THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health

OFFICE OF THE COMMISSIONER

Anchorage
3601 C Street, Suite 902
Anchorage, Alaska 99503-5923
Main: 907.269.7800
Fax: 907.269.0060

Juneau
350 Main Street, Suite 404
Juneau, Alaska 99801
Main: 907.465.3030
Fax: 907.465.3068

April 24, 2026

Re: DOH Response to Tribal Response State Plan Amendment – Weighted Acquisition Cost Change for Out of State Pharmacies

Dear Tribal Health Leaders,

On behalf of the Department of Health (the department) thank you for your email on April 17th, 2026 describing medications you believe are incorrectly reimbursed.

Tribal Comment – Alaska Native Health Board (ANHB)

We appreciate your time yesterday in talking through our request to use the currently proposed pharmacy SPA to create a reimbursement methodology that aligns with Medicare for certain high-cost drugs dispensed by tribal health facilities. We are following up with specific instances of drugs that would be impacted by the change in reimbursement methodology that we are requesting.

DOH response

Thank you for your comment. We appreciate your feedback.

Tribal Comment – ANHB

The list of examples for high cost infusion and injectable drugs can be found on Medicare's Addendum Q which is updated quarterly:
https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient-pps/quarterly-addenda-updates/april-2026-addendum-q

The examples mentioned on yesterday's call are all on the list. Tribal pharmacists recommend using this list, as it will need to be maintained. With the rate of new drugs coming to market, referring to CMS' quarterly list with some flexibility to adapt to the AK Medicaid population would make the most sense. In addition, high cost drugs used in Pediatrics such as Zolgensma (not on Addendum Q) should also be covered. Otherwise, due to the financial burden to the THOs, these patients are referred out and receive care at

other facilities (ex: Providence), fractionating care and missing the opportunity for 100% FMAP.

Medicare does not require a prior authorization for medications on Addendum Q; we would ask that AK Medicaid follow suit.

DOH response

Thank you for your comment. 42 USC 1396r-8 and 42 CFR 440.230(d) both allow for broad authority of utilization controls, including but not limited to prior authorization. The department does not foresee any changes to the current process for which prior authorization must be obtained. As a reminder, 7 AAC 105.130(b) states that a failure to obtain the required prior authorization may result in nonpayment, regardless of the eligibility of the recipient or the appropriateness of the services.

Tribal Comment - ANHB

The chart at the bottom of this email gives scenarios and possible impacts. Tribal pharmacists are available to answer any questions or clarify any information.

Scenario	Patient Need	AIR Limitation	Possible THO Response	Impact on Patient Care
1.Biologic infusions (autoimmune disease)- (Ex: Ocreluzimab-Ocrevus ®)	Ongoing high-cost biologic therapy (e.g., rheumatoid arthritis, multiple sclerosis)	Single encounter rate must cover drug + administration; does not scale with drug cost	Delay treatment, refer out, or use less effective therapies	Disease progression, increased disability, travel burden
2. Oncology infusions (Ex: Keytruda ®)	Chemotherapy or immunotherapy (very high per-dose cost)	AIR payment far below actual drug cost per visit	Refer to non-tribal providers or avoid offering service in-house	Travel burden, fragmented care, missed treatments
3. Behavioral health long-acting injectables (LAIs) (Ex: Invega Sustenna ®)	Monthly or every 6 month injectable antipsychotics for adherence	Medication cost bundled into one visit payment	Shift to oral meds or limit LAI availability	Increased relapse, hospitalization risk
4. Rare disease therapies (Ex: Zolgensma ®, Spinraza ®)	Gene therapy or specialty infusions (extreme cost per dose)	AIR based on average visits, not outlier costs	Require exceptions or transfer care externally	Delayed access, significant travel for families
5. Infusion service capacity (system-level)	Local infusion center access in rural areas	No separate reimbursement for infrastructure, staffing, or drug inventory	Avoid building or expanding infusion services	Long-distance travel, reduced access to care

Our understanding based on yesterday's call is that the State will review whether a different State Plan page might be a more appropriate place to address this request, and get back to us. After our call, we did review the State Plan and were not able to identify a more appropriate page ourselves. We do not see a path to reimbursing for high-cost drugs under facility or medical services. We do look forward to hearing what the State finds. If it is best to do this through a different page, we would also request to know what page of the State Plan could be changed and the timeline this could be completed.

DOH response

Thank you for your comment. Services such as drugs that are incidental to an encounter-generating service are included in the calculation of the All-Inclusive Rate (AIR). To ensure these drugs are appropriately captured in the AIR, they should be billed on the professional claim using the applicable HCPCS code along with the corresponding NDC units.

The associated drug costs are incorporated into the tribal cost report and subsequently allocated across all encounters for the Tribal Health Organization (THO). As a result, while there is no separate reimbursement for these drugs under the medical benefit, their costs are reflected in the encounter-based payment made under the prospective payment system (PPS) or an Alternative Payment Methodology (APM). The department acknowledges that these high-cost drugs are billable through the retail pharmacy benefit, with the exception of cell and gene therapy.

As a result, the inclusion of drug costs increases the overall encounter rate. Specifically, total allowable costs (the numerator in the rate calculation) increase, while the total number of encounters (the denominator) remain unchanged, thereby yielding a higher per-encounter payment.

Tribal Comment – ANHB

For now, we stand by our recommendation to address this request through section 4.19B as part of the current SPA leveraging the "same-page rule" by which CMS may negotiate revisions to multiple items on the same page even if those items were not in the State's original request. We believe that addressing reimbursement rates for provision of high-cost drugs logically fits into the Plan's discussion of reimbursement rates for prescribed drugs. If necessary, we may consider seeking technical assistance through Tribal Consultation with CMS on this issue.

DOH Response

The department does not agree with the assertion that this would be changed on the same page as our intended OOS WAC SPA (which was tribally and publicly noticed) but rather is a matter of operations and billing methods on the part of the THOs. Our tribal partners are more than welcome to seek TA with CMS, however, the department will be proceeding with the current intent of the OOS WAC SPA as originally stated.

Based on the department's review of the state plan, we have not identified a place

to change the AIR rate to include the requests detailed above. This rate is set between Tribal Health Organizations and the federal government.

Thank you for your continued support and engagement in the tribal consultation process.

Sincerely,

[redacted]

Christal Hays
Medicaid State Plan Coordinator