DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
2201 6th Avenue, Mailstop RX-43
Seattle, Washington 98121

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

Division of Medicaid & Children's Health Operations

DEC 03 2012

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 11-007

Dear Mr. Streur:

The Centers for Medicare & Medicaid Services (CMS) Pharmacy Team recently approved Alaska State Plan Amendment (SPA) 11-007.

Although the Pharmacy Team has already sent the State a copy of the approval for this SPA, the Seattle Regional Office is following up with an additional copy for the reason that we were in receipt of the original, signed amendment request.

Therefore, 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,

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

Enclosure

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

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

Center for Medicaid and CHIP Services

Disabled and Elderly Health Programs Group

NOV 30 2012

William J. Steur, Commissioner
Alaska Department of Health and Social Services
Office of the Commissioner
P.O. Box 110601
Juneau, Alaska 99811-0601

Dear Mr. Steur:

I am responding to your request to approve Alaska State Plan Amendment (SPA) 11-007, received in the Regional Office on September 29, 2011. This proposed SPA would establish a State Maximum Allowable Cost (SMAC) program. Additionally, this SPA proposed a change to the estimated acquisition cost (EAC). The ingredient cost reimbursement changed from the Average Wholesaler Price (AWP) minus 5% to Wholesale Acquisition Cost (WAC) plus 8%. The proposed SPA also changed the dispensing fee from a flat rate methodology to a tiered based on pharmacy volume. The State is also adding an additional mediset unit dose system and changing the dispensing fee for compounded drugs.

While we review proposed SPAs to ensure their consistency with the relevant provisions of the Social Security Act (the 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 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." 42 U.S.C. § 1396a(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 1902(a)(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 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, 2011 proposed rule, CMS believes that the appropriate focus of section 1902(a)(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 service. *See* 42 U.S.C. § 1396d(a) (emphasis added).

[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).

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 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. In this respect, CMS's interpretation differs from that first adopted by the Ninth Circuit in *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997), which established a bright line rule requiring a State to rely on "responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting."[2]

CMS's interpretation does not, of course, *prevent* states or CMS from considering provider costs. Indeed, we recognize that for certain proposed SPAs, such as the SPA at issue here, provider cost information may be useful to CMS as it evaluates proposed changes to payment methodologies. This is in part because, under the authority of section 1902(a)(30)(A), the Secretary has issued regulations prescribing the state rate setting procedures and requirements for covered outpatient drugs. Longstanding requirements in Federal regulations, presently codified at 42 C.F.R. § 447.512, provide that payments for drugs are to be based on ingredient costs of the drug (calculated based on estimated acquisition costs) and a reasonable dispensing fee. When federal regulations expressly base payment rates for a particular service on costs, CMS believes it is reasonable to consider costs as part of the SPA approval process. Moreover, CMS believes that costs are relevant here to the statutory factors of efficiency and economy.

In addition, the State furnished documentation and supplemental information which CMS evaluated in the course of its SPA review. In particular, CMS relied on the following information provided by the State as justification for the proposed SPA's compliance with section 1902(a)(30)(A)'s access requirement:

- The State provided detailed explanations and responses to CMS' request for additional information.
- The State supplied the November 2008 Dispensing Fee Survey (available online at http://hss.state.ak.us/dhcs/PDL/20090824_dispensing_fee_survey.pdf) for the proposed EAC of WAC plus 8 and dispensing fee methodology. The survey indicated that the average discount for single source brand name products was about 7% with greater discount for generic medications. The State indicated that the survey suggested using a reimbursement formula with "a five percent greater discount off AWP for Tier 1 medications and a SMAC program…" in conjunction with the three tier dispensing fee methodology based on total annual prescription volume. The State performed the cost analysis based on the EAC of AWP minus 10%, but due to the sunset of AWP by First Data Bank, the WAC plus 8% was used in place of AWP minus 10%. The survey also indicated that the average adjusted cost of dispensing based on annual Medicaid claim volume was $12.63 and the study findings appears to indicate that the State should continue its variable rate pharmacy provider reimbursement policy to account for cost of dispensing variances which primarily exist because of differences in prescription volume and/or services provided between retail pharmacy providers. The survey also indicated that the cost of dispensing associated with compounded prescriptions was approximately twice the mean adjusted cost of dispensing of the survey.

