THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health

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Dear Tribal Health Leaders,

On behalf of the Department of Health (the department) and in keeping with the responsibility to conduct tribal consultation, I am writing to inform you of proposed future amendments to the Medicaid state plan and Alternative Benefit Plan (ABP). This opportunity for consultation runs concurrently with public comment on proposed regulations.

Purpose and content of the proposed amendment:

The department proposes to submit a state plan amendment (SPA) and ABP amendment containing revisions to the following benefits – preventive services, vision services, and therapy services – including physical therapy, occupational therapy, and speech-language therapy. The language proposed for each benefit (below) is in draft form and may be revised before submission or during post-submission negotiations with the Centers for Medicare and Medicaid Services (CMS). The proposed state plan revisions to each benefit are as follows:

Preventive Services – The proposed SPA adds language to clearly comply with requirements in section 2713 of the Patient Protection and Affordable Care Act, 42 CFR § 440.130, and 45 CFR § 147.130. As a Medicaid expansion alignment state, the Alaska Medicaid state plan must comply with the ten essential health benefits requirements for alternative benefit plans.

> Attached Sheet to attachment 3.1-A page 4.4 &4.a - PREVENTIVE SERVICES (*new section and language*):

Coverage and provider qualifications are in accordance with 42 CFR 440.130. Alaska Medicaid covers all preventive services described in 45 CFR 147.130, including

- Evidence-based items or services with an A or B rating by the United States Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) and listed on the current immunization schedules of the Centers for Disease Control and Prevention (CDC);
- With respect to infants, children, and adolescents - evidence-informed preventive care and screenings guidelines are provided based on the current American Academy of Pediatrics Bright Futures periodicity schedule for screenings and follow-up visits;
- With respect to women, evidence-informed preventive care and screenings are provided based on the contents of this section and the current Health Resources and Services Administration (HRSA) Women's Preventive Services guidelines; and
- Any qualifying coronavirus preventive service, which means an item, service, or immunization intended to prevent or mitigate coronavirus disease 2019 (COVID-19) and that is, for the individual involved –

- An evidenced-based item or service with a rating of A or B in the current recommendations of the USPSTF; or
- An immunization recommended by ACIP and adopted by the Director of the CDC.

Children under twenty-one (21) years of age receive all medically necessary services without limitation, per section 1905(r) of the Social Security Act (EPSDT). Service limitations delineated in the attached sheets to attachment 3.1-A do not apply to EPSDT recipients subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

Vision Services – The proposed SPA and ABP amendment incorporate language aligning benefits with general industry coverage and clarifies existing limitations with the following language.

> Attached Sheet to attachment 3.1-A page 2 - OPTOMETRIST SERVICES (*revises existing language to read*):

Vision services are provided to recipients experiencing significant vision-related difficulties or complaints or if an attending ophthalmologist or optometrist finds health reasons for a vision examination once per calendar year. For recipients twenty-one (21) years of age and older, additional vision exams in a 12-month period are subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

> Attached Sheet to attachment 3.1-A page 4.4 – EYEGLASSES (*replaces existing language*):

Medicaid recipients twenty-one (21) years of age and older may receive one complete pair of eyeglasses per two-year calendar period without prior authorization. A recipient may receive a two-year supply of contact lenses in lieu of glasses if determined medically necessary. Recipients may obtain an additional pair of glasses or an additional supply of contact lenses subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

The following vision products and services require prior authorization – based on medical necessity – from the Medicaid agency or its designee: ultraviolet coating, prism lenses, specialty lenses, specialty frames, and tinted lenses.

The department excludes the following vision products and services for Medicaid recipients twenty-one (21) years of age and older: aspherical lenses, progressive or no-line multi-focal lenses, vision therapy services, polarized lenses, and anti-reflective or mirror coating.

Eyeglasses are purchased for recipients under a competitively bid contract.

> Attached Sheet to attachment 3.1-A page 1.b. – VISION SERVICES (*new EPSDT subsection*):

Medically necessary eye examinations, refractions, eyeglasses, and fitting fees for individuals under twenty-one (21) years of age are covered once per calendar year. The Medicaid agency may cover additional vision services subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

Eyeglasses are purchased for recipients under a competitively bid contract.

Medicaid recipients under twenty-one (21) years of age receive vision services, including diagnosis and treatment of defects in vision and eyeglasses, in accordance with sections 1905(a)(4)(B) and 1905(r)(2) of the Social Security Act, subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

Therapy Services – The proposed SPA adds language to comply more plainly with the requirements in section 1302(a) of the Patient Protection and Affordable Care Act (the ACA) and 42 U.S.C. § 18022 regarding coverage of "rehabilitation and habilitation services and devices." As a Medicaid expansion alignment state, the Alaska Medicaid state plan must comply with the ten essential health benefits requirements for alternative benefit plans.

