 6, 20011 proposed rule, CMS believes that the appropriate focus on Section (30)(A) is on beneficiary access to quality care and services. CMS has followed this interpretation for many years when reviewing proposed SPAs.[1]

This interpretation---which declines to adopt a bright line rule requiring the submission of provider cost studies---is consistent with the text of Section (30)(A) for several reasons. First, Section (30)(A) does not mention the submission of any particular type of data or provider costs; the focus of the Section is instead on the availability of services generally. Second, the Medicaid Act defines the "medical assistance" provided under the Act to mean "payment of *part* or all of the cost" of the covered services. *See* 42 U.S.C. § 1396d(a)(emphasis added). Third, when Congress has intended to require states to base Medicaid payment rates on the costs incurred in providing a particular service, it has said so expressly in the text of the Act. For example, the now-repealed Boren Amendment to the Medicaid Act required states to make payments based on rates that "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A). By contrast, Section (30)(A) does not set forth any requirement that a state consider costs in making payments. Finally, CMS observes that several federal courts of appeals have interpreted Section (30)(A) to give states flexibility in demonstrating compliance with the provision's access requirement and have held that provider costs need not always be considered when evaluating a proposed SPA. *See Managed Pharm. Care v. Sebelius, 716 F.3d 1235 (9th Cir. 2013); Rite Aid of Pa., Inc. v. Houstoun,* 171 F.3d 842, 853 (3d Cir. 1999); *Methodist Hosps., Inc. v. Sullivan,* 91 F.3d 1026, 1030 (7th Cir. 1996); *Minn. Homecare Ass'n v. Gomez,* 108 F.3d 917, 918 (8th Cir.1997) (per curiam). These decisions suggest that CMS's interpretation of Section (30)(A) is a reasonable one. "

CMS's interpretation does not, of course, *prevent* states or CMS from considering provider costs.[2] CMS believes it is reasonable to consider costs as part of the SPA approval process.

The state furnished documentation which CMS evaluated in the course of its SPA review. In particular, CMS relied on the following factors identified by the state as justification for the proposed SPA's compliance with Section (30)(A)'s access requirement:

- The state conducted extensive provider outreach and research on the proposed rates, issued a Public Notice and had consultation with the Tribes.

- In 2012, the state released for notice and comment the proposed changes in the regulations that would allow the state to update the Medicaid Pharmacy Program's reimbursement methodology for covered drugs. The initial feedback the provider community gave the state was that the rates

[1] *See, e.g.* Br. of the United States as Amicus Curiae, *Douglas v. Independent Living Ctr.,* No. 09-958, at 9-10 (2010); Br. of United States as Amicus Curiae, *Belshe v. Orthopaedic Hosp.,* 1997 WL 33561790, at *6-*12 (1997).

[2] CMS also reserves the right to insist on cost studies to show compliance with Section (30)(A) in certain limited circumstances – particularly when considering a SPA that involves reimbursement rates that are substantially higher than the cost of providing services, thus implicating concerns about efficiency and economy.

were insufficient to reimburse pharmacies engaged in convenience packaging. The state did make revisions to the regulations based on this feedback. The regulations were re-released for public comment in 2013 that proposed an additional mediset dispensing fee.

- The Office of the Inspector General issued the report Review of Drug Costs to Medicaid Pharmacies and their Relation to Benchmark Prices (A-06-11-00002) that found pharmacy acquisition cost of single source drugs ranged from 98.39% of WAC for urban –independent pharmacies to 100.47% of WAC for rural chain pharmacies. As a result of those findings, the state selected WAC +1% as the ceiling reimbursement for single source drug costs. The state believes WAC+1% is consistent with the requirements of Section (30)(A).