[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.

- The State issued a Public Notice and Consultation Meeting with Tribes, and obtained assurances that pharmacy providers will continue to provide services to the Medicaid enrollees.

Applying our interpretation of section 1902(a)(30)(A) to your proposed SPA, we believe that the data and information the State has provided is sufficient to support its proposed payment change. Although section 1902(a)(30)(A) of the Act does not require States to base payment rates on the costs incurred by providers, this payment proposal is designed to provide payment based on the estimated acquisition costs of WAC plus 8 of the drugs subject to this proposed plan amendment and dispensing fee, as well as, a SMAC, an additional mediset unit dose system and dispensing fee for compounded drugs when applicable.

Accordingly, we believe the State plan, as modified by the proposed SPA, will be consistent with the access requirement under section 1902(a)(30)(A) of the Act. In particular, the State indicated that the changes are not anticipated to restrict access for Medicaid recipients and since implementation there have been no pharmacies that disenrolled from the Medicaid program.

We also conclude that the proposed SPA is consistent with the efficiency and economy requirements in section 1902(a)(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 Ass'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 neither efficient nor economical. Consistent with this view, HHS has 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. As these provisions reflect, we believe that States must balance access concerns with efficiency and economy concerns. Applying our interpretation of the statute to the proposed SPA at issue here, we believe that paying estimated acquisition cost of WAC plus 8 for the ingredient plus a reasonable dispensing fee, as well as, a SMAC, an additional mediset unit dose system and dispensing fee for compounded drugs when applicable, is both economical and efficient, as doing so ensures that providers are not paid substantially in excess of their costs.

Furthermore, we conclude that that the proposed payment methodology is consistent with the quality of care requirement in section 1902(a)(30)(A) of the Act. CMS does not interpret section 1902(a)(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 statutes 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 through pharmacies will continue to meet FDA quality standards. *But see Orthopaedic*, 103 F.3d at 1497 ("The Department, itself, must satisfy the requirement that the payments themselves be consistent with quality care.").

Finally, the State's implementation of these payment rates on September 7, 2011, was permissible under the Medicaid statute and our regulations, as set forth in 42 C.F.R. § 430.20 and 42 C.F.R. § 447.256. Those regulations provide that a State may implement amendments to its State plan prior to CMS approval. *See* Letter Br. of the United States as Amicus Curiae, *Douglas v. Independent Living Ctr.*, No. 09-958, at 7 (Nov. 11, 2001). Consistent with those provisions, 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 statutes make Federal Financial Participation available as of the first day of the quarter in which a SPA is submitted.)[3]

Based on the foregoing, we believe the State has demonstrated that 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 service are available to the general population in the geographic area.

Because we find that this amendment complies with all applicable requirements, we are pleased to inform you that the Alaska SPA 11-007 is approved, effective September 7, 2011. A copy of the 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 Terry Simananda (410) 786-8144.

Sincerely,

Larry Reed
Director
Division of Pharmacy

cc: Carol Peverly, ARA, Seattle Regional Office
Maria Garza, Seattle Regional Office

[3] *See, e.g.*, P.L. 110-161, Division G – Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008, Title II – Department of Health and Human Services (H.R. 2764, Consolidated Appropriations Act, 2008)("Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.").

