

ADDITIONAL REGULATION NOTICE INFORMATION
(AS 44.62.190(d))

1. Adopting agency: Department of Health.
2. General subject of regulation: Medicaid Payment Rates for Pharmacy Dispensing Fees.
3. Citation of regulation (may be grouped): 7 AAC 145.410.
4. Department of Law file number: 2025200194.
5. Reason for the proposed action:
 - (X) Compliance with federal law or action (identify): 42 CFR 447.502.
 - () Compliance with new or changed state statute
 - () Compliance with federal or state court decision (identify): _____
 - () Development of program standards
 - (X) Other (identify): The changes are necessary to (1) update existing Alaska Medicaid pharmacy professional dispensing fees to reflect current cost survey data; and (2) ensure that the Department of Health reimburses pharmacies correctly in compliance with applicable state and federal requirements.
6. Appropriation/Allocation: Medicaid Services/Medicaid Services; OMB Component Number: 3234.
7. Estimated annual cost to comply with the proposed action to:
 - A private person: \$0
 - Another state agency: \$0
 - A municipality: \$0
8. Cost of implementation to the state agency and available funding (in thousands of dollars): The proposed regulation changes are not expected to require an increased appropriation.

	Initial Year FY2025.	Subsequent Years
Operating Cost	<u>\$0</u>	<u>\$0</u>
Capital Cost	<u>\$0</u>	<u>\$0</u>
1002 Federal receipts	<u>\$0</u>	<u>\$0</u>
1003 General fund match	<u>\$0</u>	<u>\$0</u>
1004 General fund	<u>\$0</u>	<u>\$0</u>
1005 General fund/ program	<u>\$0</u>	<u>\$0</u>
Other (identify)	<u>\$0</u>	<u>\$0</u>

9. The name of the contact person for the regulation:
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10. The origin of the proposed action:
☐ Staff of state agency
☒ Federal government
☐ General public
☐ Petition for regulation change
☐ Other (identify):
11. Date & Prepared by: _____
[e-signature]
Name (printed): Triptaa Surve, M.P.H., J.D.
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