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State/Territory Name: Alaska

State Plan Amendment (SPA) #: 16-0006

This file contains the following documents in the order listed:

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

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

Financial Management Group

DEC 23 2016

Jon Sherwood, Deputy Commissioner
Department of Health and Social Services
Post Office Box 110601
Juneau, AK 99811-0601

RE: AK State Plan Amendment (SPA) Transmittal Number #16-0006 – Approval

Dear Mr. Sherwood:

We have reviewed the proposed amendment to Attachments 4.19-A, B and D of your Medicaid State plan submitted under transmittal number (TN) 16-0006. This SPA extends the elimination of inflation rate increases for multiple services into a second state fiscal year (2017).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 16-0006 is approved effective as of July 1, 2016. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan page.

If you have any questions concerning this state plan amendment, please contact Tom Couch, CMS' RO NIRT Representative at 208-861-9838 or Thomas.Couch@cms.hhs.gov .

Sincerely,

[redacted]

Kristin Fan
Director

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: 16-0006
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: July 1, 2016

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:
42 CFR 447.201, 42, CFR 447.302

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $ ~~1,250,000~~ ($2,200,000) (P&I) ~~($8,000,000)~~ (P&I)
b. FFY 2017 ~~$5,000,000~~ (P&I) ~~($8,800,000)~~ (P&I) ~~($6,600,000)~~ (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A page 7
Attachment 4.19-B pages 1, 1.1, 2a, 2b, 4, 5b, 6, 7, 8, 8a, and 11a.
Attachment 4.19D page 7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable):*
Attachment 4.19A page 7
Attachment 4.19-B pages 1, 1.1, 2a, 2b, 4, 5b, 6, 7, 8, 8a, and 11a.
Attachment 4.19D page 7

10. SUBJECT OF AMENDMENT:
Updating rates

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: Jon Sherwood

14. TITLE: Deputy Director SOA DHSS

15. DATE SUBMITTED: 9/26/16

16. RETURN TO:
Department of Health and Social Services
P.O. Box 110660
Juneau, Alaska 99811-0660

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/27/16

18. DATE APPROVED: DEC 23 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:
12/5/16: State authorized P&I change to box 7
12/9/16: State authorized P&I change to box 7

FORM HCFA-179 (07-92)

Instructions on Back

Its prospective payment rate will be determined pursuant to Subsection IVa until a rebasing has been executed.

A facility electing to be reimbursed under this Subsection must have an agreement with the department that will not expire, lapse, or be revoked before four facility fiscal years have lapsed. The agreement may be renewed after it expires if the facility still qualifies for reimbursement under this Subsection. A re-basing of the prospective payment rate for the renewed agreement will occur in accordance with Subsection IV.

For a facility that was not reimbursed under the Optional Payment Rate Methodology for Small Hospitals prior to its first fiscal year beginning after December 31, 2000, that elects to be reimbursed under this Subsection rather than Subsection IVa, its prospective payment rate will be based on its 1999 established rate or the rate calculated under Subsection IVa at the election of the facility. If the facility elects its 1999 payment rate, its initial year prospective payment rate during calendar year 2001 will be determined as follows:

The prospective payment rate will be expressed as a per-day rate, composed of separate capital and non-capital components.

(2) The capital component is calculated by dividing the facility's Medicaid capital per adjusted admission reflected in its 1999 payment rate by the average Medicaid length of stay and adjusted for inflation by 1.1 percent per year for each fiscal year after the first year of election and ends at the expiration of its agreement.

(3) The non-capital component is calculated by dividing the facility's allowable Medicaid costs per adjusted admission by the facility's average Medicaid length of stay, and subtracting the capital component from the quotient. The resulting amount is adjusted for inflation at three percent per year for each fiscal year after the first year of election and ends at the expiration of the agreement.

For state fiscal years 2016 and 2017, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

For a facility that was not reimbursed under the Optional Payment Rate Methodology for Small Hospitals prior to its first fiscal year beginning after December 31, 2000, that elects to be reimbursed under this Subsection under the provisions of Subsection IVa, its prospective payment rate for the first year beginning in calendar year 2001 and each year thereafter until the facility's agreement expires will be determined pursuant to Subsection IVa except that the non-capital and capital components of the payment rate will be adjusted annually for inflation, except when the state implements cost containment, after the first year by 3 percent and 1.1 percent respectively. For state fiscal years 2016 and 2017, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

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. Except as otherwise noted in the plan, state developed fees schedule rates are the same for both governmental and private providers. The fee schedule and its effective date are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2016.

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 is published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2016.