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: 11-007

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: September 7, 2011

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: 1927

7. FEDERAL BUDGET IMPACT:
a. FFY 11 0.00
b. FFY 12 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attached Sheets to Attachment 3.1A Pages 3, ~~4~~, & 4.3,
Attachment 4.19-B Page 1, 1.1, 13 (P&I)
Attachment 4.19-B Page 6
Attachment 4.19-B Pages~~7-8c~~ 7-8b (P&I)
Attached Sheet to Attachment 3.1-A, page 3b (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attached Sheets to Attachment 3.1A Pages 3, ~~4~~, & 4.3
Attachment 4.19-B Pages 1 & 6 , 1a.1 , 13 (P&I)
Attachment 4.19-B Pages7-8a

10. SUBJECT OF AMENDMENT:
Pharmacy reimbursement

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kimberli M Poppe-Smart

13. TYPED NAME:
Kimberli Poppe-Smart

14. TITLE:
Deputy Commissioner

15. DATE SUBMITTED:
September 29, 2011

16. RETURN TO:
Alaska Department of Health and Social Services
Office of the Commissioner
P.O. Box 110601
Juneau, Alaska 99811-0601

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2011

18. DATE APPROVED: November 30, 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
September 7, 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
Carol J Peverly

21. TYPED NAME: Carol J.C. Peverly

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

23. REMARKS:

3/20/12 - Pen & Ink changes authorized by the State.

3.21.12 - state authorized removal of page 4 to Attach 3.1A in box 8 & 9
4.24.12 - state authorized pen and ink (P&I) changes for blocks 8 and 9
11.30.12 - state authorized pen and ink (P&I) changes for block 9

FORM HCFA-179 (07-92)

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-d.

12.a. **PRESCRIBED DRUGS**

(1) The following prescribed drugs are included:

(a) drugs, which require a prescription, except for those drugs specifically excluded;

(b) a compounded prescription, if at least one ingredient requires a prescription for dispensing and the recipient's drug therapy needs cannot be met by commercially available dosage strengths or forms
of the therapy;

Claims for compound drugs are submitted using the national drug code (NDC) number and quantity for each compensable ingredient in the compound;

No more than 25 ingredients are reimbursed in any compound; and

Reimbursement for each drug component is determined in drug the Department reimbursement methodology.

(c) an outpatient drug for which payment under CMS' drug rebate program is is not covered, except that the department will pay for

(A) active pharmaceutical ingredients for which a drug rebate is unavailable, if the ingredient is used in a compounded prescription in accordance with (1)(b)of this section; and

(B) laxatives and bismuth preparations in accordance of (1)(f) of this section.

(2) Drugs not otherwise specifically excluded from payment may be covered only after prior authorization has been obtained by the Division. These drugs may be further limited on the minimum and maximum quantities per prescription or on the number of refills to discourage waste and address instances of fraud or abuse by individuals. The Division will ensure a response to each prior authorization request is provided within 24 hours. In emergency situations, at least a 72-hour supply of the covered outpatient prescription may be dispensed.

(3) A pharmacy shall maintain documentation of receipt of prescribed drugs by recipients. The documentation may be kept as a signature log showing which prescription numbers are received or as mailing labels if prescribed drugs are mailed to the recipient.

(4) A provider that dispenses drugs in unit doses to a recipient in a nursing home or other long term care facility shall return unused medications to the pharmacy and the claim shall be adjusted.

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation(s)		Provision(s)
1927 42 CFR 447.201 42 CFR 440	X	(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific categories below)
	X	(h) barbiturates
	X	(i) benzodiazepines
	X	(j) smoking cessation (except for dual-eligibles beginning January 1, 2006.)

(The Medicaid agency lists specific category of drugs below)

X	(k) Drugs for weight gain (Anabolic Steroids); Megace Oral Suspension
X	(l) All cosmetic drugs are covered except hair growth drugs, which are not covered
X	(m) Prescription vitamins: oral vitamins, folic acid, Vitamin A, Vitamin K, Vitamin D, and analogs, Vitamin B Complex when medically necessary.
X	(n) Non-prescription drugs: laxatives and bismuth preparations, vaginal antifungal creams and suppositories, Nonoxyl 9 contraceptives, Bacitracin Topical Ointment, Tobacco cessation drugs, loratadine, omeprozole.

