TRIBAL CONSULTATION MEETING

January 18, 2017
9:00 a.m. – 12:00 p.m. (Arizona Time)
NATIVE HEALTH, 4041 N. Central Avenue, Phoenix, AZ 85012
2nd Floor Conference Room
Conference Bridge: 1-877-820-7831, Participant Passcode: 108903#

NOTIFICATION TO TRIBES:

Good Afternoon,

I'm pleased to announce the first quarterly AHCCCS Tribal Consultation meeting of 2017. The meeting is scheduled for **January 18, 2017** at the following location. The draft meeting agenda is attached, as well as a directional/parking map and list of surrounding restaurants and hotel.

NATIVE HEALTH
4041 N. Central Ave., Phoenix, AZ 85012
Second Floor Conference Room
9:00 a.m. – 12:00 p.m. (Phoenix Time)
Teleconference Number: 1-877-820-7831, Participant Passcode: 108903#
(Visitor parking is available in the parking structure on the property)

Please inform me if leaders from your tribe will attend this meeting as it is AHCCCS Director Betlach's practice to recognize tribal dignitaries. Starting with this meeting, AHCCCS will no longer provide meeting packets. Instead, meeting materials will be posted to the AHCCCS website a few days prior to the meeting. You can download meeting materials at this link: http://www.azahcccs.gov/tribal/consultations/meetings.aspx.

Thank you in advance for your participation in this important meeting.

Wishing you all the best in 2017!

Bonnie Talakte
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AGENDA

AHCCCS TRIBAL CONSULTATION MEETING

With Tribal Leaders, Tribal Members, Indian Health Services, Tribal Health Programs Operated Under P.L. 93-638 and Urban Indian Health Programs

Date: January 18, 2017
Time: 9:00 a.m. – 12:00 p.m. (Arizona Time)
Location: NATIVE HEALTH, 4041 N. Central Ave., 2nd Floor Conference Room Phoenix, AZ 85012
Conference Call-In: **1-877-820-7831** Participant Passcode: **108903#**

TIME	TOPIC	Presenter
9:00 - 9:20 a.m.	Welcome	Beth Kohler, *AHCCCS Deputy Director*
	Opening Prayer	John Molina, M.D., J.D., *Native Health Corporate Compliance Officer*
	Introductions	Deputy Director Kohler
9:20 – 9:40 a.m.	Overview of NATIVE HEALTH Services	Walter Murillo, NATIVE HEALTH Chief Executive Officer
9:40 – 10:10	Senate Bill 1092	Deputy Director Kohler Mohamed Arif *Waiver Manager*
10:10 – 10:50	AHCCCS Updates: • Traditional Healing • 1115 Waiver Update • Budget	Deputy Director Kohler
10:50 - 11:00 a.m.	Disproportionate Share Hospital (DSH) Payments	Amy Upston, *Hospital Finance Administrator*
11:00 - 11:25 a.m.	Legislative Update and Tribal Court Involuntary Treatment Legislative Proposal	Christopher Vinyard, *Chief Legislative Liaison*
11:25 - 11:40 a.m.	AHCCCS Medical Policy Manual (AMPM) and AHCCCS Contractor Operations Manual (ACOM) Policies	Deputy Director Kohler
11:40 - 11:55 a.m.	Specialty Drugs (High Cost)	Suzanne Berman, *Pharmacy Program Administrator*
11:55 - 12:00 p.m.	Announcements/Wrap-Up/Adjourn	Deputy Director Kohler

Next Meeting: April 20. 2017, San Carlos Apache Health Care Corporation

ATTENDEES:

