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## **Table of Contents**

**State/Territory Name: Alaska**

**State Plan Amendment (SPA) #: 14-0011**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) 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**

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**MAR 09 2015**

Valerie Davidson, Commissioner  
Department of Health and Social Services  
3601 C Street, Suite 902  
Anchorage, AK 99503

**RE: Alaska State Plan Amendment (SPA) Transmittal Number 14-0011**

Dear Ms. Davidson:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number AK 14-0011. This SPA is being submitted in order to request an exemption from the federal requirement of a Recovery Audit Contract.

This SPA is approved with an effective date of October 1, 2014.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Yvonne Martin at (206) 615-3802 or [yvonne.martin@cms.hhs.gov](mailto:yvonne.martin@cms.hhs.gov).

Sincerely,

A black rectangular redaction box covering the handwritten signature of Frank A. Schneider.

Frank A. Schneider  
Acting Associate Regional Administrator  
Division of Medicaid and Children's Health  
Operations

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
14 - 011

2. STATE  
Alaska

FOR: HEALTH CARE FINANCING ADMINISTRATION

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  
October 1, 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:  
Section 1902(a)(42)(B) of the Social Security Act

7. FEDERAL BUDGET IMPACT:  
a. FFY 14                      \$0  
b. FFY 15                      \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 36b-1  
Page 36b-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Page 36b-1  
Page 36b-2

10. SUBJECT OF AMENDMENT:  
Exemption from RAC program

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:

13. TYPED NAME: Jon Sherwood

14. TITLE: Deputy Commissioner for Medicaid and Health Care  
Policy

15. DATE SUBMITTED: Dec., 2014

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: 12/17/2014

18. DATE APPROVED: 3/09/15

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
10-01-2014

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Frank Schneider

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

23. REMARKS:



Revision:

State ALASKA

**PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION**

**4.5 Medicaid Recovery Audit Contractor Program**

<p>Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act</p>	<p>_____ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.</p> <p>_____ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee): The state will pay a contingency fee rate at the same percentage as for overpayments.</p>
<p>Section 1902 (a)(42)(B)(ii)(III) of the Act</p>	<p>_____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).</p>
<p>Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act</p>	<p>_____ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.</p>
<p>Section 1902(a)(42)(B)(ii)(IV)(bb) of the Act</p>	<p>_____ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.</p>
<p>Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act</p>	<p>_____ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.</p>

TN No. 14-011  
 Supersedes  
 TN No. 12-008

Approval Date: 3/09/15

Effective Date: 10-1-14