DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

Disabled and Elderly Health Programs Group

August 26, 2019

Ms. Elizabeth Lorenz
Assistant Director
Arizona Health Care Cost Containment System
801 East Jefferson
Phoenix, Arizona 85034

Dear Ms. Lorenz:

We have reviewed Arizona's State Plan Amendment (SPA) 18-0012, Prescribed Drugs, received in the San Francisco Regional Office on November 9, 2018. This SPA proposes to bring Arizona into compliance with the reimbursement requirements in the Covered Outpatient Drug final rule with comment period (CMS-2345-FC).

Arizona SPA 18-0012 includes reimbursement methods that use, among others, the National Average Drug Acquisition Cost (NADAC), plus a professional dispensing fee of $10.11 for covered outpatient drugs, including specialty medications, and $15.34 for compounded prescriptions. This SPA also includes reimbursement rates for 340B drugs, long-term care and specialty drugs, drugs purchased at a nominal price, and physician administered drugs.

In keeping with the requirements of section 1902 (a)(30)(A) of the Social Security Act, we believe the state has demonstrated that their reimbursement is consistent with efficiency, economy, and quality of care, and are sufficient to ensure that care and services are available to Medicaid beneficiaries at least to the extent they are available to the general population in the geographic area. We believe that there is evidence regarding the sufficiency of Arizona's pharmacy provider network at this time to approve SPA 18-0012. Specifically, Arizona has reported to CMS that there are 1,326 of the state's 1,326 licensed in-state retail pharmacies are enrolled in Arizona's Medicaid fee-for-service program. With a 100 percent participation rate, we can infer that Arizona's beneficiaries will have access to pharmacy services at least to the extent available to the general population since Medicaid requires that beneficiaries be provided access to all covered outpatient drugs of participating drug manufacturers with a rebate agreement through a broad pharmacy network. In contrast, commercial insurers often have more limited drug formularies and a more limited pharmacy network.

Based on the information provided and consistent with the regulations at 42 CFR 430.20, we are pleased to inform you that SPA 18-0012 is approved with an effective date of October 1, 2018. A copy of the signed CMS-179 form, as well as the pages approved for incorporation into Arizona's state plan will be forwarded by the San Francisco Regional Office.

If you have any questions regarding this request, please contact Lisa Shochet at 410-786-5445 or lisa.shochet@cms.hhs.gov.

Sincerely,

/s/

John M. Coster, Ph.D., R.Ph.
Director, Division of Pharmacy

cc: Richard C. Allen, Director, Western Regional Operations Group
Brian Zolynas, San Francisco Regional Operations Group
Suzanne Berman, RPH, Director of Pharmacy Services, AHCCCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: Centers for Medicare and Medicaid Services**	1. TRANSMITTAL NUMBER: 18-012	2. STATE Arizona
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2018	

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 Part 447	7. FEDERAL BUDGET IMPACT: FFY 19: $0 FFY 20: $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B Page 2, 2(a), 2(b)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-B Page 2

10. SUBJECT OF AMENDMENT:

Updates the State Plan to comply with the Outpatient Drug Rule

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Elizabeth Lorenz 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034
13. TYPED NAME: Elizabeth Lorenz	
14. TITLE: Assistant Director	
15. DATE SUBMITTED: 11/8/18	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: November 9, 2018	18. DATE APPROVED: August 26, 2019
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2018	20. SIGNATURE OF STATE AGENCY OFFICIAL: 
21. TYPED NAME: Richard C. Allen	22. TITLE: Director, Regional Operations Group Centers for Medicaid and CHIP Services
23. REMARKS:	

State: ARIZONA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Out-of-State Hospitals

Out-of-state hospitals will be paid for covered outpatient services by applying the outpatient hospital fee schedule and methodology.

Specialty Rates

- **Laboratory Services**

AHCCCS'' outpatient hospital fee schedule will not exceed the reimbursement amounts authorized for clinical laboratory services under Medicare as set forth in 42 CFR 447.362. AHCCCS' rates are published on the agency's website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

- **Pharmacy Services**

1. CMS covered outpatient drugs including specialty drugs, that are prescribed by an authorized prescriber and dispensed by a Retail Community, Long-term Care or Specialty Pharmacies, will be reimbursed at the lesser of:
    a. The usual and customary charge to the public, or
    b. The AHCCCS Fee-For-Service's established Maximum Allowable Cost (MAC) for the drug plus a professional dispensing fee, or
    c. The current National Average Drug Acquisition Cost (NADAC) for the drug plus a professional dispensing fee, or
    d. The contracted rates between AHCCCS and the FFS Pharmacy Benefit Manager plus a professional dispensing fee.

