

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



Division of Medicaid & Children's Health Operations

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

RE: Alaska State Plan Amendment (SPA) Transmittal Number 12-006

Dear Mr. Streur:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Alaska State Plan Amendment (SPA) Transmittal Number 12-006.

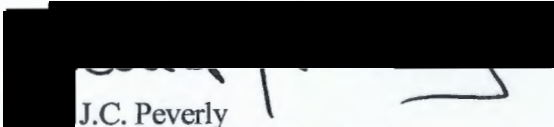
This amendment was submitted to revise the payment methodology for renal dialysis physician clinic services.

This SPA is approved effective April 1, 2012, as requested by the State.

During the review of Alaska SPA 12-006, 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 will release a letter detailing those issues, and provide guidance on timeframes for correction.

If you have any questions concerning this SPA, please contact me, or have your staff contact Treva Wornath at (907) 271-1920 or via email at treva.wornath@cms.hhs.gov.

Sincerely,


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

cc:

Jon Sherwood, Senior Medicaid Policy Analyst for Health Care Services
Gennifer Moreau-Johnson, State Plan Coordinator



Centers of Medicaid and CHIP Services

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 12-006

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 12-006, which was submitted on June 29, 2012. Alaska submitted this SPA to revise the payment methodology for renal dialysis physician clinics.

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 1

1. Please update the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) section of the State plan, Attached Sheet to Attachment 3.1-A, Page 1, to include the following assurance:

"Any Medicaid eligible child under 21 years of age, pursuant to Section 1905(r) (5) of the Social Security Act, has access to necessary health care, diagnostic services, treatment and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."
2. In the above referenced EPSDT section, please include the appropriate service category (e.g., section 1905(a) (6) – Other Licensed Practitioners (OLP)), service description, provider qualifications, and prior authorization requirements, if any. Please note whether the service is offered only under EPSDT. If services available for children under EPSDT are described elsewhere in the plan, there is no need to specify those services in the EPSDT section.

Attached Sheet to Attachment 3.1-A, Page 3

3. 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.).
4. Please remove the following language from the plan page "Ambulatory surgical clinic services and renal disease physician clinics are provided as separate services."

Attached Sheet to Attachment 3.1-A, Page 10

5. Please revise item 16, Attached Sheet to Attachment 3.1-A, Page 10, to "Inpatient Psychiatric Services for Individuals under Age 21." Although 42 CFR 441.151(a)(3) allows under certain circumstances for services to be provided through the age 22, the correct benefit category title is inpatient psychiatric services for individuals under age 21.
6. Item 16, Attached Sheet to Attachment 3.1-A, Page 10, indicates that this benefit is provided with limitations, but does not specify any details of service limitations other than prior authorization of services is required. Please revise the plan page to specify any service limitations.
7. Please remove the following language "*Inpatient psychiatric facility services under 21 benefits provided only to emotionally disturbed children.*" This appears to be the medical necessity criteria and does not need to be in the plan. This language can be replaced with the following: "*Medically necessary inpatient psychiatric facility services are provided in accordance with 42 CFR 440.160 and 42 CFR 441.151.*"
8. Attachment 4.19-B, Page 9, indicates that payment is limited to a non-profit facility accredited by JCAHO for treatment of emotionally disturbed children. Limiting providers to non-profit facilities does not appear to comply with free choice of provider requirements found at 42 CFR 431.51(c)(2). Please provide CMS with the rationale for limiting service providers to non-profit facilities only.

Respiratory Therapy Services

9. In response to informal questions, the state indicated that respiratory therapy services are covered when provided as a component of another service (inpatient/outpatient hospital, durable medical equipment (DME)) and are not reimbursed as a separate service. For CMS to determine the appropriate benefit category for the provision of such services, please provide a description of the activities included in respiratory therapy services and a description of the provider qualifications of the individuals and or entities providing this service.

EPSDT coverage questions for other services were also included in the companion letters for Alaska SPA 11-007 and 12-009. The State must respond to this question in one of the companion letters, and only reference in the response to the other letters where it has been addressed.

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 Jan Mertel at (206) 615-2317 or via email at jan.mertel@cms.hhs.gov.

[REDACTED]

[REDACTED]

Carol Peverly

Associate Regional Administrator

Division of Medicaid and Children's Health Operations

cc: Jon Sherwood, Senior Medicaid Policy Analyst for Health Care Services
Gennifer Moreau-Johnson, State Plan Coordinator

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 12-006	2. STATE Alaska
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE April 1, 2012	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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: Section 1905(a) of the Social Security Act	7. FEDERAL BUDGET IMPACT: a. FFY 12 \$0 \$-2,685,000 (P&I) b. FFY 13 \$0 \$-5,371,000 (P&I)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Page 9 Attachment 3.1-A, Page 7 (added) (P&I) Attached Sheet to Attachment 3.1-A, Page 1 & 2 (added) (P&I)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Page 9 Attachment 3.1-A, Page 7 (added) (&I) Attached Sheet to Attachment 3.1-A, Page 1 & 2 (added) (P&I)

10. SUBJECT OF AMENDMENT:
Renal Dialysis Physician Clinics

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Does not wish to comment
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE: [Redacted]	16. RETURN TO: Alaska Department of Health and Social Services Office of the Commissioner P.O. Box 110601 Juneau, Alaska 99811-0601
13. TYPED NAME: Kimberl Poppe-Stuart	
14. TITLE: Deputy Commissioner for Medicaid and Health Care Policy	
15. DATE SUBMITTED: June 29, 2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 29 2012	18. DATE APPROVED: MAR 13 2013
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2012	20. SIGNATURE OF REGIONAL OFFICIAL: [Redacted]
21. TYPED NAME: Carol J.C. Peverly	22. TITLE: Associate Regional Administrator

23. REMARKS:

12/20/2012 - Pen and Ink (P&I) changes authorized by State to block 7.
02/01/2013 - Pen and Ink (P&I) changes authorized by State to blocks #8 and 9.
02/19/2013 - Pen and Ink (P&I) changed authorized by State to blocks #8 and 9.