> Attachment 3.1-A page 24a – PHYSICAL THERAPY (*revises existing language*):

Physical therapy services are provided upon the order of a physician, advanced practice registered nurse, physician assistant, or other licensed health care professional operating within the scope of the practitioner's license. All services are provided in accordance with 42 CFR 440.110(a). Physical therapists are enrolled in Alaska Medicaid and meet the requirements of 42 CFR 484.115(h). Physical therapy assistants, meeting the requirements of 42 CFR 484.115(i) and enrolled as rendering providers for physical therapists, may provide services if they meet Alaska licensure requirements.

Physical therapy services are either

(1) Habilitative – limited to forms of treatment to help a beneficiary attain, maintain, or prevent deterioration of skills and functioning for daily living never learned or acquired.

(2) Rehabilitative – limited to forms of treatment that help a beneficiary maintain, regain, or prevent deterioration of skills and functioning for daily living lost or impaired because a person was sick, hurt, or disabled.

Maintenance physical therapy services related to conditions caused by developmental disabilities or developmental delay to a recipient under twenty-one (21) years of age are covered if determined medically necessary and prior authorized by Alaska Medicaid or its designee.

Except for the initial evaluation, physical therapy services must be provided by or under the direction of a physical therapist enrolled in Alaska Medicaid and provided in accordance with the initial evaluation and the treatment plan developed by the enrolled physical therapist. Services must be documented in a progress note to include start and stop times for time-based billing codes used as provided in the Healthcare Common Procedure Coding System (HCPCs) or the CPT Fee Schedule.

Alaska Medicaid excludes from coverage the following services for beneficiaries twenty-one (21) years of age or older: swimming therapy, physical fitness, or weight loss. Services provided by a physical therapist aide are not covered.

Pursuant to section 1905(r) of the Social Security Act (EPSDT), the Medicaid agency does not impose limitations on services for individuals under twenty-one (21) years of age subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

> Attachment 3.1-A page 24b – OCCUPATIONAL THERAPY (*revises existing language*):

Occupational therapy services are provided upon the order of a physician, advanced practice registered nurse, physician assistant, or other licensed health care professional operating within the scope of the practitioner's license. All services are provided in accordance with 42 CFR 440(b). Occupational therapists are enrolled in Alaska Medicaid and meet the requirements of 42 CFR 484.115(f). Occupational therapy assistants, meeting the requirements of 42 CFR 484.115(g) and enrolled as rendering providers for occupational therapists may provide services if they meet Alaska licensure requirements.

Occupational therapy services are

(1) Habilitative – limited to forms of treatment to help a beneficiary attain, maintain, or prevent deterioration of skills and functioning for daily living never learned or acquired.

(2) Rehabilitative – limited to forms of treatment that help a beneficiary maintain, regain, or prevent deterioration of skills and functioning for daily living lost or impaired because a person was sick, hurt, or disabled.

Maintenance occupational therapy services related to conditions caused by developmental disabilities or developmental delay provided to a recipient under twenty-one (21) years of age are covered subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

Except for the initial evaluation, occupational therapy services must be in accordance with an initial evaluation conducted by an enrolled occupational therapist and a treatment plan developed by the enrolled occupational therapist. Services must be documented in a progress note to include start and stop times for time-based billing codes used as provided in the Healthcare Common Procedure Coding System (HCPCS) or the CPT Fee Schedule.

Alaska Medicaid excludes from coverage the following services for an individual twenty-one (21) years of age or older: swimming therapy, physical fitness, or weight loss. Services provided by an occupational therapist aide are not covered.

Pursuant to section 1905(r) of the Social Security Act (EPSDT), the Medicaid agency does not impose limitations on services for individuals under twenty-one (21) years of age subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

> Attachment 3.1-A page 24c-d – SPEECH-LANGUAGE THERAPY (*revises existing language*):

Speech pathology and audiology services are provided upon the order of a physician, advanced practice registered nurse, physician assistant, or other licensed health care professional operating within the scope of the practitioner's license. Services are provided in accordance with 42 CFR 440.110(c). Speech-language pathologists are enrolled in Alaska Medicaid and meet the requirements of 42 CFR 484.115(n). Audiologists are enrolled in Alaska Medicaid and meet the requirements of 42 CFR 484.115(b). Speech-language pathology assistants enrolled as rendering providers for speech-language pathologists may provide services if registered and meet Alaska requirements.