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 rehabilitative 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 Behavioral Rehabilitative Service 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 Residential Behavioral Health Service handbook 2013 at http://dhss.alaska.gov/dbh/Documents/TreatmentRecovery/RBRS%20Documents/BRS%20Handbook%2010-28-13.pdf

Certified Nurse Anesthetist 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. Payment rates are set using the Medicare Physician RBRVS payment rates and Alaska's state-specific conversion factor and inflation adjustments. The Medicare Physician RBRVS payment rates are published in the federal register as described under the Physician reimbursement section of this attachment (4.19B). Alaska's state-specific conversion factor and inflation adjustments are published in the Alaska Administrative Code. Changes to the Medicaid rates will only occur when Medicare updates the RBRVS payment rates each year and the department incorporates those changes with its Alaska-specific conversion factor and inflation adjustments the following July 1.

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. The fee schedule and its effective dates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2016.

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

Community Health Aides - Payment for the services of community health aides III and IV or a community health practitioner certified by the state 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 the procedures that do not have an RVU. For EPSDT screening services paid at 100 percent of the Resource Based Relative Value Scale methodology used for physicians. Payment rates are set using the Medicare Physician RBRVS payment rates and Alaska's state-specific conversion factor and inflation adjustments. The Medicare Physician RBRVS payment rates are published in the federal register as described under the Physician reimbursement section of this attachment (4.19B). Alaska's state-specific conversion factor and inflation adjustments are published in the Alaska Administrative Code. Changes to the Medicaid rates will only occur when Medicare updates the RBRVS payment rates each year and the department incorporates those changes with its Alaska-specific conversion factor and inflation adjustments the following July 1.

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. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and is effective dates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated, to be effective for services on or after 7/1/2016.

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. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated to be effective for services on or after 7/1/2016.

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, except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The fee schedule and its effective dates are published at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

The fee schedule was last updated to be effective for services on or after 7/1/2016.

Freestanding Birthing Center Services

Facility rates for freestanding birthing centers are based on 75 percent of the weighted average of the Medicaid hospital inpatient rates paid to the general acute care hospitals in Anchorage, Fairbanks, Juneau, Palmer, and Soldotna with a one day length of stay designated by a primary diagnosis code of 080 as described in the *International Classification of Diseases – 10th Revision, Clinical Modification* (ICD-10-CM, adopted by reference in 7 AAC 160.900; this amount is calculated each state fiscal year using the units of services from the most recent 12 month period starting at the beginning of the state fiscal year's fourth quarter and for which timely filing has already passed and the Medicaid hospital inpatient rates for each facility that are in effect at the start of the fourth quarter of the state fiscal year preceding the July 1 effective date.

Federally Qualified Health Center Services

Payment for Federally Qualified Health Center Services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

Prospective Payment System

All Federally Qualified Health Centers (FQHCs) are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the center's reasonable costs for the center's fiscal years 1999 and 2000.These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is adjusted to take into account any increase or decrease on the scope of services. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each center fiscal year thereafter, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the center. The center must supply documentation to justify scope of service adjustments. For state fiscal years 2016 and 2017, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year with no increase by the percentage increase in the Medicare Economic Index (MEI) for primary care services, but adjusted to take into account any increase (or decrease) in the scope of services furnished by the center.

For newly qualified FQHCs after State fiscal year 2000, initial payments are established by either reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers, and adjustments for increases or decreases on the scope of service furnished by the Center during that fiscal year. For state fiscal year 2016 and 2017, after the initial year for a center, the center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year with no increase by the percentage increase on the Medicare Economic Index (MEI) for primary care services, but adjusted to take into account any increase (or decrease) in the scope of services furnished by the center.

Alternative Prospective Payment System

Beginning with the Federally Qualified Health Center's fiscal year 2003 (FY03), qualifying centers may agree to have their payment rates set using an alternative prospective payment methodology outlined below. The alternative payment methodology agreement between the State and the Federally Qualified Heath Center results in payment to the FQHC of an amount at least equal to the Prospective Payment System payment rate. The State annually evaluates the Medicare Economic Index for primary care services to insure the alternative rate is at least equal to or greater than the PPS rate.

Base rates are calculated prospectively on a per visit basis equal to 100 percent of the inflated average, as explained below, of the allowable and reasonable costs of services furnished during the center's fiscal years 1999 and 2000. The base year costs for FY99 are inflated using the number set out in the first quarter 1999 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket, inflated to 2002.

The center's allowable and reasonable costs for fiscal year 2000 are inflated by the number set out in the first quarter 2000 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket, inflated to 2002. The cost per visit is then adjusted for any increase or decrease in the scope of services, based on documentation supplied by the center to justify such an adjustment. For each subsequent fiscal year, the payment rate is increased using the first quarter publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket, then adjusted for any increase or decrease in the scope of services. At least every four years, the department will change the base year to reflect more current cost data for establishing rates. For the state fiscal years 2016 and 2017, if the center's base year is not changing, then the center's payment rate is not increased using the first quarter publication of Global Insight's *Health Care Cost Review,* Skilled Nursing facility Total market Basket, but is adjusted for any increase or decrease in the scope of services.

