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Via email: Courtney.king@alaska.gov

Dear Ms. King.

On behalf of Southcentral Foundation (SCF) and the 65,000 Alaska Native and American Indians we serve, I write to state our support of the Department's decision to extend Medicaid coverage to Applied Behavioral Analysis services, to confirm our view that, except for initial assessments, the services may appropriately and effectively be delivered via telemedicine, and to urge the Department to modify its draft State Plan Amendment (SPA) in three respects. Specifically, we recommend that the SPA be modified: (1) to expressly cover the services for treatment of other conditions, in addition to Autism Spectrum Disorder, for which there is evidence the services are effective; (2) to provide that, for services furnished to homeless individuals or within the "four walls" of a community behavioral health center operated by a tribal organization, the services will be reimbursed at the tribal behavioral health encounter rate; and (3) to remove the prior-authorization requirement.

SCF is the Alaska Native tribal health organization designated by Cook Inlet Region, Inc. and eleven Federally-Recognized Tribes – the Aleut Community of St. Paul Island, Igiugig, Iliamna, Kokhanok, McGrath, Newhalen, Nikolai, Nondalton, Pedro Bay, Telida, and Takotna – to provide healthcare services to beneficiaries of the Indian Health Service (IHS) pursuant to a contract with United States government under the authority of the Indian Self Determination and Education Assistance Act (ISDEAA) P.L. 93-638.

SCF provides a variety of medical services, including dental, optometry, behavioral health and substance abuse treatment to over 65,000 Alaska Native and American Indian people. This includes 52,000 people living in the Municipality of Anchorage, the Matanuska-Susitna Borough to the north, and 13,000 residents of 55 rural Alaska villages. Our services cover an area exceeding 100,000 square miles. SCF employs more than 2,000 people to administer and deliver these critical healthcare services.

SCF is a member of the Alaska Tribal Health System (ATHS) which is comprised of 229 Federally Recognized Alaska tribes and tribal organizations who have all contracted with the IHS to carry out the management and administration of federal Indian programs. Collectively, the tribes and tribal organizations form an integrated statewide network with more than 7,000 employees providing services to over 150,000 Alaska Native and American Indian people. Additionally, the ATHS is a critical component of the Alaska Public Health System serving thousands of non-Native people in rural Alaska. We believe Alaska is the only state where all

SCF is in the process of building a 25,000 square foot multidisciplinary clinic dedicated to treating all Alaska Native children with neurodevelopmental issues on the Alaska Native Health Campus. This clinic, which will focus on both diagnostic and treatment of neurodevelopmental issues, will be a "one-stop-shop" for Alaska Native families from across the State. Currently, staffing includes a developmental pediatrician, developmental nurse practitioners, speech and language pathologists, physical therapists, occupational therapists, neuropsychologists, behavioral health consultants, child and adolescent psychiatrists, and board-certified behavioral analysts (BCBAs), among other staff to support children with developmental issues. Although many of the children at the neurodevelopment clinic will have a diagnosis of autism, we plan to diagnose and treat all children with neurodevelopmental issues. We believe the cornerstone of this treatment will be ABA services, as many parents of children with developmental issues state that BCBAs are the most important people on their treatment team. In addition, we expect up to half of the children being followed at the clinic will be from homes outside of Anchorage. Thus, to ensure that care plans are fully implemented, many of these children will be followed via telemedicine, which will include ABA services.

Below I will elaborate on our requested SPA changes and on using telemedicine to deliver elements of the service. First, however, I wish to thank you and your colleagues at DHSS for the very positive, frank, and productive face-to-face tribal consultation meeting held on October 20th. The tone, substance, participation, and quality of that meeting was characteristic of our tribal consultations with the Department over the last 18 months or more. I firmly believe, and it has become clear the Department agrees, that meaningful and robust tribal consultation on Medicaid matters strengthens the State/tribal partnership and helps us achieve our mutual goal of providing the best possible health care services to our Medicaid-eligible customers/owners as efficiently and economically as possible.