Division of Medicaid &
Children's Health

Description of Service Limitations

1. **INPATIENT HOSPITAL SERVICES:** All hospitalizations must be physician-prescribed. The maximum hospital length of stay for any single admission is three days, except for
 - a. psychiatric admissions authorized by the division's utilization review contractor, and
 - b. maternal and newborn hospital stays related to childbirth which are limited to 48 hours of inpatient stay for a normal vaginal delivery and 96 hours of inpatient stay for a cesarean delivery.

Hospitals must secure a continued stay authorization from the division, or its designee, for patients to exceed the three day maximum length of stay.

Selected surgical procedures and medical diagnoses require preadmission certification from the division or its designee. Organ transplants must be prior authorized by the division or its designee. Coverage for organ transplants is limited to kidney, corneal, skin, bone, and bone marrow transplants for adults and children under 21; liver transplants for adults and children under 21 with biliary atresia or other form of end-stage liver disease; and heart transplants for children under 21. Coverage for transplants also extends to coverage for outpatient immunosuppressive therapy. Organ transplants and requisite related medical care will be covered at an available transplant center either within the state or at a transplant center located outside the state that has been authorized by the division.

2. a. **OUTPATIENT HOSPITAL SERVICES:** "Outpatient hospital services" excludes services not generally furnished by most hospitals in the state, such as outpatient psychiatric and substance abuse treatment services.
3. **LABORATORY AND RADIOLOGY SERVICES:** Laboratory and radiology services must be medically necessary and ordered by a physician. Medically necessary diagnostic mammograms are covered. Laboratory tests are performed by a laboratory certified in accordance with the Clinical Laboratory Improvement Amendments (CLIA), at 42 CFR 493. Other laboratory and radiology services are furnished in an office or similar facility other than a hospital outpatient department or clinic and meet the State's provider qualifications. All medically necessary lab and radiology services are furnished without limitations. Selected laboratory and radiology services, however, require prior authorization.
4. a. **NURSING FACILITY:** Placement in a nursing facility providing a skilled level of nursing care requires prior authorization by the Division of Medical Assistance.
4. b. **EPSDT -- ENHANCED SERVICES:**
 - (1) Private duty nursing services are limited to children who are either recently discharged from or admissible to an acute care or long-term-care facility. Services must be prior authorized; provided by a private nursing agency, a home health agency, or a hospice agency, must be less than 24 hours per day; and, when combined with the other Medicaid services the child uses, cannot exceed the cost of institutionalization.

Description of Service Limitations

- (2) Podiatry services are limited to services prescribed by a physician that relate to a specific condition of the ankle or foot.

**AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services.
Provided with No limitations
 Limitations*
Not provided
- b. Skilled nursing facility services.
Provided with No limitations
 Limitations*
Not provided
- c. Intermediate care facility services.
Provided with No limitations
 Limitations*
Not provided
15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.
Provided with No limitations
 Limitations*
Not provided
- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.
Provided with No limitations
 Limitations*
Not provided
16. Inpatient psychiatric facility services for individuals under 21 years of age provided in accordance with 42 CFR 440.160 and 441.151.
Provided with No limitations
 Limitations*
Not provided

* Description provided on attached sheet.

**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.

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 agency's rates for radiology services were updated on July 1, 2012 and are effective for dates of service after on or after that date. The state assures that the requirement of 42 CFR 447.325 regarding upper limits of payment will be met.

Renal Dialysis Physician Clinics

Services at an amount equal to 135 percent of the Medicare end-state renal disease prospective payment system base rate in effect on the date of service multiplied by 1.10, not to exceed the Medicare Upper Payment Limit as noted in 42 CFR 447.321. This maximum allowable payment is a single rate per procedure code. These rates are effective April 1, 2012. Payment for physician services, drugs, supplies, supplies, and other items not included in the Medicare composite rate under the end-stage renal disease prospective payment system are paid according to the methodologies described for those services in this Attachment.

Inpatient Psychiatric Services for Individuals for Children Under 21

Payment to a non-profit facility accredited by JCAHO for residential treatment of emotionally disturbed children is an all-inclusive daily rate established by the department, effective July 1, 2010. The department will pay for therapeutically appropriate, medically necessary diagnostic and treatment services for a child experiencing a severe emotional disturbance, including the following services: individual psychotherapy; group psychotherapy; family psychotherapy; group skill development services; individual skill development services; family skill development services; pharmacologic management and medication administration; crisis intervention; and intake assessment.

Respiratory Therapy Services

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

TN No. 12-006
Effective Date April 1, 2012

Approval Date
Supersedes TN No.

MAR 13 2013
02-003