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State/Territory Name: Alaska
State Plan Amendment (SPA)#: 13-002

This file contains the following documents in the order listed:

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

NOV 27 2013

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 13-002

Dear Mr. Streur:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Alaska State Plan Amendment (SPA) Transmittal Number 13-002.

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

This SPA is approved effective January 1, 2013, as requested by the State.

During the review of Alaska SPA 13-002, 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,

/s/

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

cc:
Deborah Etheridge, Medicaid Policy Analyst for Health Care Services
Gennifer Moreau-Johnson, State Plan Coordinator

DEPARTMENT OF HEALTH & HUMAN SERVICES
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NOV 27 2013

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 13-002

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 13-002, which was submitted on March 26, 2013. 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.

Private Duty Nursing

10. Please include language that Private Duty Nursing (PDN) services are provided in accordance with 42 CFR 440.80.

11. Please separate Hospice services from private duty nursing services and make Hospice into its own separate benefit type. Please provide a separate description for Hospice services and add an assurance that the State complies with Section 2302 (Concurrent Care) of the Affordable Care Act.

12. What kind of "institutional care" is the basis for the cap: Nursing Facility (NF), Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), or Inpatient hospitalization? Is there more than one rate for the "institutional care" identified above (i.e. is there more than one institutional provider or kind of institutional provider used to calculate the cap amount? If so, do they have different cost structures and rates? If so, which institutional provider will be used to determine the amount of the cap? Please explain.

13. How will a physician, who is considering prescribing PDN services for a child, know what the "cost of institutional" care happens to be so that the physician can make the necessary monetary calculations and know that prescribing PDN services are a viable option?

14. If the "cost of institutional care" changes (e.g. due to rate or fee schedule change) and the cap is lowered, how will the physician know of this change so that the prescription for PDN services can be reevaluated and to assure the amount of PDN services delivered stays below the cap?

15. How will the physician know the cost of "the other Medicaid services used by the child" that are not under the physician's control or being provided without the physician's knowledge? How can the physician account for these unknown costs as they are incurred so that the physician can properly calculate the cost of combined PDN and other Medicaid services to assure they are and remain under the "cost of institutional care"?

16. What is the unit of time when measuring whether the costs of all Medicaid services exceed the "costs of institutional care?" Are costs compared monthly, quarterly, yearly?

17. What are the consequences to the prescribing physician if the actual costs of PDN plus the cost of other Medicaid services exceed the cost of institutional care?

18. What are the consequences to the PDN service provider if the actual costs of PDN plus the cost of other Medicaid services exceed the cost of institutional care?

19. What are the consequences to the child/guardian if the actual costs of PDN plus the cost of other Medicaid services exceed the cost of institutional care?

20. How will the state monitor the total costs of care for children receiving PDN services?

21. Will the state notify the prescribing physician, PDN provider or child/guardian if the total costs of care look like they may exceed the cost of institutional care?

22. Can a child qualify for PDN services that would, in combination with other Medicaid services, exceed the cost of institutional care, if the physician nonetheless indicates that the "above the cap" services are medically necessary?

23. If the total cost of PDN and other Medicaid services exceed the cost of institutional care, will the state require the child to be institutionalized in order to obtain the necessary PDN services?

EPSDT coverage questions for other services were also included in the companion letters for Alaska SPA 11-007, 12-006, 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.

Sincerely,

/s/

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

cc:
Deborah Etheridge, Medicaid Policy Analyst for Health Care Services
Gennifer Moreau-Johnson, State Plan Coordinator

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: AK – 13 - 002

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
January 1, 2013

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 13 $1M
b. FFY 14 $1.26M $625,000 (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 9

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

10. SUBJECT OF AMENDMENT:
Renal Dialysis Physician Clinics

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:
[redacted]

13. TYPED NAME: [redacted]

14. TITLE: Director, Division Health Care Services

15. DATE SUBMITTED: 3/26/2013

16. RETURN TO:
[redacted]
Division of Health Care Services
4501 Business Park Blvd., Suite 24, Bldg L
Anchorage, Alaska 99503-7167

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3/26/13

18. DATE APPROVED: 11/27/13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/13

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Carol J.C. Peverly

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

23. REMARKS:

11/14/13- state authorizes P&I change to box 7

FORM HCFA-179 (07-92)

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

Private Duty Nursing for Children Under 21

Payment for private nursing is the lesser of 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

Payment for renal dialysis clinic services is a composite, per-treatment rate of $1,000 for hemodialysis and $500 for peritoneal dialysis. This maximum allowable payment is a single rate per procedure. The rates established for renal dialysis clinic services are all inclusive, except that erythrocyte-stimulating agents and parenteral iron replacement products are separately reimbursable under existing prescribed drug payment methodology. These rates are effective January 1, 2013. To ensure that payment rates are economic and efficient, the State will calculate a clinic upper payment limit as described at 42 CFR 447.321.

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.