ALASKA NATIVE HEALTH BOARD

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALEUTIAN PRIBILOF ISLANDS ASSOCIATION
ARCTIC SLOPE NATIVE ASSOCIATION
BRISTOL BAY AREA HEALTH CORPORATION
CHICKALOON VILLAGE TRADITIONAL COUNCIL
CHUGACHMIUT
COPPER RIVER NATIVE ASSOCIATION
COUNCIL OF ATHABASCAN TRIBAL GOVERNMENTS
EASTERN ALEUTIAN TRIBES
KARLUK IRA TRIBAL COUNCIL
KENAITZE INDIAN TRIBE
KETCHIKAN INDIAN COMMUNITY
KODIAK AREA NATIVE ASSOCIATION
MANIILAQ ASSOCIATION
METLAKATLA INDIAN COMMUNITY
MT. SANFORD TRIBAL CONSORTIUM
NATIVE VILLAGE OF EKLUTNA
NATIVE VILLAGE OF EYAK
NATIVE VILLAGE OF TYONEK
NINILCHIK TRADITIONAL COUNCIL
NORTON SOUND HEALTH CORPORATION
SELDOVIA VILLAGE TRIBE
SOUTHCENTRAL FOUNDATION
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM
TANANA CHIEFS CONFERENCE
YAKUTAT TLINGIT TRIBE
YUKON-KUSKOKWIM HEALTH CORPORATION
VALDEZ NATIVE TRIBE

Alaska Native Health Board

THE VOICE OF ALASKA TRIBAL HEALTH SINCE 1968

T 907.729.7510 F 907.729.7506 • 4000 Ambassador Drive (ANHB Office) • Anchorage, Alaska 99508 • **www.anhb.org**

April 30, 2025

Transmitted via email: christal.hays@alaska.gov

Christal Hays
Medicaid State Plan Coordinator
Alaska Department of Health
3601 C Street, Suite 902
Anchorage, AK 99503

RE: Tribal Consultation – Pharmacy Dispensing Fee SPA

Dear Ms. Hays,

On behalf of the Alaska Native Health Board (ANHB)[1], I write to express our appreciation for the opportunity to provide comments in response to the proposed Medicaid State Plan Amendment (SPA) related to pharmacy dispensing fees. As we have communicated to the Department of Health (Department) throughout the analysis of the 2024 Cost of Dispensing (COD) Survey and development of this SPA, the rates proposed in the SPA do not reflect the cost of dispensing, and will have significant negative impacts on the availability of services at Tribal pharmacies.

ANHB agrees with the Department that any process delays in implementing a new SPA and regulatory package that would result in reverting to the pre-Pandemic dispensing fee rate should be avoided. ANHB agrees as well that the dispensing fee should be set using an objective, data-driven approach. However, it defies both logic and the lived experience of Tribal pharmacy providers that the cost of dispensing would have gone down between 2019 and 2024. Moreover, the Department's manipulation of the survey results artificially and arbitrarily reduced the proposed rates. Therefore, we recommend that the Department submits an updated SPA that reflects proposed rates using cost data that does not include "reasonableness" adjustments or adopts the current interim dispensing fee rates on a permanent basis. If neither of these solutions can be accomplished in a timely manner to avoid reversion to the pre-Pandemic rates, we ask that the State request an extension of the interim rate until a new SPA can be developed and implemented that reflects the actual cost of dispensing.

As the Department is aware, section 1902(a)(30)(A) of the Social Security Act, commonly referred to as the "equal access provision," is a federal law intended to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." This provision requires states to pay providers enough to ensure that care and services are available on the same basis for beneficiaries for as the general population in the area.

---

[1] ANHB was established in 1968 to promote the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people. ANHB is the statewide voice on Alaska Native health issues and is the advocacy organization for the Alaska Tribal Health System (ATHS), which is comprised of Tribal health programs that serve all 229 Tribes and over 234,000 Alaska Native and American Indian people throughout the state. As the statewide Tribal health advocacy organization, ANHB supports Alaska's Tribes and Tribal programs to achieve effective consultation and communication with state and federal agencies on matters of concern.

This provision also justifies setting appropriate dispensing fees based on actual cost-based data from Tribal pharmacies. Otherwise, the dispensing fees may not be consistent with this section. We also note that the regulatory definition of "professional dispensing fee" at 42 CFR § 447.502 includes those costs "associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid recipient" whether or not directly related to patient care.