Prescription drugs and hospital deliveries are excluded from this payment system because they are subject to different methodologies per state regulation.

If the rate established using the alternative prospective payment methodology does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the center might apply to the deputy commissioner for consideration of exceptional relief from the rate-setting methodology. The application must include the estimated amount necessary to allow reasonable access to quality care, reasons for the relief requested, management actions taken to respond to the situation, corresponding audited financial statements, descriptions of efforts to offset the deficiencies, an analysis of community needs for the services and how Medicaid patients will lose access available to the general public in the same geographic location without this relief, and any other information requested by the deputy commissioner to evaluate the request.

Methods and Standards for

Establishing Payment Rates: Other Types of Care

The alternative payment methodology agreement between the State and the federally Qualified Health Center will result in payment to the FQHC of an amount that is equal to the Prospective Payment System payment rate. The State will annually evaluate the alternative payment rate to ensure that the alternative rate is at least equal to or greater than the PPS rate and that it does not exceed the payment limit se under 42 CFR 447.300 through 447.371.

Initial payments for FQHCs becoming qualified after State FY00 are established by computing a state-wide weighted average payment to other centers or by cost reporting methods if a minimum of six months of cost data for years 1999 and 2000 is submitted. For each subsequent year, the center will be paid the rate it was entitled to the previous clinic fiscal year plus the percentage increase in the Skilled Nursing Facility Total Market Basket and adjusted for increases or decreases in the scope of service furnished by the Center during that center's fiscal year. For state fiscal years 2016 and 2017, if it is a center's subsequent year, the center will be paid the rate it was entitled to the previous fiscal year with no percentage increase in the Skilled Nursing Facility Total market Basket, but adjusted for increases or decreases in the scope of services furnished by the center during that center's fiscal year.

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

Mental Health Clinic Services

Mental health clinic services provided by a community mental health clinic, state operated mental health clinic, or mental health physician clinic (which is a group of psychiatrists or other mental health professionals working under the supervision of a psychiatrist) are reimbursed at the lesser of the amount billed the general public or the state maximum allowable. Community mental health clinics bill the Division of Behavioral Health under a separate reimbursement schedule for performing pre-admission screening and annual resident reviews (PASARR) of mentally ill persons seeking admission to or residing in long-term care facilities. The State assures that the requirements of 42 CFR 447.321 regarding upper limits of payment will be met. Except as otherwise noted in the plan, state developed fee schedules rates are the same for both governmental and private providers of mental health clinic services. The agency's fee schedule was updated 12/26/2008 and is published in the Departments' Community Behavioral Health Clinic billing manual dated 6/29/12 available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Mental Health Rehabilitation Services

Mental health rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable. Except as otherwise noted in the plan state developed fee schedule rates are the same for both governmental and private providers of mental health rehabilitation services. The agency's fee schedule was updated 12/26/08 and is published in the Department's Community Behavioral Health Clinic billing manual dated 6/29/2012 available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Nurse-Midwife Services

Payment is made at the lesser of billed charges, 85% 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 the amount billed the general public or at the Medicare fee schedule. Drugs are covered at 95 percent of the AWP but without a dispensing fee. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of nurse-midwife services. The fee schedule was last updated, to be effective for services on or after 7/1/2016 and is available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Method and Standards for

Establishing Payment

Personal Care Services

Services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable.

Except as otherwise noted in the plan, payment for these services is based on state developed fee schedule rates, which are the same for both governmental and private providers of personal care services. The agency's rate for personal care services were updated on 2/01/2012 and are effective for services rendered on or after 07/01/12. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are included in the fee schedule for personal care services published at http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx

Physical and Occupational Therapy Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for the physicians, the provider's lowest charge, or the maximum allowable for procedures that do not have an established RVU.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of physical and occupational therapy services. The fee schedule was last updated, to be effective for services on or after 7/1/2016 and is available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

Physician Assistants

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 maximum allowable for procedures that do not have an established RVU.

Payment rates are set using the Medicare Physician RBRVS payment rates and Alaska's state-specific conversion factor and inflation adjustments. The Medicare Physician RBRVS payment rates are published in the federal register as described under the Physician reimbursement section of this attachment (4.19B). Alaska's state-specific conversion factor and inflation adjustments are published in the Alaska Administrative Code. Changes to the Medicaid rates will only occur when Medicare updates the RBRVS payment rates each year and the department incorporates those changes with its Alaska-specific conversion factor and inflation adjustments the following July 1.

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 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.

Surgical reimbursement is in accordance with the Resource Based Value Scale methodology except that multiple surgeries performed on the same day are reimbursed at 100 percent 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 the payment between the two 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.

Payment to physicians for in-office laboratory services are reimbursed at the lesser of the amount billed the general public or the Medicare fee schedule.