Revise the SPA to Cover the Service for Additional Diagnoses for Which it is Shown to be Effective.

The Department shared its draft SPA with Tribal Health Organizations in advance of the October 20th face-to-face meeting. That draft did not limit the diagnoses for which the service would be covered when medically appropriate, but during the meeting, the Department said it was considering revising the SPA to cover the service only for recipients diagnosed with Autism Spectrum Disorders (ASD). (The Department's proposed implementing regulations, on which we are submitting separate comments, also would limit the service to those with ASD.)

We believe it would be a mistake to narrow the SPA in that way. To be sure, the best-known and supported application of Behavioral Analysis services is for the treatment of ASD. But there is every reason to expect the service would be beneficial for children with other developmental disabilities as well, and there is a growing body of research supporting such benefits.¹

¹ TBI, <http://www.tandfonline.com/doi/abs/10.1080/02699050701482470> and <http://www.tandfonline.com/doi/abs/10.1080/02699050600744194>; FASD: look to pages 1-33 & 1-35: https://store.samhsa.gov/shin/content//SMA13-4803/TIP58_LiteratureReview.pdf; promising current programs: https://www.nofas.org/wp-content/uploads/2014/04/NOFAS_Brochure_4_Programs_Final.pdf; promoting health behavior <https://link.springer.com/article/10.1007/s40614-014-0017-y>; toilet training:

Washington State’s Medicaid program now covers the services for ASD and any other “developmental disability for which there is evidence ABA services are effective.”² If the service would be effective and medically necessary for children Fetal Alcohol Spectrum Disorder, for example—and our clinicians believe it would be in many cases—then it should be covered for them by Medicaid. Covering the services for additional diagnoses will also help the State fulfill its obligations related to EPSDT services. As CMS has explained, under the mandatory EPSDT benefit:

States are required to arrange for and cover . . . any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, *including children with ASD*, are aware of and have access to a broad range of services to meet the individual child’s needs; that is, all services that can be covered under section 1905(a), including licensed practitioners’ services; speech, occupational, and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and dental services. . . . This longstanding coverage design is intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under age 21, including those with ASD, based on individual determinations of medical necessity.”³

In other words, when an EPSDT screening examination indicates the need for behavioral analysis services, States have a legal obligation to cover the service, regardless whether the child’s diagnosis is ASD or another developmental disability for which the treatment has been shown to be effective to treat associated behavioral challenges.

Alaska’s Complex Behavior Collaborative uses ABA for a wide variety of behavioral challenges, chronic mental illness, intellectual disability, dementia/Alzheimer’s, brain injury, substance abuse.

Rather than narrowing the SPA, we recommend it be revised to expressly cover the service both for recipients diagnosed with ASD and for recipients with other diagnoses for which the services are shown to be clinically effective.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3592490/>; reducing disruptive behavior: Porterfield, J. K., Herbert-Jackson, E., & Risley, T. R. (1976); Contingent observation: An effective and acceptable procedure for reducing disruptive behavior of young children in a group setting, *Journal of Applied Behavior Analysis*, 9, 55-64. Other citations available upon request.

² Washington State Health Care Authority, *Washington Apple Health (Medicaid) Applied Behavioral Analysis (ABA) Program Billing Guide (For clients age 20 and younger)*, October 1, 2016, p. 14, available at <https://www.hca.wa.gov/assets/billers-and-providers/ABA-services-20161001.pdf>

³ CMCS Informational Bulletin, July 7, 2014, “Clarification of Medicaid Coverage of Services to Children with Autism.” (Emphasis added.) Importantly, CMS’ guidance “includes” services to recipients with ASD, and by extension applies equally to children with other diagnoses that could benefit from the same array of services.

Alternatively, we urge the Department to retain the current draft language, which covers the service without identifying or limiting the diagnoses to which it may be applied. That approach would allow the Department to flesh-out the covered diagnoses through regulations, and to amend the regulations and expand coverage to additional diagnoses as indicated by the medical literature, without the necessity of again amending the State Plan. This appears to be the approach taken by several other States and approved by CMS. Recently-approved SPAs covering the services in Washington,⁴ Maryland,⁵ and Missouri⁶ do not list or restrict the covered diagnoses, even when other materials indicate the State's intent is to cover the service for recipients with an ASD.