The Department's imposition of a 5% "reasonableness" cap on indirect cost data means that the data used to develop the proposed rates does not reflect the true cost of dispensing as reported by Tribal pharmacies. These pharmacies serve enormous geographic areas that are extremely isolated. As just one example, the Tanana Chiefs Conference (TCC) pharmacy serves a geographic area over 235,000 square miles and stocks medications for 28 rural clinics throughout Interior Alaska. By providing high-quality, timely, and safe medication access close to the location of patients, saving millions of dollars in medical transports, morbidity and mortality are saved by the overall healthcare system at large. Oversight, regulatory compliance, quality improvement, security, billing/ financial, patient safety, controlled substance management, and a vast array of related services are delivered by Tribal pharmacies at hundreds of sites across the entire state on a daily basis. In addition, Tribal pharmacies spend tremendous sums of money on expediting medications to patients in rural Alaska to treat both chronic and acute medical conditions. Tribal pharmacies employ telepharmacy services to improve the quality, safety, and timeliness of care for patients in rural Alaska. And the Alaska Tribal Health System relies on pharmacists to improve health outcomes of AN/AI patients. Tribal pharmacies serve a vast array of clinical needs including outpatient, inpatient, emergency room, urgent care, Community Health Clinics, oncology and infusion centers, outpatient surgery centers, immunization services, and direct pharmacist-delivered primary care. To be clear, a majority of the cost saving, improving outcomes and safety-oriented patient care provided by Tribal pharmacists is not rendered in standard, billable clinical pharmacists-rendered visits.

These unique circumstances justify the continued Tribal-specific pharmacy dispensing fee. However, combined with the nature of the integrated organizational structures used by Alaska THOs, they also mean that the line between "direct" and "indirect" costs is not always perfectly clear. But that is irrelevant to the cost of dispensing—both "direct" and "indirect" costs are "associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid recipient."[2]

Previous discussion and communication with the Department suggests that the 5% reasonableness cap imposed on the data used to develop the proposed rates was intended to manage outliers and "anomalous indirect pharmacy cost data." Although we stand behind the veracity of the indirect costs that we have reviewed from Tribal pharmacies in their COD survey responses, we acknowledge DOH's concerns regarding how the CMS might view "outliers" in the COD survey data. However, capping indirect costs at the median reported value from Tribal pharmacies is an arbitrary and unjustifiable solution to this problem.

To use a straightforward example, nothing in the COD survey responses or DOH's discussion of this matter suggests that a Tribal pharmacy that reported a 6% indirect cost, for example, is in any way anomalous or an outlier—but the Department would have nonetheless thrown out that reported data as an unreasonable outlier. Specifically, by setting a "reasonableness" cap, the Department made a determination that any reported indirect costs above that cap was inherently not "reasonable." And because the Department set the cap at the median, the result is that the

[2] 42 CFR § 447.502

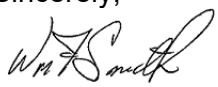
reported indirect cost data from one-half of Tribal pharmacies was discarded for purposes of setting the pharmacy dispensing fee.

To the extent that the Department is required to make any adjustments to the reported cost data to satisfy concerns from CMS regarding outliers, the Department should use an established statistical method of identifying outliers. For example, the standard median-based statistical method for identifying outliers in a data set is to multiply the interquartile range by 1.5 and add that value to the third quartile. Setting the reasonableness cap at this point would result in a more equitable calculation that is no less objective or data-based than the flawed approach of setting the reasonableness cap at the median—and would be far easier to justify with CMS because it (unlike the approach used in developing the SPA rates) is based on a standard statistical method for identifying outliers.

Maintaining patient access to medications is critical to safeguarding public health. Tribal pharmacies are the de facto pharmacies for vast areas in the State of Alaska that are roadless and/or where health care is difficult to access. If pharmacy dispensing fees are not sufficiently reimbursed, health care providers have no alternative but to compensate for these costs in other areas of operating health programs, which in effect limits services and reduces access to health care for Medicaid beneficiaries. We strongly urge the Department to submit proposed dispensing fees that reflect the cost of dispensing without arbitrary “adjustments” or maintains the current interim rates on a permanent basis. And if the Department cannot do so in a manner avoids the threat of a disastrous reversion to pre-Pandemic rates, the Department should propose to extend the interim rates until a solution can be reached.

Thank you for your partnership. If you have any comments or questions regarding our recommendations, please contact ANHB at anhb@anhb.org or 907-729-7510.

Sincerely,



Chief William F. Smith, Chairman
Alaska Native Health Board