Tribes	Gila River Indian Community: Priscilla Foote Havasupai: Mark Standing Eagle Hopi Tribe: Laverne Dallas, Brendalee Lopez Navajo Nation: Jonathan Hale Pascua Yaqui Tribe: Reuben Howard White Mountain Apache Tribe: Abilene Burnette
I/T/Us	Fort Defiance Indian Health Board: Terrilynn Nez-Chee Native Health: Walter Murillo, John Molina Navajo Area IHS: KL Dempsey Phoenix Area IHS: John Meeth, Dave Civic, Doreen Pond San Carlos Apache Tribe: Vicki Began, Melinda White Tohono O'odham Nation Medical Center: Dan Marino Tuba City Regional Health Care Corporation: Yolanda Burke, Melverta Barlow, TJ Riggs, James Brant Young Winslow Indian Health Care Corp.: Kelly Sagan, Alutha Yellowhair
Other	Arizona Advisory Council on Indian Health Care: Kim Russell, Brenda Martin Cenpatico: Sheina Yellowhair, Julia Chavez Health Choice Integrated Care: Holly Figueroa, Gabriel Yaiva Mercy Maricopa: Faron Jack Mental Health of AZ: Chuck Goldstein Native American Connections: Janel Striped Wolf, Juanita Denetclaw, Alyssa Paone Native Resource Development: Jermiah Kanuho NRDCI: Yvonne Toledo Vitalyst: Liz Grey, Marcus Johnson, Jesse Walbere
AHCCCS Representatives	Beth Kohler, Elizabeth Lorenz, Bonnie Talakte, Elizabeth Carpio, Markay Adams, Mark Carroll, Albert Escobedo, Karen Grady, Kyle Sawyer, Lorie Mayer, James de Jesus, Tricia Krotenberg

MEETING SUMMARY

All meeting materials and presentations can be found at the AHCCCS Tribal Consultation website: https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html

TOPICS	SUMMARY
Overview of NATIVE HEALTH Services	**Walter Murillo, Chief Executive Officer,** provided an overview of the services provided at NATIVE HEALTH, an urban health facility, operating in Phoenix, AZ. Mr. Murillo indicated that NATIVE HEALTH is a Federally Qualified Healthcare Center (FQHC) urban Indian Health Program and is also a 330 HERSA funded Community Health Center that provides holistic, patient centered, culturally sensitive health and wellness services. NATIVE HEALTH has grown from a small clinic founded in 1978 to its current location on Central Avenue. Mr. Murillo provided information on the many community partnerships and programs they have in an effort to provide health service options for their clients.

Senate Bill 1092	**Beth Kohler, AHCCCS Deputy Director**, provided an update on a separate waiver request that AHCCCS is required to submit annually as mandated by the Arizona State Legislature in regard to provisions that were included in the 1115 Demonstration Waiver submitted to CMS in 2016, but were not approved. A separate waiver is due March 30 of every year. The presentation provided information on the potential implications of the separate waiver. Feedback is requested. The provisions required to be in the waiver include;
	• A work requirement in which able bodied members must be employed, must actively seek employment to be verified by AHCCCS and attend school or a job training program, or both, at least 20 hours per week.
	• A lifetime enrollment limit of 5 years. This applies to adults age 19 and older "physically and mentally capable of working". There are no exemptions for American Indian members.
	• Other requirements include;
	  ○ Cost sharing requirements to deter use of ambulance services for non-emergency transportation when not medically necessary.
	  ○ Requires persons to verify compliance with work requirement monthly
	  ○ A 1-year ban for making false statements regarding compliance with work requirements or knowingly failing to report change in income.
	Public hearings/forums are scheduled in January. More information about the proposed waiver amendment, including the proposed waiver application and the full public notice process, can be found on the AHCCCS website at: https://azahcccs.gov/Resources/Federal/sb1092legislativedirectivewaiverproposal.html. Comments and questions can be submitted to PublicInput@azahcccs.gov or by mail to AHCCCS c/o Office of Intergovernmental Relations; 801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034. All comments must be received by February 28, 2017.