Pay the Encounter Rate for Services Furnished in Community Mental Health Clinics Operated by Tribal Organizations.

Under the draft SPA, the services would be reimbursed on a fee-for-service basis only, and would be ineligible for payment under the tribal provider behavioral health encounter rate even when they are furnished by practitioners employed by a tribal organization's enrolled community behavioral health clinic. In the October 20th, 2017 meeting, the Department explained that CMS would be unlikely to authorize payment of the encounter rate for these services, because they are "rehabilitative" rather than "clinical" in nature.

We do not doubt the Department's assertion that CMS has told it that behavioral health rehabilitative services do not qualify as a "clinic" benefit. But we believe CMS's advice to the Department is mistaken, and directly contrary to CMS's own regulation defining the clinic benefit, which expressly *includes* "rehabilitative services." According to 42 C.F.R. 440.90:

Clinic services means preventive, diagnostic, therapeutic, **rehabilitative**, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

- (a) Services furnished at the clinic by or under the direction of a physician or dentist.
- (b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

⁴ Washington State Plan Amendment # 17-0024, approved October 11, 2017 and effective July 1, 2017.

⁵ Maryland State Plan Amendment # 16-0009, approved December 15, 2016 and effective January 1, 2017. Maryland's SPA describes the service broadly and does not limit it to ASD, but its application materials show that its purpose was to add the services "under EPSDT benefit for children with an Autism Spectrum Disorder."

⁶ Missouri State Plan Amendment # 15-003, approved May 6, 2016 and effective January 15, 2016. Like Maryland's, Missouri's SPA defines the benefit broadly and does not limit it to recipients diagnosed with an ASD, even though its stated purpose was "to include Behavior Analysis (ABA) Services for individuals under age 21 with Autism Spectrum Disorder."

[Emphasis added.]

We have looked, but we have not found any CMS rules, manuals, publications, or other materials that state or suggest that rehabilitative services fall outside the clinic benefit or may not be reimbursed to tribal organizations under the encounter rate.

We know that CMS has recently clarified that the clinic benefit does not include services provided outside the clinic's "four walls" except to homeless individuals, and that this means tribal clinics may not be paid the encounter rate for the off-site services after January 30, 2021. And we know that, by their nature, many Applied Behavior Analysis Services will be delivered outside a clinic setting, in a child's home, school, or other community setting. When they are delivered in those settings after January 30, 2021, we understand that CMS will not allow the encounter rate to be used and that the services will then be reimbursed under a different methodology, such as a fee schedule or State-established daily rate. However, if the service is furnished within the clinic's four walls, by or under the direction of a physician and consistent with other applicable requirements, we believe it qualifies as a "clinic service" and may be reimbursed at the encounter rate.

Paying the encounter rate for such services is not only allowed under federal Medicaid rules; it is also the most appropriate payment for services delivered on-site at a tribal organization's enrolled clinic. The encounter rate is based on cost reports and encounter data submitted by representative tribal facilities, OMB-approved, and has been the established Medicaid payment rate for all tribal outpatient clinic services for decades. Because it is calculated based on average costs per encounter, rather than on the specific cost of individual services, and because it incorporates the cost of the full array of services tribal clinics provide, the encounter rate supports the ability of tribal health clinics to be "full service" providers, furnishing a compendium of services to their recipients, even in communities whose small population or remote location would make it impossible to support the service on a fee-for-service basis.⁷ If Behavior Analysis Services furnished at the clinic are instead paid outside the encounter rate, then their associated costs must also be excluded when the rate is calculated, needlessly complicating the analysis. Separate payment for the service also creates the very real risk that the State-established fee will be insufficient to support the true cost of delivering the service, especially in the small, remote, and high-cost communities served almost exclusively by the Alaska Tribal Health System.