- Myers and Stauffer LC (M&S) prepared a Survey of the Average Cost of Dispensing a Medicaid Prescription in the State of Alaska in 2012 for the Alaska Department of Health and Social Services. The survey found that the state would need to revise its current pharmacy reimbursement rates to account for the cost incurred by pharmacies to dispense and acquire prescriptions, market dynamics, and the need to maintain sufficient pharmacy access for Medicaid recipients. M&S took into consideration that should the proposed rule published by CMS on February 2, 2012 be finalized and be implemented, the Medicaid program will be required to transition from EAC or WAC + 8% to a basis that matches actual acquisition cost to (AAC). M&S also applied CMS guidance to the survey analysis noting that Medicaid programs that switch to AAC methodology will need to implement a professional dispensing fee in addition to covering the cost of the drug. The results of the study showed that a single statewide dispensing fee of $16.75 would reimburse the weighted median cost of dispensing prescriptions to Medicaid recipients for non-specialty prescriptions. A tiered system is an alternative approach where two to four variable dispensing fees correspond to ranges in annual total prescription volume of a pharmacy. M &S noted that a tiered system allows dispensing fees to be better matched, on average, to an individual pharmacy's cost of dispensing. Basing the dispensing fee on volume can be a drawback. Low volume may not be a reflection of efficiency. For example, low volume could be due to a store newly opening. A tiered system could also be developed from other attributes such as pharmacy location. This system has the potential to provide positive enhancement for pharmacies for low volume pharmacies located in remote rural areas since these pharmacies are not able to demonstrate efficiency through higher volumes. M&S calculated the weighted median average for the cost of dispensing for pharmacies on the road, pharmacies off the road, and Long Term Care (LTC) institutional pharmacies. M&S found that the weighted median for pharmacies dispensing on the road system to be $13.36. The cost of dispensing for off the road pharmacies was $21.28. For a one week period, the weighted median cost of dispensing for LTC pharmacies was $8.29.

- The state compared its proposed dispensing fee of $13.36 for a pharmacy located on the road to the National Average Retail Price (NARP) survey conducted by CMS.[3] The state found its reimbursement to be 2% higher than the published NARP prices for all 3rd parties. The state feels justified in paying a higher reimbursement than that of NARP because of the higher costs associated with doing business in Alaska.

[3] Effective July 1, 2013, CMS suspended the NARP.

- The state did not rely upon the 2012 Survey of the Average Cost of Dispensing in determining the out-of-state dispensing fee of $10.76. The state averaged the dispensing fee from 5 states using an acquisition cost based reimbursement model.

Applying our interpretation of Section (30)(A) to this proposed SPA, we believe that the information that the state has provided, as described above, is sufficient to support its proposed payment change. Although Section (30)(A) of the Act does not require states to base payment on the costs incurred by providers, the payment proposal is designed to provide payment based on the cost of dispensing and drug acquisition. We believe that the criteria are reasonable given provider feedback, Survey of the Average Cost of Dispensing, OIG report and the NARP comparison. Accordingly, we believe the State plan, as modified by the proposed SPA, will ensure access consistent with Section (30)(A).

CONCLUSION

We conclude that the proposed SPA is consistent with the efficiency and economy requirement in Section (30)(A) of the Act. We have generally considered a proposed payment rate as being inefficient or uneconomical if it was substantially above the cost of providing covered services. *See Pa. Pharmacists Assn'n v. Houstoun,* 283.F.3d 531, 537 (3d Cir. 2002) ("What sort of payments would make a program inefficient and uneconomical? Payments that are too high."). For this reason we do not believe that it is appropriate for states to address potential access concerns by setting rates unreasonably high in relation to costs, such rates would necessarily be either efficient nor economical. Consistent with this view, HHS promulgated Upper Payment Limit ("UPL") regulations that "place an upper limit on overall aggregate payments" for certain types of services. 65 Fed.Reg. 60151-01. Applying our interpretation of the statute to the proposed SPA at issue here, we believe payment under the state plan, will be both economical and efficient, as doing so ensures that providers are not paid substantially in excess of their costs.