Questions/Answers/ Comments	**Q:** Does the clock start ticking after the waiver is approved? **A:** Yes, the way the legislation is written, any enrollment prior to the approval date of the waiver doesn't count toward the 5 year limit. We only start counting toward that 5 year limit after the waiver is approved. ∞ **Q:** I need clarification on the lifetime limit and no exemption for American Indian members. **A:** The legislation establishes very specific exemptions for certain populations and enrollment period and it explicitly does not exempt American Indian members from the work and lifetime limit requirements. There is no exemption as part of the legislation that was passed by the legislature several years ago. ∞ **Q:** If it were to pass this year, you're saying 10/1/17 would be the operative date? **A:** The earliest we would be able to operationalize this is 10/1/17. But waiver negotiations can take much longer than that, and that would be only if CMS approves it. They've never approved a lifetime limit or a work requirement that could end coverage. But this is a new administration and we don't know what the approval process will look like or the timing of the process. ∞ **Q:** So 10/1/22, is this a period when the clock starts ticking? **A**: Let's say the approval was effective 10/1/17 - nobody would hit the 5 years until 10/1/22. ∞ **Q:** The last time I heard this presentation, I remember that American Indians were excluded from this. Now you're saying that we're not excluded. This was packaged as part of our larger waiver submittal for the period beginning 10/1/16. It included the AHCCCS program which included exclusion for AI's. This legislation does not include exclusion for AI's. **A**: I don't remember that. American Indians are not required to participate in the AHCCCS CARE

program and that might be what you're thinking of.

∞

Q: How do you propose that this applies to tribal lands, sovereign nations? If it's a state law, how does it apply?
A: This governs the AHCCCS program and many tribal members are enrolled in AHCCCS. It applies equally to tribal and non-tribal populations.

∞

Q: How is it considered at AHCCCS, we are an underserved population, we may need to have longer than 5 years for these types of services. What is the position of AHCCCS when we have these tribal consultations? Is it just checking a box to say we had tribal consultation and showing the comments? They can't do anything to change things. What is the point of the consultation?
A: It's much bigger than a checked box. We consider all the feedback that we get. The legislation does not include an exemption but we want your comments about the potential impacts so we can have that conversation with CMS. CMS could consider other options based on input from tribal partners and other stakeholders. This conversation is not just a formality. It's critical that we capture your comments and submit them to CMS so they have a good sense of the impacts and other options.

∞

C: My position on this issue is although 1092 is already passed, that's not to say that tribes can't try to change this. This is why we have elected officials. That's why I came down here as a tribal leader to collect information, take it back and formulate a position. So ITCA would be an entity to introduce legislation. We can also make that recommendation to CMS as well. Going forward, everyone under IHS gave recommendations for budget. Tribal leadership should go, present, and have meetings with Ms. Verma to express concerns about this. Use data to show why they should be set apart from this law. It's all contingent upon teamwork. If tribal consultation is there and they're asking for comment, we should give comment. Everyone needs to submit a sentence or a paragraph, a coordinated initiative to generate discussion and further political power through this system.

∞

C: We are very concerned with this proposal not only because people could fall off Medicaid and it flies in the face of the data we have. It does contradict what this administration stands for which is providing access to care to communities most in need. Even when you look at CMS' previous letter, they said these proposals undermine what Medicaid is all about. We look forward to providing written comment and we encourage everyone else to also.

∞

Q: Do you have a definition on schools and job training programs?
A: At this point we do not. The current exemption applies to students attending school or job training more than 20 hours a week, we don't know if that's just class time or time beyond that.

∞

Q: We have issues with transportation and this is a big concern. Also, when is the Flagstaff forum?
A: January 30th. Information is posted on website.

∞

C: Nonprofits have been reticent to get involved in debates like this out of fear of losing nonprofit status. Rule is if you're not spending more than 15% of money doing advocacy, you're not in danger. Consult with your own attorneys.

∞

Q: Does the foster children exemption (lifetime limit does not apply to former foster children up to the age of 26) apply to state only or tribal?
A: It's not specified in legislation.

∞

Q: If tribes want to ask representatives to write a bill to amend SB 1092 so there's an exemption