At the close of this letter, we suggest specific changes to the SPA to ensure proper payment at the encounter rate for services provided on-site at a tribal clinic or enrolled community behavioral health center.

Remove the Prior-Authorization Requirement. To ensure scarce behavioral health resources are

⁷ Of course, no tribal health organization in Alaska currently furnishes Applied Behavior Analysis services, so at present there are neither costs nor encounters for the service in the encounter rate. However, as services are furnished, costs and encounters will be included in future encounter rates.

spent on actual service delivery rather than burdensome administrative requirements, and to ensure greater parity between coverage of behavioral and medical health services, we urge the Department to eliminate the prior-authorization requirement from the SPA.

As SCF's representatives explained during our October 20th meeting, and as we have discussed on several other occasions, the prior authorization and documentation requirements Alaska Medicaid now imposes on behavioral health services providers are extremely burdensome and time-consuming. Typically, each service authorization request consumes an hour of clinician time, time that could be much better be spent actually treating our customers-owners.

Notably, Alaska Medicaid requires service authorizations almost exclusively for behavioral health services, and almost never for medical health services. That dichotomy reflects the now-discredited view that behavioral health conditions are not "real" health problems, and that treatments for them are not scientifically valid. The federal Mental Health Parity and Addiction Equality Act, as amended by the Affordable Care Act and implemented by CMS, now requires private insurers, Medicaid Managed Care Organizations, and CHIP programs to equitably cover behavioral conditions and services on essentially the same basis as medical services. While the law has not yet been extended to traditional Medicaid, it establishes non-discrimination and parity principles that we believe Alaska Medicaid should emulate.

We suggest the following changes to the draft SPA to incorporate all our recommendations above. (Added language is underlined; deleted language is struck-through:

Attached Sheet to Attachment 3.1A, Page 2 ...

6.d.4 LICENSED BEHAVIOR ANALYST: In accordance with 42 CFR 440.60, licensed behavioral analysts are covered for services within their scope of practice as defined by the state of Alaska, and shall provide services to Medicaid eligible recipients under twenty-one (21) years of age. Licensed behavioral analysts shall be reimbursed for covered services that are medically necessary and furnished to individuals with a diagnosis of autism spectrum disorder or other developmental disability or condition for which there is evidence the services are effective and ~~prior authorized by the Medicaid program.~~

Attachment 4.19-B, Page 1.2.

Licensed Behavior Analysts. Reimbursement for Behavioral Analysis services are made through the licensed certified behavior analyst who is the supervising health care provider for these services, or through the enrolled Community Behavioral Health Services center or tribal clinic that employs the supervising licensed certified behavior analyst.

All covered services are paid at the lesser of the provider's billed charges, or the state maximum allowable for the procedures. State developed fee schedule rates are the same for both governmental and private providers of Behavior Analysis services. Tribal behavioral health encounter rates ~~do not apply to services in this section~~ apply only to services that are furnished inside an enrolled tribal clinic or

community behavioral health services center, or to homeless individuals by the clinic's or center's staff.

Services Appropriate for Telemedicine Delivery. During the October 20th face-to-face meeting, the Division asked whether, in the opinion of the participating tribal organizations, Applied Behavioral Health Services may appropriately be delivered via telemedicine. SCF's Dr. Hirschfeld responded, explaining why, in his professional opinion, all services except initial assessments are appropriate for telemedicine services. SCF agrees and endorses that statement. We thank you for seeking our views on that important question, and if any changes to the SPA are needed to ensure coverage of services furnished via telemedicine, we ask that you draft them and consult further with us about them before submitting the SPA to CMS.

Thank you again for engaging with us in consultation on these important changes to our State Medicaid Program. If you believe further discussion on any of these issues is warranted, we would be pleased to meet with you again at your convenience. I can be reached by phone at (907) 729-4938 or by email, katherineg@scf.cc.

Sincerely,

SOUTHCENTRAL FOUNDATION



Katherine Gottlieb, MBA, DPS
President/CEO