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

April 28, 2020

Ms. Dana Hearn
Assistant Director
Arizona Health Care Cost Containment System (AHCCCS)
801 E. Jefferson, MD#4200
Phoenix, Arizona 85034

Dear Ms. Hearn:

The CMS Division of Pharmacy team has reviewed Arizona's State Plan Amendment (SPA) 19-0004 received by the San Francisco Regional Operations Group on September 6, 2019. This SPA proposes to authorize the state to enter outcome-based supplemental rebate agreements with drug manufacturers for drugs provided to the Medicaid program.

Based on the information provided and consistent with the regulations at 42 CFR 430.20, we are pleased to inform you that SPA 19-0004 is approved with an effective date of July 1st, 2019. 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 Operations Group.

If you have any questions regarding this amendment, please contact Whitney Swears at (410) 786-6543 or Whitney.Swears@cms.hhs.gov.

Sincerely,

/s/

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

cc: Suzanne Berman, AHCCCS State Pharmacy Director
Alex Demyan, AHCCCS State Plan Manager and Health Policy Consultant
Brian Zolynas, San Francisco Regional Operations Group

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 004

2. STATE: Arizona

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 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 Part 447

7. FEDERAL BUDGET IMPACT
a. FFY 2019 $ 0
b. FFY 2020 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A Limitations Page 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A Limitations Page 9

10. SUBJECT OF AMENDMENT

Provides the state the authority to enter into value based payment (outcome-based) agreement s with pharmacy drug manufacturers.

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

13. TYPED NAME: Dana Hearn

14. TITLE: Assistant Director

15. DATE SUBMITTED: September 5, 2019

16. RETURN TO

Dana Hearn
801 E. Jefferson, MD#4200
Phoenix, Arizona 85034

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 6, 2019

18. DATE APPROVED: April 28, 2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL

Digitally signed by James G. Scott -S
Date: 2020.04.28 16:14:44 -05'00'

21. TYPED NAME: James G. Scott

22. TITLE: Director, Division of Program Operations

23. REMARKS

Instructions on Back

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12a. Prescribed drugs.

Medicare Part D drugs are not covered for full benefit dual eligible members, as coverage is provided through Medicare Part D PDPs and MAPDs

Prescription drugs for covered transplantation services shall be provided in accordance with AHCCCS transplantation policies.

AHCCCS only covers over-the-counter medications in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and less costly than the covered prescription medication.

In compliance with Section 1927(b) of the Social Security Act (the Act), the State collects drug rebates in accordance with established policy for drug rebate agreements as provided in Exhibit 12(a) to Attachment 3.1-A.

CMS has authorized the state of Arizona to enter into Outcomes-Based contract arrangements with drug manufacturers for drugs provided to Medicaid beneficiaries. These contracts will be executed on the contract template titled "Outcomes-Based Supplemental Rebate Agreement" submitted to CMS and authorized for use beginning July 1, 2019.

12c. Prosthetic devices.

Prosthetic devices are limited to devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed or malfunctioning portions of the body and which are medically necessary to the rehabilitation of the member.

Covered prosthetic devices for members age 21 and older do not include hearing aids, cochlear implants, bone anchored hearing aids, percussive vests, microprocessors for controlled joints for the lower limbs in addition to microprocessor-controlled joints for the lower limbs, penile implants, and vacuum devices.

Orthotic devices, which are defined as devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body, are covered when the use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare guidelines and the orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.

12d. Eyeglasses.

Eye examinations for prescriptive lenses and the provision of prescriptive lenses under EPSDT services.

Adult services are limited to eyeglasses and contact lenses as the sole prosthetic device after a cataract extraction.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

13a. Diagnostic Services.

Genetic testing is not covered unless the results of the genetic tests are necessary to differentiate between treatment options. Genetic testing is not covered to determine specific diagnoses or syndromes when such determination would not definitively alter the medical treatment of the member.