Futhermore, we conclude that the proposed payment methodology is consistent with the quality of care requirement in Section (30)(A) of the Act. CMS does not interpret Section (30)(A) of the Act as requiring a state plan by itself to ensure quality of care. As the text of the statute reflects, payments must be "consistent" with quality of care, but they do not need to directly assure quality of care by themselves. CMS therefore believes that Section (30)(A) leaves room to rely on factors external to a state plan to ensure quality of care. In this particular instance, for example, CMS relies on applicable statues and regulations including those promulgated by the Food and Drug Administration, to ensure the quality of covered outpatient drugs provided through the Medicaid program. CMS believes that it is reasonable to assume that covered outpatient drugs provided to Medicaid patients by pharmacy providers will continue to meet FDA quality standards.

Finally, the state's May 18, 2014, effective date is permissible under the Medicaid regulations. Consistent with 42 C.F.R. § 430.20 and 42 C.F.R. § 447.256, a SPA that is approved may become effective as early as the first day of the quarter in which the amendment is submitted; however, Federal Financial Participation is not available until the SPA is approved. (We note that annual appropriations

statues make Federal Financial Participation available as of the first day of the quarter in which a SPA is submitted.)

Based on the foregoing, we believe the state has demonstrated that the proposed payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. Because we find this amendment complies with all applicable requirements, we are pleased to inform you that Alaska SPA 14-006 is approved, effective May 18, 2014. A copy of the signed CMS-179 form as well as the pages approved for incorporation into the Alaska state plan will be forwarded by the Seattle Regional Office. If you have any questions regarding this approval, please contact Jessica Walker at (410) 786-2457.

Sincerely,

[redacted]

John M. Coster, Ph.D.,R.Ph.
Director
Division of Pharmacy

cc: Carol J.C. Peverly, ARA, Seattle Regional Office
Maria Garza, Seattle Regional Office

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

Division of Medicaid & Children's Health Operations

OCT 2 2 2014

William J. Streur, Commissioner
Department of Health and Social Services
Post Office Box 110601
Juneau, Alaska 99811-0601

RE: Alaska State Plan Amendment (SPA) Transmittal Number 14-006

Dear Mr. Streur:

This letter is being sent as a companion to the Centers for Medicare & Medicaid (CMS) approval of Alaska State Plan Amendment (SPA) Transmittal Number 14-006, which modifies pharmacy coverage and reimbursement for covered outpatient and physician administered drugs. This amendment was submitted on April 29, 2014, with an effective date of May 18, 2014.

Regulations at 42 Code of Federal Regulations (CFR) 430.10 require that the State plan be a comprehensive written statement describing the nature and scope of the State's Medicaid program and that it contain all information necessary for CMS to determine whether the plan can be approved to serve as the basis for Federal Financial Participation (FFP) in the state program. The CMS' analysis determined that additional changes related to coverage of the benefits specified below are needed in the Alaska Medicaid State plan.

Attached Sheet to Attachment 3.1-A, Page 3, Clinic Services:

1. The state submitted SPA 13-005 in June, 2013, to address CMS' questions in the companion letter for SPA 12-006 and 13-002, regarding the Clinic Services section of the State plan. The state withdrew that SPA October, 2013, because the state required additional time to reconsider the intent of the SPA. With the withdrawal of SPA 13-005, and recent approval of SPA 13-010 issued with a companion letter, CMS reminds the state to provide a timeline and a formal response to the ongoing questions regarding the *clinic services* section:

    a) In the Clinic Services section, Attached Sheet to Attachment 3.1-A, Page 3, please revise this section to clearly state that ambulatory surgical clinic services and renal dialysis physician clinics are covered under the clinic benefit. Please make sure the language indicates that renal dialysis physician clinics include comprehensive outpatient dialysis and related services, including labs, drugs (erythrocyte-stimulating agents, parenteral iron replacement products, etc.). Please include provider qualifications, prior authorization requirements, and limitations, if any.

Attached Sheet to Attachment 3.1-A, Page 3, Clinic Services (cont.):

b) Please remove the following language from the plan page "Ambulatory surgical clinic services and renal disease physician clinics are provided as separate services."