Speech, hearing, and language disorder services are either

(1) Habilitative – limited to forms of treatment to help a beneficiary attain, maintain, or prevent deterioration of skills and functioning for daily living never learned or acquired.

(2) Rehabilitative – limited to forms of treatment that help a beneficiary maintain, regain, or prevent deterioration of skills and functioning for daily living lost or impaired because a person was sick, hurt, or disabled.

Except for the initial evaluation, all speech pathology/audiology services must occur according to an initial evaluation conducted and a treatment plan developed by an enrolled speech-language pathologist. Services must be documented in a progress note to include start and stop times for time-based billing codes used as provided in the Healthcare Common Procedure Coding System (HCPCS) or the CPT Fee Schedule.

Before initiating treatment, the speech-language pathologist must conduct an initial evaluation of the recipient that includes

(1) an assessment of the recipient's significant past medical history;

(2) a diagnosis and prognosis, if established, and the extent to which the recipient is aware of the diagnosis and prognosis;

(3) the prescribing health care practitioner’s orders, if any;

(4) the treatment goals and potential for achievement;

(5) any contraindications; and

(6) a summary of any known prior treatment.

After conducting the initial evaluation, the speech-language pathologist must establish a written treatment plan. The plan must specify the diagnosis, the anticipated treatment goals, and the type, amount, frequency, and duration of each service. The prescribing health care practitioners must sign the treatment plan no more than fourteen (14) days after treatment plan development or revisions to service levels.

After the treatment plan is signed, the prescribing health care practitioner shall review and sign the treatment plan as often as the recipient's medical condition requires, or

(1) when the treatment plan is revised;

(2) no less than every six(6) months for recipients under three (3) years of age;

(3) annually for recipients three years of age or older and under twenty-one (21) years of age;

(4) every thirty (30) days for recipients twenty-one (21) years of age or older.

The speech-language pathologist must record any changes made to the treatment plan in the recipient's clinical record.

Pursuant to section 1905(r) of the Social Security Act (EPSDT), the Medicaid agency does not impose limitations on services for individuals under twenty-one (21) years of age subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

Anticipated impact on Medicaid-eligible Alaska Native/American Indian beneficiaries:

The department anticipates, absent a medical necessity determination, that Alaska Native/American Indian Medicaid beneficiaries twenty-one (21) years of age and older may receive a complete set of eyeglasses every two years instead of every year under the current practice. Additionally, Alaska Native/American Indian Medicaid beneficiaries twenty-one (21) years of age and older will experience an expanded list of excluded items and services, with the following additional items: aspherical lenses, polarized lenses, anti-reflective or mirror coating, lenses, or the placement of lenses, into frames not covered under the Medicaid program, and the fitting or repair of a vision product not covered under the Medicaid program.

With the clarified language surrounding preventive and therapy services in the proposed SPA, the department anticipates that Alaska Native/American Indian Medicaid beneficiaries twenty-one (21) years of age and older may experience greater access to preventive, rehabilitative, and habilitative services.

Alaska Native/American Indian Medicaid beneficiaries under twenty-one (21) years of age continue to receive benefits in compliance with section 1905(r) (EPSDT).

Anticipated impact on tribal health programs and the Indian Health Service:

The department anticipates that the revisions to vision coverage – specifically, the coverage of eyeglasses – may reduce reimbursement to tribal health programs. However, additional benefits are available for beneficiaries whose providers submit documentation of medical necessity and receive prior authorization from the Medicaid agency or its designee.

The department anticipates tribal health programs to be able to use accurate coding for preventive, rehabilitative, and habilitative services with the clarified language surrounding preventive and therapy services in the proposed SPA. In addition to facilitating improved record-keeping for these services, the clarified language may offer tribal health programs additional opportunities for services reimbursement.

Mechanism and timeline for comment

Written comments or questions regarding the proposed amendment are due no later than the close of business, September 2, 2022. If seeking an in-person meeting regarding the proposed changes, please provide a written request within 15-days of the date of this letter to Courtney O'Byrne King at courtney.king@alaska.gov. Please direct all written correspondence to Courtney O'Byrne King, Alaska Department of Health, 3601 C Street, Suite 902, Anchorage, AK 99503, or courtney.king@alaska.gov.

Comments received in response to this letter are considered for consultation purposes only and do not constitute a comment on the corresponding regulations. Comments on the regulations are not considered comments for consultation on the SPA. ***If you wish to provide comments for consideration in both the SPA and the regulations processes, you must do so separately.*** *To locate the regulations, please refer to the State of Alaska web page at the "Public Notices" link*

Sincerely,

/s/

Courtney O'Byrne King, MS
Medicaid State Plan Coordinator