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State/Territory Name: Alaska

State Plan Amendment (SPA) #: 19-0003

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2) 179 Form
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, WA 98104

Western Division - Regional Operations Group

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

June 25, 2019

Adam Crum, Commissioner
Department of Health and Social Services
3601 C Street, Suite 902
Anchorage, AK 99503-7167

RE: Alaska State Plan Amendment (SPA) Transmittal Number 19-0003

Dear Mr. Crum:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Alaska's State Plan Amendment (SPA) Transmittal Number 19-0003. The SPA was approved on June 21, 2019. This SPA brings the state into compliance with the 21st Century Cures Act regarding the limit on federal financial participation for durable medical equipment, prosthetics, orthotics, and supplies in Medicaid.

This SPA is approved effective June 2, 2019, as requested by the state.

If there are additional questions, please contact me or your staff may contact Frank A. Schneider at frank.schneider@cms.hhs.gov or at (206) 615-2335.

Sincerely,

[redacted]

Wendy Hill Petras
Acting Deputy Director

cc:
Donna Steward, DHSS

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: 19-0003

2. STATE: AK

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
June 02, 2019

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 19 $ 0
b. FFY 20 $ 200,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B page 3 and 3a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B page 3

10. SUBJECT OF AMENDMENT:
Compliance with the 21st Cures ACT and SMD #17-006 regarding the limit on federal financial participation for durable medical equipment, prosthetics, orthotics and supplies in Medicaid.

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: Donna Steward

14. TITLE: State of Alaska, DHSS Deputy Commissioner

15. DATE SUBMITTED: May14, 2019

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 5/14/19

18. DATE APPROVED: 6/21/19

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 6/2/19

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Wendy Hill Petras

22. TITLE: Acting Deputy Director

23. REMARKS:

FORM HCFA-179 (07-92)

Home Health Services

Payment is made at 80 percent of billed charges.

Hospice Care Services

Payment is set and adjusted according to the yearly releases from the Centers for Medicare & Medicaid Services (CMS). Alaska's Medicaid program adjusts the rates by the start of the CY (January 1) immediately after the release of the updated rates by CMS, and these rates are retroactive to the effective date of the CMS material released (usually, October 1 of each year).

Laboratory Services

Payment for laboratory services provided by independent laboratories, physicians in private practice, and hospital laboratories acting as independent laboratories is made at the lesser of billed charges or the Medicare fee schedule. The state Medicaid program recognizes the Medicare fee schedule in place as of June 1 for the annual update of these rates that occurs at the beginning of the next SFY (on July 1). Unlisted procedures are paid at 80 percent of the amount billed to the general public.

Mammograms

Payment is made at the lesser of the billed charges or the Resource Based Relative Value Scale methodology used for physicians.

Durable Medical Equipment, Medical Supplies, and Prosthetic and Orthotic Devices

Reimbursement for durable medical equipment and supplies dispensed by enrolled durable medical equipment (DME) and prosthetic and orthotic (P&O) providers to recipients physically located in the state is made at the lesser of the amount billed, the Medicare rate current at the time of dispensing, or the state maximum allowable posted on the fee schedule.

Reimbursement for dispensed medical supplies and prosthetic and orthotic devices identified as billable only by an enrolled certified P&O provider occurs at the lesser of the amount billed, the Medicare rate current at the time of dispensing multiplied by 1.2, or the state maximum allowable posted on the fee schedule.

Effective June 2, 2019 for prosthetic and orthotic supplies, and July 2, 2019 for durable medical equipment, that do not have an established Medicare rate or established state maximum allowable rate at the time of dispensing, the agency sets rates based on a methodology set in regulation and publishes the rate on the agency's fee schedule site (http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp).

For a covered, non-priced, non-miscellaneous Healthcare Common Procedure Coding System (HCPCS) code, the rate is based on the submitted unaltered final purchase invoice price plus 35 percent for claims submitted on or after June 2, 2019, and before the date the rate is established, until CMS or the department sets a rate:

(1) if the median unaltered final purchase invoice price of the non-miscellaneous HCPCS item for the first 10 claims is less than $5,000, the final rate will be set at
    (A) the median submitted unaltered final purchase invoice price of the first 10 claims plus 35 percent if the first 10 claims were paid to at least two different enrolled providers; or
    (B) the median submitted unaltered final purchase invoice price of the number of claims paid, plus 35 percent after 15 claims are paid but have not been paid to at least two different enrolled providers;

(2) if the median unaltered final purchase invoice price of the non-miscellaneous HCPCS item for the first ten claims is $5,000 or more, the final rate will be set at

(A) the median submitted unaltered final purchase invoice price plus 30 percent if the first ten claims were paid to at least two different enrolled providers; or

(B) the median submitted unaltered final purchase invoice price of the number of claims paid, plus 30 percent after 15 claims are paid but have not been paid to at least two different enrolled providers;

Reimbursement rates for covered items submitted using an HCPCS code, for which CMS or the department has not issued a rate, will be reimbursed at the unaltered final purchase invoice price plus 20 percent.

Used or refurbished durable medical equipment will be reimbursed at no more than 75 percent of the allowed rate for the specific HCPCS code.

Rental rates are set at 10 percent of the total allowed price of the item.

Reimbursement rates for items and services provided to recipients when the recipient is physically located outside of this state will be based on 100 percent of the current quarter's Medicare DMEPOS Fee Schedule established by CMS for these items and services in the state where the item or service was provided.

Reimbursement for unusual or custom equipment may be authorized on a case-by-case basis and may not exceed the authorized amount.

Due to the unique remote geography of Alaska, payment for the reasonable and necessary direct costs of delivery or shipping using the most cost-effective method may be authorized if:

- the recipient resides outside the municipality where the enrolled provider is physically located, and the item or service is unavailable from an enrolled provider in the municipality where the recipient resides;
- the item is durable medical equipment or replacement parts that are specialized or unique to a recipient’s equipment, is shipping from the manufacturer, and the cost of the item exceeds $250; or
- the item is a home infusion therapy product, and the cost of shipping exceeds 40 percent of the sum of the per diem rate for the number of days of therapy represented in the shipment.

For certain durable medical equipment (DME) that are also covered by Medicare, the state will reimburse at no more than Medicare rates current at the time of dispensing. As such, the aggregate amount expended by the state Medicaid program for DME should compare as equal to or less than the aggregate amount which would be paid for such items on a fee-for-service basis under Medicare Part B, including as applicable, under section 1847 of the Act. If payments for DME items subject to statute exceed the FFP limit outlined in section 1903(i)(27) of the Act, the overpayment shall be returned to CMS.