	for American Indians, this should be considered. This statute requires AHCCCS to keep applying for this every single year. You will submit this request by March 30. Let's say its implemented 10/1/17. But if tribal leaders are successful in getting exemption for AI's legislatively, how would this work? **A:** Timeline depends. If legislation was this session, we could ask CMS via waiver request to comply with new legislation. If legislation happened after approval, we'd send a waiver amendment requesting CMS to reflect this. ∞ **Q:** There are other exemptions that need to be clarified like with foster children (does this apply to those in tribal care?). **A:** From tribal participant: I'd be happy to assist Tribes in taking another look at current statute to provide recommendations. We will include all these comments in our submittal. I encourage you to submit written comments via email or mail.
AHCCCS Update **Questions/Answers/ Comments**	**Traditional Healing:** **Kitty Marx, CMS Director of the Division of Tribal Affairs in the Office of Intergovernmental Affairs,** informed participants that CMS received the AHCCCS proposal for its support of reimbursement for traditional healing and has been looking to see how the services can be reimbursed under Medicaid. She suggested utilizing the Traditional Healing Workgroup, whose task would be to map out which of the traditional healing services in the proposal are already covered under the state plan. She indicated there might be a more efficient way of securing reimbursement for services. She used an example of talking circles which could be interpreted as a counseling service which is a covered service and could be reimbursed. Next steps will be to reconvene the Workgroup to map out the traditional healing services, compare the services in the state plan and determine to what extent AHCCCS can fit the services into covered services. **Q:** If the Workgroup cannot identify an existing covered service that will encompass services identified by the Workgroup, what will be the path toward coverage of that service? **A:** Ms. Marx: We will need to discuss that further. **Q:** Two of the services, sweat lodge and Native American Church, can be categorized as group therapy. Are we looking at changing the language? Does the language need to be changed to fit into a Western approach which is a non-traditional approach? **A:** That's what the workgroup needs to map out. There are broad descriptions in the Medicaid state plan of covered services. There is no intent to change the actual services being provided. It's finding a vehicle that we can use our authority under the state plan provided by the federal government that outlines when we can reimburse the services. It's a matter of how we can fit the services that fall under traditional healing into that definition of covered services. **Waiver Update:** Highlights of the AHCCCS Update include: American Indian Medical Home (AIMH)**:** CMS has identified a path that doesn't involve the use of a waiver for the approval of the AIMH. The process AHCCCS will use to gain authority is through the state plan that will look similar to the AIMH proposal using 1932 authority which establishes a primary case management process for reimbursement. Traditional Healing: See Kitty Marx presentation. DSRIP: The Targeted Investment Program Proposal, alias for the DSRIP program, was approved by CMS in the amount of $300M over the term of the Waiver. The proposal targets children and adult integration at the provider level to include individuals transitioning out of the justice system. Potential Impact ACA Changes: Two (2) scenarios were presented in regard to the potential for ACA repeal and replacement:

1. A complete repeal with no replacement will cost the state $3.2B. 425,000 Arizona AHCCCS members will loose coverage.
2. Impacts to the matching rate the state collects for the 100-138% expanded population. The funding for this group will go away and enrollment will be frozen. 0-100% childless adult population will continue. For either, it will cost the state $1B.

- Ohio Sate Medicaid Analysis on Medicaid Expansion:
  - Reduced uninsured rate to lowest ever – 89% had no coverage
  - Improved access to care - inappropriate use shifted – new diagnosis of chronic issues
  - Nearly half reported improved health and only 3.5% reported worsening
  - One third met screening criterial for depression or anxiety and they reported higher level of improvement
  - Coverage has allowed participants to better pay for other necessities
  - Supported employment and job seeking

-Replacement strategies currently being discussed at the federal level:
- Block grants or PMPM contributions from the federal government. Transferring Medicaid from a historical entitlement structure to more a managed capped federal contribution. The impact depends on what the structure looks like.
- Risk Transfer Challenges to Arizona:
  - Previously expanded population– loss of federal funds
  - Voter-Protected coverage requirements (will not be able to avoid "available funding" in perpetuity)
  - Overall lower per capita income to support programs and risk
  - Large American Indian population – fed $
  - Particularly vulnerable in recessions (see Great Rec.)
  - Ongoing instability due to funding pressure will undermine managed care delivery system
  - Lower-cost state
    - Fewer optional benefits (e.g., no dental)
    - High rates of HCBS
    - Aligned Duals
    - Low pharmacy spend
    - Mature managed care – for almost all populations
    - Delivery system performs well
    - Few special payments funded with non-state $

-How will Arizona manage the risk? What levers do states have?
- Changes will be states' responsibility and many will be very politically challenging:
  - Reducing Benefits
  - Reducing Eligibility
  - Reducing Payments
  - Increasing Cost Sharing
  - Program Administration
- Will likely be annual discussion as part of state budget negotiations

-Block Grant/PMPM policy questions for American Indian Population:
- How is the 100% federal funding for I.H.S./638 services treated?
- Implications of states making coverage level changes
- What are the implications for the non-I.H.S./638 services that AI members receive?
  - Currently, AI members receive same benefits that apply to AHCCCS members
  - If financing for Medicaid changes, how is AI population funded?
  - If states make program changes (e.g., benefits), how do those apply to AI members?
    - Currently no differentiation; will depend on financing

	<u>FY 2018 Budget:</u> • Executive funds caseloads and some limited inflation • Includes funding to restore emergency dental with $1,000 member cap per year • Includes resources to pursue opioid epidemic strategies • Includes recommendation expansion of newborn screening to include Severe Combined Immunodeficiency (SCID) – rare genetic disorder that if not detected and treated early can be deadly <u>Proposition 206:</u> -AHCCCS increased rates to select HCBS providers, nursing facilities and behavioral health respite providers by 7% to provide funding associated with minimum wage requirements of Proposition 206. -AHCCCS is a defendant in litigation surrounding the constitutionally of the proposition. AHCCCS takes no position on the constitutionality but are obligated under Medicaid to continue access to services for our members. AHCCCS felt the need to increase the rates to continue to assure access. -Rate increases went into effect January 1, 2017.
<u>Questions/Answers Comments</u>	**Q:** Is the state making a contingency as part of the budget for having to fulfill its prop 204 obligations? **A:** The budget assumes that everything stays the same. Depending on action at federal level we'll make decisions on how to move forward with that population. For 0-100% AI members it's 37,338 enrolled members and for 100-138% it's 5,533. ∞ **Q:** Is the state in litigation over prop 204? **A:** Right now, the prop 204 population is funded, so it depends on what happens at the federal level. It's important for individuals to communicate with their policy makers about potential impact here in AZ. ∞ **Q**: If FMAP changes, is reduction in eligibility immediate? **A**: It would be on effective date of FMAP change (it would not be on enactment date but upon effective date). ∞ **Q:** The Governor has come out with his budget but the legislature has not. What's the timeline re: budget? **A**: The process is; 1) Appropriations committees will hear presentations by the legislative staff (JLBC) about a baseline budget for governor's budget and legislature's budget. 2) There will be a time for public comment. 3) Budget Committee then makes recommendations on what should be included then draft bills for the floor. 4) There are amendments to bills, votes taken in each chamber. 5) The governor signs. ∞ **Q:** Regarding the $1000 cap on emergency dental, is there an opportunity to work with the sponsor of the bill for emergency dental which will allow the American Indian population to be excluded from the FMAP capped at $1000? **A:** I recommend contacting the governor's office first about excluding American Indians since it's the Governor's proposal. Also, it would require a waiver from CMS because it would treat a population or a facility differently. 100% FMAP only applies when services are received at an IHS or 638 facilities. If services are received elsewhere, regular FMAP applies. ∞ **Q**: What would happen if we were designated as FQHC's? **A**: I heard that CMS announced that 638s could become FQHCs. We need more guidance from the federal government and it is much more complicated that what CMS said. We can't simply register everyone as FQHCs - we need to sit down and think about implications. CMS said we

	could put in state plan that AIR is the FQHC rate they would be paid. However, there are limits on numbers of visits you can receive at FQHCs and other limitations on FQHC services so we need to understand what CMS is really saying or is there a different way to accomplish it, and also what are implications of being FQHCs? We need additional details and need to map this out. We have additional guidance so we will review that.
Disproportionate Share Hospital (DSH) Payments **Questions/Answers/ Comments**	**Amy Upston, AHCCCS Hospital Finance Administrator**, indicated that the Disproportionate Share Hospital (DSH) program provides payments to hospitals that serve a large number of individuals who are on Medicaid or are uninsured. Currently the DSH language appears in the 1115 Waiver. CMS has requested that AHCCCS move the DSH language from the Waiver to the State Plan. IHS/638 facilities receive a total of approximately $60,000 each year from DSH payments. Typically 10 IHS/638 facilities apply annually for DSH. Although the DSH is being moved from the Waiver to the State Plan, AHCCCS does not intend to make any changes which would impact the payments for the IHS/638 facilities. No questions were asked.