All of the above logic will apply to:

1. Drugs Dispensed by an Urban Indian Health Center not participating in the 340B Drug Pricing Program
2. Drugs not dispensed by a Retail Community Pharmacy and dispensed primarily through the mail,
3. 340B entities submitting claims for drugs purchased that are not available for purchase through the 340B Drug Pricing Program.
4. 340B entities dispensing medication to a member and the member is not a patient of the 340B entity.

For drugs purchased through the 340B Drug Pricing Program for members who qualify under the 340B program (FR Vol. 61 #207):

1. 340B entities are required to submit 340B claims at their Actual Acquisition Cost (AAC) for physician administered drugs and drugs dispensed to members.
2. The 340B entity shall be reimbursed at the lesser of AAC or the 340B Ceiling Price plus a professional dispensing fee.
3. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B Contract Pharmacies are not covered, unless the AHCCCS Administration has a contractual arrangement or there is a demonstrated need approved by AHCCCS that requires participation by a 340B Entity Contracted Pharmacy.

State: ARIZONA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

For Federal Supply Schedule purchased drugs, the provider shall be reimbursed at no more than their actual acquisition cost plus a professional dispensing fee.

For drugs purchased at Nominal Pricing, the provider shall be reimbursed at the actual acquisition cost plus a professional dispensing fee.

The professional dispensing fee for all of the above pharmacy reimbursement methodologies is $10.11 for CMS Covered Outpatient Drugs including specialty medications, $15.34 for compounded prescriptions when a CMS Covered Outpatient Drug is an ingredient in the compound.

All Indian Health Service and Tribal 638 pharmacies are paid according to the methodology in Attachment 4.19B "REIMBURSEMENT FOR INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH FACILITIES" section.

State: ARIZONA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Physician Administered Drugs will be reimbursed using the following methodology:

1. Physician billing:
   For non-chemotherapy drugs that are priced on the Medicare Part B Drug Schedule, AHCCCS sets its FFS rates as 95% of the Medicare Part B rate. For chemotherapy drugs and drugs that are not priced on the Medicare Part B Drug Schedule, AHCCCS sets its rates as 80.75% of the Average Wholesale Price.

2. Outpatient Hospital billing:
   For all drugs that are priced on the Medicare Outpatient Prospective Payment System fee schedule, AHCCCS sets its FFS rates as 80% of the Medicare OPPS rate. For drugs that are not priced on the Medicare Outpatient Prospective Payment System fee schedule, AHCCCS sets its FFS rates equal to the FFS rates for physician billing methodology as defined in subsection 1- Physician billing.

3. Ambulatory Surgery Center billing:
   For all drugs that are priced on the Medicare Ambulatory Surgery Center Fee Schedule, AHCCCS sets its FFS rates as 95% of the Medicare ASC Fee Schedule rate.

4. Investigational/experimental drugs are not reimbursed by AHCCCS.

5. AHCCS will meet the reimbursement requirements of Federal Upper Limit (FUL) defined drugs in the aggregate by reviewing that the NADAC does not exceed the FUL levels.

- **EPSDT Services Not Otherwise Covered in the State Plan**

AHCCCS reimburses for chiropractor services and personal care services using a capped fee schedule. Personal care services are described in Attachment 3.1-A Limitations, page 2(a). Payment is the lesser of the provider's charge for the service or the capped fee amount established by AHCCCS. AHCCCS' rates are published on the agency's website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

- **Hospice**

AHCCCS reimburses for the hospice benefit, including routine home care, continuous home care, inpatient respite care and general inpatient care at the AHCCCS Fee Schedule rates published on the agency's website described on page 1, first paragraph of Attachment 4.19B. Effective January 1, 2016:

- Routine Home Care (RHC) will be reimbursed at one of two rates depending on the number of days in the episode of care, such that a higher rate will apply to the first 60 days of RHC and a lower rate will apply to days sixty-one and beyond. A gap of sixty days or more in hospice care will begin a new episode of care.
- A Service Intensity Add-On (SIA) add-on payment will be made for a visit by a social worker or registered nurse when provided during RHC in the last seven days of a member's life for up to 4 hours per day of service. The SIA will be an hourly rate equal to the hourly rate for continuous home care.

The hospice rates are developed based on the Medicaid Hospice Payment Rates and Hospice Wage Indices authorized by section 18 14(i)(c)(ii) of the Social Security Act, and published annually by CMS.