Payment is made to the independently enrolled hospital-based physician for certain services at the lesser of the amount billed the general public or 100 percent of the Resource Based Relative Value Scale methodology.

Anesthesia services are reimbursed using the 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. 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 7/1/2016 and is available at:

http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp

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 7/1/2016, 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 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) Effective 7/1/2014 the department will use the National Average Drug Acquisition Cost (NADAC), as calculated and supplied by the Centers for Medicare and Medicaid Services, as the state maximum allowable cost for both brand and generic drugs.

(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.

  (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

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

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.

Targeted Case Management

For care coordination services see Substance Abuse Rehabilitation Services.

For family and client support services see Mental Health Rehabilitation Services.

Payment Methodology for all types of Targeted Case Management

Payment for Infant Learning Program Targeted Case management will be based on a monthly encounter rate. The payment rate is calculated prospectively and is based on the following:

Rate Computation Methodology

The prospective rate for payment of case management services is computed annually using the following formula. The data for this computation will be taken from the base year, that is the first full year before providers billed for Targeted Case Management services under this section, and will be inflated forward using an inflation index approved by the Department. For fiscal years 2016 and 2017, the data for this computation taken from the base year will not be inflated forward.

Compute the	Annual Case Manager salary and fringe benefits
Plus	Other anticipated operating cost including travel, supplies, telephone, and occupancy cost
Plus	Direct supervisory cost
Plus	Average indirect administrative cost of provider organization
Divided by	TOTAL STATEWIDE NUMBER OF CASE MANAGERS
Equals	TOTAL STATEWIDE ANNUAL COST PER CASE MANAGER
Divided by	12
Equals	MONTHLY STATEWIDE AVERAGE COST PER CASE MANAGER
Divided by	Statewide average number of children served per month
Equals	TOTAL STATEWIDE AVERAGE MONTHLY COST PER CHILD

The total cost per case manager is the sum of the case manager's reasonable salary, direct supervisory cost, indirect administrative costs of the provider organization, and other operating costs such as travel, supplies, occupancy, and telephone. Dividing the statewide average cost per case manager by twelve (12) months yields the average statewide monthly cost per manager. Dividing the statewide monthly cost per case manager by the average monthly number of children served statewide results in the total monthly cost per child. This is the encounter rate to be used by the provider for billing whenever a Medicaid eligible client receives a TCM service during the month. Providers may only bill the encounter rate once per child per month and must keep documentation to verify this practice.

Payment Methodology for Under 21 Targeted Case Management

Rate Determination: The monthly rate for case management services is based on the total average monthly cost per client served by the provider. The monthly rate is limited to the provider's direct service and administrative costs associated with case management service delivery. The rate is computed by taking the provider's monthly case management cost divided by the monthly number of clients that are provided case management services.

The rate is established prospectively. In the first year, the rate is based on estimates of cost and the number of clients to be served. For subsequent years, the rate is based on actual case management costs for previous years. A cost statement is completed at the end of each state fiscal year once the actual costs incurred have been determined.

Payment Methodology: Payment will be made through MMIS. The provider will bill at the full monthly rate for each client provided case management services during that month. An encounter is a case management activity performed on the client's behalf. Each encounter will be documented to support the billing. Encounters include but are not limited to in-person, phone, mail, email, and other means.

(2) For the first year of the agreement, the capital component is calculated as described in Subsection IVa. The resulting amount is adjusted for inflation at 1.1 percent per year for each fiscal year after the first year of election until the agreement expires.

(3) For the first year of the agreement, the non-capital component is calculated as described in Subsection IVa. The resulting amount is adjusted for inflation at three percent per year for each fiscal year after the first year of election until the agreement expires.

For state fiscal years 2016 and 2017, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

Increases in the capital component of the prospective payment rate for new assets placed in service during the period covered by the agreement will be allowed, based on the provisions in Subsection IVa, if the following conditions are met:

1) The assets placed into service have a value of at least $5,000,000;
2) The facility obtains one or more Certificates of Need for the assets placed into service; and
3) The facility provides a detailed budget that reflects the allowance for the new assets before the prospective payment rate is increased.

In most cases, a facility must use the “exceptional relief” process for appealing department decisions pursuant to Subsection XII. The administrative appeals process outlined in Subsection VIII, will be used only when an appeal relates to one of the following subjects:

1) The facility’s eligibility to elect rate setting under this Subsection;
2) The violation of a term of the rate agreement between the facility and the department;
3) The denial of an increase in the capital component of the prospective payment rate for new assets related to an approved Certificate of Need.

A small facility acute care hospital may elect a new four-year rate agreement as described in this Subsection if the facility becomes a combined acute care hospital-nursing facility. The facility may choose this option within 30 days after the combination of the two facilities. The nursing facility payment rate is calculated as follows: