AHCCCS NOTICE OF PUBLIC INFORMATION
INTENT TO SUBMIT A STATE PLAN AMENDMENT (SPA)

Name of the Agency: Arizona Health Care Cost Containment System (AHCCCS)

The topic of the public information notice: Inform the public of AHCCC'S intent to submit a State Plan Amendment.

SPA Title: Prescribed Drug Shortage

SPA Overview: This SPA authorizes coverage of certain drugs when the FDA allows temporary importation of non-FDA approved drugs to mitigate the effects of a drug shortage.

Tribal Consultation:
AHCCCS will consult with Tribes regarding this SPA on August 5, 2024. Below is a link to more information regarding the tribal consultation meeting.
https://www.azahcccs.gov/AmericanIndians/TribalConsultation/

State Plan Amendment and Public Comment Period
The proposed SPA is located on the next page of this document.

Public notice was posted on May 29, 2024.

Comments will be accepted through June 30, 2024.

Comments can be submitted through email or postal mail. The addresses where comments may be sent are provided below.

- Email:
  publicinput@azahcccs.gov

- Postal Mail:
  AHCCCS
  Attn: Division of Community Advocacy and Intergovernmental Relations
  801 E. Jefferson St., MD 4200
  Phoenix, AZ 85034

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.

Prescribed drugs that are not covered outpatient drugs (including drugs authorized for import by the Food and Drug Administration) are covered when medically necessary during drug shortages identified by the Food and Drug Administration.

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.