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. 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/FeeSchedule.asp. The fee schedule was last updated on 02/09/12, to be effective for services on or after 12/01/11.

Ambulatory Surgical Clinic Services

Payment is made to ambulatory (outpatient) surgical clinics on a prospectively determined rate. Payment covers all operative functions attendant to medically necessary surgery performed at the clinic by a private physician or dentist, including admitting and laboratory tests, patient history and examination, operating room staffing and attendants, recovery room care, and discharge. It includes all supplies related to the surgical care of the beneficiary while in the clinic. The payment excludes the physician, radiologist, and anesthesiologist fee. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/FeeSchedule.asp. The fee schedule was last updated on 03/02/10, to be effective for services on or after 01/01/10.

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 rehabilitation 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 Behavior Rehabilitation Services 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 the Office of Children's Services Residential Behavioral Health Services Handbook 2010 at: http://www.hss.state.ak.us/ocs/ResidentialCare/docs/2009_BRS_Handbook.pdf

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, or the provider's lowest charge. 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/FeeSchedule.asp. The fee schedule was last updated on 02/17/12, to be effective for services on or after 12/01/11.

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

Dental Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. 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/FeeSchedule.asp. The fee schedule was last updated on 08/10/11, to be effective for services on or after 07/01/11.

Direct Entry Midwife Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. 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/FeeSchedule.asp. The fee schedule was last updated on 02/10/12, to be effective for services on or after 12/01/11.

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 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/FeeSchedule.asp. The fee schedule was last updated on 03/02/12, to be effective for services on or after 12/01/11.

Midwife Birthing Center Services

Rates for midwife services provided in a birthing center are based on the lesser of billed charges, 85% of the Medicare Resource Based Relative Value Scale Methodology used for physicians in the current year, or the provider's lowest charge, plus an amount equal to 50% of the statewide average rate for a normal vaginal hospital birth for the previous state fiscal year. See fee schedule rates for Advanced Nurse Practitioners (p.1 of this attachment) and Direct Entry Midwives (page 1.1 of this attachment) for fee schedule rates.

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 code 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.

Payment for the services of a physician collaborator is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Physician collaborators are a physician assistant, advanced nurse practitioner, physical therapist, occupational therapist, audiologist, speech language pathologist, certified registered nurse anesthetist, or a community health aide III or IV or a community health practitioner certified by the state.

Surgical reimbursement is in accordance with the Resource Based Relative Value Scale methodology except that multiple surgeries performed on the same day are reimbursed at 100 percent of the RBRVS rate for the highest procedure and 50 percent of the RBRVS rate 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 payment between the 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.

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 lessor of the amount billed the general public or 100 percent of the Resource Based Relative Value Scale methodology.

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

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/FeeSchedule.asp. The fee schedule was last updated on 02/02/12, to be effective for services on or after 12/01/11

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 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/FeeSchedule.asp. The fee schedule was last updated on 03/02/10, to be effective for services on or after 01/01/10.

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 multiple source 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 other than those of (b) above, and for brand names of multiple source drugs specified by the prescriber in accordance with 42 C.F.R. 447.331 will be the dispensing fee plus the in state estimated acquisition cost of that drug, which is the wholesale acquisition cost published by First Data Bank as updated weekly plus 8 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. Physician and advance nurse practitioner administered drugs are reimbursed at the lower of the billed amount or Wholesale Acquisition Cost plus 8 percent.

(d) For out-of-state providers the estimated acquisition cost is the wholesale acquisition cost plus 1 percent.

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

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

(f) The department establishes a state maximum allowable cost for a drug if two or more therapeutically equivalent, multisource, non-innovator drugs exist for the given drug; and by reviewing the pricing sources, wholesale acquisition cost and direct price for the drug as identified in the First Data Bank file.

(g) Reconsideration of a state maximum allowable cost price for a drug is subject to the following procedures:
(1) the provider must submit, by electronic mail or facsimile transmission, a completed *Alaska Medicaid MAC Price Research Request Form*, ; the provider must include with the form a copy of the invoice listing the current acquisition cost;
(2) the provider must contact the department in writing and must include all information supporting the request for reconsideration, including the national drug code (NDC) for the drug in question;
(3) a request for reconsideration of a state maximum allowable cost price for a drug will be investigated and resolved no more than three days after the department receives the written contact described in (2) of this subsection;
(4) the provider will be supplied with the names, if available, of one or more manufacturers that have a price comparable to the state maximum allowable cost price;
(5) the state maximum allowable cost price and effective date of that price will be adjusted accordingly, retroactive to the date of service for the state maximum allowable cost price prescription in question, if
i. the department determines that all manufacturers' costs exceed the state maximum allowable cost; or
ii. the provider is able to document that despite reasonable efforts to obtain access, the provider does not have access to the one or more manufacturers whose names the department supplied to the provider;
(6) when the change in state maximum allowable cost price for a price that is adjusted becomes effective, the provider will be informed that the claim may be resubmitted for the price adjustment.

(h) 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.

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(i) 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 low-volume pharmacy, the dispensing fee is $26.74, to be paid no more than once every 28 days per individual medication strength;
  (2) for a medium-volume pharmacy, the dispensing fee is $16.98, to be paid no more than once every 28 days per individual medication strength; and
  (3) for a high-volume pharmacy, the dispensing fee is $12.12, to be paid no more than once every 28 days per individual medication strength.
  (4) The dispensing fee for an out-of-state pharmacy is $3.50, to be paid no more than once every 28 days per individual medication strength.
  (5) A dispensing provider located over 45 miles from a retail pharmacy that is not a covered entity under 42 USC 256b will receive a dispensing fee of $5.73.
  (6) In addition to a dispensing fee, a mediset fee of $5.00 per claim to be billed no more than once every seven days will be paid to a mediset pharmacy for recipients in congregate living homes, recipients on a home and community based waiver, and children eligible for Medicaid services under the Tax Equity and Fiscal Responsibility Act of 1982.
  (7) In this section,
    i. "high-volume pharmacy" means a pharmacy filling more than 85,000 prescriptions a year;
    ii. "low-volume pharmacy" means a pharmacy filling fewer than 29,500 prescriptions a year;
    iii. "medium-volume pharmacy" means a pharmacy filling at least 29,500 and no more than 85,000 prescriptions a year.

(j) A pharmacy may not refuse to fill an interim prescription occurring before the end of 28 days as the monthly dispensing fee covers the monthly period.

(k) 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.

(l) The department will pay, the lesser of the pharmacy's assigned dispensing fee, as specified in section (i) or the submitted dispensing fee. A newly established in-state pharmacy that does not have the information available to establish a fee will be assigned the lowest dispensing fee of $12.12 until that pharmacy can provide 12

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months of prescription data to the department, after which the new dispensing fee will be applied to pharmacy payments within two weeks for future prescription claims.

(m) The compound dispensing fee for an in-state pharmacy is the lowest of the submitted compound dispensing fee; or two times the assigned dispensing fee in (i) of this section.

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Clozapine Medication Therapy Management

Pharmacies providing prescribed clozapine medication therapy through a qualified pharmacist to a recipient with a prescription will be paid the lesser of billed charges or $15 for clozapine medication therapy management fee no more than once every 30 days.

Tobacco Cessation

Phamacies 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 rate paid to an advanced nurse practitioner for services assigned code 99406 in the Current Procedural Terminology, Professional Edition, adopted by reference in 7 AAC 160.900.

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/Billing1.shtml. The fee schedule was last updated on 02/08/12, to be effective for services on or after 12/01/11.

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:
   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.