Tribal Court Involuntary Treatment Legislative Proposal	**Kyle Sawyer, AHCCCS Legislative Liaison**, informed participants that the legislative proposal for this session is HB-2084, the Tribal Court Involuntary Treatment proposal. The need for this proposal was brought to AHCCCS' attention through tribal stakeholder engagement. At issue is the current statutory process required for tribal members to receive court ordered treatment outside of tribal lands. Tribal members often wait up to 48 hours or more for treatment. By not receiving immediate or timely treatment, tribal members can be of danger to self and others. HB-2084 seeks to take a positive step in addressing this issue.
	
	Civil commitment is defined as a legal process to determine whether a person with mental illness should be ordered to receive court ordered evaluation (COE) or court ordered treatment (COT). A civil commitment is not a criminal proceeding or conviction. The criteria for civil commitment (COE/COT) are that a person is:
	• Unwilling or unable to accept voluntary evaluation/treatment; and
	• As a result of mental illness is:
	  o A danger to self;
	  o A danger to others;
	  o Gravely disabled (unable to take care of one's basic physical needs); or
	  o Persistently or acutely disabled (likely to suffer severe mental or physical harm because of impaired judgement caused by a mental health condition).
	• Civil commitment is not available for persons who have a substance abuse and/or alcoholism condition.
	Other information presented included steps for initiating civil commitment, what happens after court ordered evaluation, what is involved in court ordered treatment and tribal court order recognition.
	
	AHCCCS Legislation – HB 2084:
	• HB-2084 amends A.R.S. 12-136 to allow a mental health treatment facility to admit a tribal member pending recognition of the tribal court order.
	• It requires the mental health treatment facility to discharge and provide transportation for the member back to the jurisdiction of the tribal court if the order is not filed with the clerk of the Superior Court by the close of business on the next day the court is open.
	• Updates the statute to reference AHCCCS, rather than the Department of Health Services (DHS) in regard to intergovernmental agreements.
	• HB-2084 **does not** affect court ordered evaluation and **is not** a mandate on any tribe,

Questions/Answers/ Comments	provider or the courts. Due to the varying dynamics and timeframes with getting tribal court orders recognized in Superior Court, the AHCCCS legislative proposal seeks to accomplish three things: o Improve processes and efficiencies within state government; o Reduce unnecessary incarceration for our tribal members; and o Ensure timely delivery of behavioral health services **Q:** Can the COT process apply to a developmentally disabled tribal individual on a reservation, a Medicaid member in the Medicaid system on tribal lands? If the provider is not responding to the member in a crisis situation, would the process apply to that individual? **A:** If the member is found to be within the parameters of the COE. Medicaid enrollment will not have any impact whatever process is used for the COE and COT. Whatever the process used through tribal courts will apply. ∞ **Q:** What is being done by the courts? **A**: They are able to accept faxes in many county courts. None currently allow e-filing for COT orders. This bill is the first step in making this process more efficient. ∞ **Q:** Is there a training mechanism to be put into place to educate tribal courts and county courts about this? **A**: Our legislation doesn't address training; we didn't hear that during stakeholder engagement. I would defer to courts on their training. We're a different branch of government. **A:** The court responded to that and courts are open to these discussions and willing to expand their training etc. ∞ **C**: I compared the first version with this one and the sentence that's not included now is the immunity piece to the providers, "May" admit a patient. So the decision is up to the provider whether they want to accept the patient. The big part of easing the provider's minds was the immunity. This is a first step but taking out the immunity part might not move things forward in this regard.
AHCCCS Medical Policy Manual (AMPM) & Contractor Operations Manual (ACOM) Policies **Questions/Answers/ Comments**	**Beth Kohler** referenced the handout that summarizes the medical manual and contractor operations manual policy changes that have gone through the Tribal Consultation process. The policies listed in the handout were presented at the 10/20/16 tribal consultation meeting. The handout is the summary of the policies and when the policies became effective. If you have additional comments please send to Bonnie Talakte, AHCCCS Tribal Liaison. No Questions were asked
Specialty Drugs (High Cost)	**Suzanne Berman**, **Pharmacy Program Administrator,** informed participants that CMS issued the *Medicaid Outpatient Drug Rule*. The rule moves the reimbursement methodology for Fee-for-Service pharmacy claims to an Actual Acquisition Cost Model for the drug, plus a Professional Fee. The professional fee was previously known as the dispensing fee. 1. AHCCCS is required to submit a state plan amendment to CMS that details how various Pharmacies and types of purchased drugs are reimbursed. AHCCCS also has to explain how IHS and 638 tribal pharmacies are reimbursed. For example, AHCCCS has to submit the reimbursement methodology for: a. Retail Pharmacies b. Long Term Care Pharmacies