2. In the Clinic Services section, please revise the plan to include a comprehensive definition and description of Mental Health Clinic Services. Please include provider qualifications, prior authorization requirements, and limitations, if any.

Attached Sheet to Attachment 3.1-A, Page 3, item 10 , Dental Services:

Item 10, reads: "*dental services for recipients age 21 or older are limited to emergency treatment for the relief of pain and acute infection and the following prior authorized additional services up to an annual limit of $1150 per Medicaid recipient.*" Please respond to the following questions related to the state's annual dental limitation:

3. Please clarify whether additional dental services can be provided beyond the monetary limit based on a determination of medical necessity, or is emergency treatment the only option? Will there be an exception or prior authorization process for beneficiaries that require services beyond the limitation? Please explain these two processes.

4. If the limit cannot be exceeded based on a determination of medical necessity:

    a) How will those affected by the limitation obtain the medical services they need beyond the stated limits?
    b) Will recipients be billed and expected to pay for any care that may not be covered?
    c) Will the provider or practitioner be expected to absorb the costs of the provided services?
    d) If the beneficiary's covered services are being reduced, will the beneficiary be notified of their appeals rights per 42 CFR 431.206?

5. How is the state tracking the monetary limitation for recipients?

6. Will both providers and beneficiaries be informed in advance so they know they have reached the $1,150 limit? Please summarize the notification process and provide an example of the notice(s) issued.

7. What is the clinical purpose of this benefit and will that purpose be achieved under this limit? Do the authorized additional dental services provided up to an annual limit of $1,150 meet that purpose?

8. Based on this purpose indicated and using claims data within the last 12 months, what percentage of Medicaid beneficiaries are fully served (i.e., receive all the services they require) under the $1,150 limit? Please provide this information for the following eligibility groups:

    a) Aged, Blind and Disabled
        i) Non-Dually Eligible Adults (for analyses of primary services for which Medicare would be primary payer)
        ii) Dually Eligible
    b) Pregnant Women

c) Parents/Caretakers /Other Non-Disabled Adults

9. If you're unable to provide the data analysis requested above, or such an analysis is not appropriate to the reduction, please indicate support for this proposed scope of services through clinical literature or evidence-based practice guidelines, or describe your consultation with your provider community that resulted in assurance that this proposed scope of services has clinical merit to achieve its intended clinical purpose.

The state has 90 days from the date of this letter to respond to the issues described above. Within that period the state may submit a SPA to address the inconsistencies and/or submit a corrective action plan describing in detail how the state will resolve the issues identified above in a timely manner. Failure to respond will result in the initiation of a formal compliance process. During the 90 days, CMS will provide technical assistance, as needed or required.

If you have questions concerning this letter, please contact me, or have your staff contact Maria Garza at (206) 615-2542 or via email at maria.garza@cms.hhs.gov.

Sincerely,

[redacted]

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Gennifer Moreau-Johnson, gennifer.moreau-johnson@alaska.gov
Deb Etheridge, deb.etheridge@alaska.gov
Margaret Brodie, margaret.brodie@alaska.gov
Christina Cross, christina.cross@alaska.gov

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: 14 - 006
2. STATE: Alaska
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:
May 18, 2014

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:
Social Security Act Section
1927 (e) and 42 CFR 447.518 (P&I)

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $ (~~$~~450,000)
b. FFY 2015 $ (~~$~~1,000,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B Page 7
~~Attachment 4.19-B page 4~~ (P&I)
Attachment 4.19-B page 8a-~~8c~~ page 8 replacement page
Attachment 4.19-B Pages 13
Attached Sheet to Attachment 3.1A page 3
~~Attached Sheet to Attachment 3.1A page 4.2~~

