AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

September 5, 2019

Brian Zolynas
Division of Medicaid and Children's Health Operations
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

RE: Arizona SPA #19-004, Pharmacy Value Based Purchasing (VBP)

Dear Mr. Zolynas:

Enclosed is State Plan Amendment (SPA) #19-004, Pharmacy VBP, which revises the State Plan to provide the state the authority to enter into VBP (outcome-based) agreements with pharmacy drug manufacturers, effective July 1, 2019.

If you have any questions about the enclosed SPA, please contact Alex Demyan at (602) 417-4130.

Sincerely,

Dana Hearn
Assistant Director
Arizona Health Care Cost Containment System (AHCCCS)

cc: Blake Holt, CMS
Mark Wong, CMS

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
1 9 — 0 0 4

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

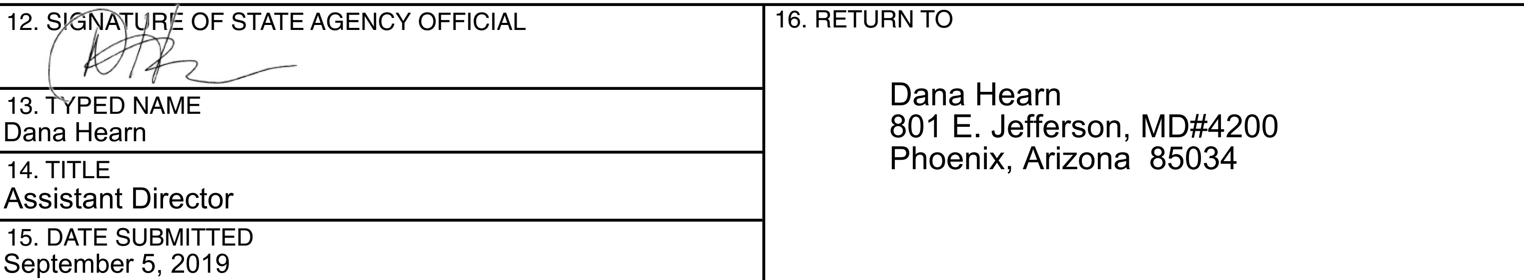
9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A Limitations
Page 9

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

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

FORM CMS-179 (07/92)

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 manu~~y~~facturers for drugs provided to Medicaid beneficiaries and for Non-Title XIX members for which the State Medicaid Agency receives federal and/or state grants that include the provision of prescription medications or other therapies with measurable outcomes. ~~-~~These contracts will be executed on the contract template titled "Outcomes-Based Supplemental Rebat~~r~~e 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.