c. Drugs purchased under the 340B program,
d. Drug purchased under the federal supply schedule or
e. Drugs purchased at nominal pricing.
f. In the SPA we also have to explain how we reimburse for Hemophilia Factor Medications.

2. For the Outpatient Drug Rule: The ALL INCLUSIVE RATE (AIR)

A. CMS has determined that this rate meets the CMS Actual Acquisition Cost definition but because this is an all inclusive rate, there is not a professional fee added to the rate.

a. AHCCCS will reimburse up to one pharmacy AIR daily, which has not changed. Facilities may submit up to 5 AIRs daily for different services and one may be for pharmacy. What will be changing is that AHCCCS will reimburse the ALL INCLUSIVE RATE for the drug dispensed by an IHS or 638 Pharmacy beginning April 1, 2017. The AIR is paid for the first federally reimbursable drug on the claim, which should be on the first line of the claim.
    i. On or after April 1, 2017, reimbursement will not be provided for the current methodology, which is reimbursement for counseling for drugs dispensed by IHS or 638 pharmacies.

B. Reimbursement to IHS and 638 Pharmacies for specialty medications.

a. Specialty medications are high-cost prescription drugs used to treat complex and chronic conditions for oncology, rheumatoid arthritis, multiple sclerosis, etc. They often require special handling and administration.
b. AHCCCS has been in discussions with the IHS and 638 Pharmacy Directors to define the specialty medication list that would be used for this program and the list has been sent to the IHS & 638 Pharmacy Directors for review.
c. The reimbursement methodology for specialty medications has been discussed with the IHS and 638 Pharmacy Directors for these medications. The CMS Outpatient Drug Rule requires the reimbursement to be based on the actual acquisition cost of the drug. The pharmacy directors communicated that they purchase drugs under the Federal Supply Schedule and therefore to meet the CMS requirements, the reimbursement would be based on the Federal Supply Schedule Price of the drug plus a Professional Fee.
d. For medications not available through the Federal Supply Schedule contract, the reimbursement would be based on the Wholesale Acquisition Cost of the drug plus the professional fee.
e. All prescription claims for medications on the specialty drug list would be processed through the FFS PBM, which is OptumRx, and reimbursement is for each submitted drug claim.
f. The IHS & 638 pharmacy directors have communicated that they currently submit claims electronically to PBMs at the point-of-sale and that they did not expect major system changes.
g. Payment for specialty medications to IHS and 638 Pharmacies under a methodology outside of the use of the AIR requires CMS approval.
h. AHCCCS requested the following for each IHS and 638 pharmacy:
    i. DEA number,
    ii. NPI number, and the
    iii. NCPCP ID number.

    Rebecca Reyes and James Young are currently gathering this information for AHCCCS. This information is needed to determine if each pharmacy is contracted with OptumRx and also for the electronic plan set up for this program.
i. The outpatient drug rule proposed State Plan Amendment (SPA) will be posted for public comment.

Questions/Answers/ Comments	**Q**: Is the HEP-C medication in the Formulary? **A:** Yes, it is included on the AHCCCS drug list. It will require prior authorization. **Q:** Do out-patient dine-in medications apply? **A:** Yes, it would apply if it's adjudicated through the PBM system. It does not apply to in-patient medication. **Q:** Will there be a line item for us to bill for that medication? **A**: There will not be a separate line. This is only for out-patient.