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B Page 7
~~Attachment 4.19-B page 4~~ (P&I)
Attachment 4.19-B page ~~8a-8c~~ 8, 8a, 8b
Attachment 4.19-B Pages 13
Attached Sheet to Attachment 3.1A page 3
~~Attached Sheet to Attachment 3.1A page 4.2~~

10. SUBJECT OF AMENDMENT:
Modify the current coverage of outpatient drugs and payments for the covered outpatient drugs and physician administered drugs

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: Margaret Brodie

14. TITLE: Director, Division of Medical Assistance

15. DATE SUBMITTED: 4/29, 2014

16. RETURN TO:
Division of Health Care Services
4501 Business Park Blvd Bldg L
Anchorage, Alaska 99503-7167

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 4/29/14

18. DATE APPROVED: 10/22/14

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
5/18/14

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Carol J.C. Peverly

22. TITLE: Associate Regional Administrator
Division of Medicaid &
Children's Health

23. REMARKS:

5/02/14: state authorizes P&I change to box 8and 9

5/21/14: state authorizes P&I change to box 6,7,8,and 9

6.23.14:State authorizes P&I change to box 8 and 9
6.20.14: state authorizes P&I change to box 8 and 9

6.13.14: state authorizes P&I change to box 6,8,9
10.08.14: state authorizes P&I change to box 8 and 9

Description of Service Limitations

9. **CLINIC SERVICES:** "Clinic Services" means services provided by state-approved outpatient community mental health clinics that receive grants under AS 47.30.520-47.30.620, state operated community mental health clinics, and mental health physician clinics. Ambulatory surgical clinic services and renal disease physician clinics are provided as separate services.

10. **DENTAL SERVICES:** See Attached Sheet to Attachment 3.1A, Page 3a.

11.a-c. **PHYSICAL THERAPY AND RELATED SERVICES:** See Attachment 3.1A, Page 24a-c.

12.a. **PRESCRIBED DRUGS**

(1) Covered outpatient drugs are drugs:

(a) dispensed only upon a prescription; and

(b) for which the United States Food and Drug Administration (FDA) requires a national drug code (NDC) number; and

(c) Alaska covers outpatient drugs in accordance with Section 1902(a)(54) and 1927 of the Social Security Act.

(2) a compounded prescription if at least one ingredient is a covered outpatient drug as defined in (1) above and the recipient's drug therapy needs cannot be met by commercially available dosage strengths or forms of the therapy; the claim for a compounded prescription is submitted using the national drug code (NDC) number and quantity for each covered outpatient drug in the compound; not more than 25 covered outpatient drugs are reimbursed in any compound.

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. 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 was last updated, to be effective for services on or after 7/1/2013, and is available at:
http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Prescribed Drugs

(a) 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.

(b) The payment for drugs for which the Centers for Medicare and Medicaid has established a specific upper limit amount will be the lowest of the amount billed, estimated acquisition cost, state maximum allowable cost or the federal upper limit plus the dispensing fee.

(c) The payment for drugs for a covered entity described in U.S.C. 256b that indicates it will use covered outpatient drugs purchased through the 340B drug pricing program to bill to Medicaid will be the lower of the submitted actual acquisition cost, the state maximum allowable cost, the federal upper limit, or the estimated acquisition cost plus the dispensing fee.

(d) The payment for drugs for 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 be the lower of the billed amount, the wholesale acquisition cost minus 15 percent, the state maximum allowable cost, or the federal upper limit plus the dispensing fee.

(e) The payment for drugs other than those of (b) through (d) above, and for brand names of multiple source drugs specified by the prescriber in accordance with 42 C.F.R. 447.512 will be the assigned dispensing fee plus the estimated acquisition

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

cost of that drug, which is the wholesale acquisition cost published by First Data Bank as updated weekly plus 1 percent of that amount, the payment will not exceed the lower of the estimated acquisition cost plus the dispensing fee or the provider's lowest charge.

(f) The estimated acquisition cost is the wholesale acquisition cost plus 1 percent.

(g) The payment for compounding prescriptions will be the sum of the costs of each of the ingredients as established under (b) through (e) (above), plus the dispensing fee to reimburse no more than the provider's lowest charge.

(h) The department establishes a state maximum allowable cost for a drug by reviewing the pricing sources, including the wholesale acquisition cost, direct price, or purchase invoices for the drug identified in the First Data Bank file.

(i) Wholesale acquisition cost with respect to a drug or biological, means the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

(j) Practitioner administered drugs are reimbursed at the lower of the billed amount or Wholesale Acquisition Cost plus 1 percent without a dispensing fee.

(k) The dispensing fee is based on the results of surveys of in-state pharmacies' cost of dispensing prescriptions. For each pharmacy, the dispensing fee will be determined using the following schedule:
  (1) for a pharmacy located on the road system, the dispensing fee is $13.36, to be paid no more than once every 22 days per individual medication strength;
  (2) for a pharmacy not located on the road system, the dispensing fee is $21.28, to be paid no more than once every 22 days per individual medication strength; and
  (3) for a mediset pharmacy the dispensing fee is $16.58, to be paid no more than once every 14 days per individual medication strength.
  (4) The dispensing fee for an out-of-state pharmacy is $10.76, to be paid no more than once every 22 days per individual medication strength.

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

(5) A covered outpatient drug dispensed by a dispensing provider will be reimbursed for the drug without a dispensing fee.

(6) In this section,

i. "pharmacy located on the road system" means a pharmacy in this state and is connected to Anchorage by road;

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

iii. "out of state pharmacy" means a pharmacy that is physically located in a state other than this state;

iv. "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 waiver 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 serious mental illness, or a recipient who is a child experiencing a severe emotional disturbance.

(l) A pharmacy may not refuse to fill an interim prescription occurring before the end of the 14 or 22 days as the dispensing fee covers the 14 or 22 days period.

(m) Payment is restricted to drugs supplied by manufacturers who have a signed national agreement or an approved existing agreement under the Medicaid Drug Rebate program of Sec 1902(a)(54) and Sec. 1927 of the Act, and the only drugs supplied by such manufacturers that are not reimbursed are those excluded under Attached Sheet to Attachment 3.1A.

(n) The department will pay, the lesser of the pharmacy's assigned dispensing fee, as specified in section (k) or the submitted dispensing fee.

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

Tobacco Cessation

Pharmacies providing prescribed tobacco cessation medication therapy management through a qualified pharmacist to a recipient with a prescription will be paid the lesser of billed charges or the tobacco cessation counseling fee of $16.00.

Vaccine Reimbursement

For Medicaid eligible individuals through 18 years of age –

1) Administration of Preventive Vaccines is only reimbursed via an Administration fee to participating/enrolled Alaska VFC providers under the Vaccines for Children (VFC) program. Information regarding the VFC program is found on page 66(b) of Alaska's Medicaid State plan.

For Medicaid eligible individuals aged 19 and over –

1) Qualified, enrolled, licensed, Medicaid providers in Alaska practicing within their scope of practice will be reimbursed an administration fee as follows:

2)

a) Physicians will be reimbursed the lesser of billed charges or 100% of the applicable physician CPT code and/or the applicable vaccine CPT code as of the effective date of October 1, 2009, and subsequently modified by any annual/periodic adjustments to the fee schedule.

b) Nurse practitioners and physicians assistants will be reimbursed the lesser of billed charges or 85% of the applicable physician CPT code and/or the applicable vaccine CPT code as of the effective date of October 1, 2009, and subsequently modified by any annual/periodic adjustments to the fee schedule.

c) Pharmacists will be reimbursed the lesser of the estimated acquisition cost or billed charges plus an administration fee of $17.46. Qualified pharmacists as authorized under "Other Licensed Practitioners" at 42 CFR 440.60 are not eligible to receive a dispensing fee for vaccines when an administration fee is paid.

State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/Billing.shtml. The fee schedule was last updated on 02/02/12, to be effective for services on or after 12/01/11.