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Bristol Bay Area Health Corporation is a tribal organization epresenting 28 villages in Southwest Alaska:

Aleknagik
Chignik Bay
Chignik Lagoon
Chignik Lake
Clark's Point
Dillingham
Egegik
Ekuk
Ekwok
Goodnews Bay
Ivanof Bay
Kanatak
King Salmon
Knugank
Koliganek
Levelock
Manokotak
Naknek
New Stuyahok
Perryville
Pilot Point
Platinum
Port Heiden
Portage Creek
South Naknek
Togiak
Twin Hills
Ugashik

Our mission is to provide quality health care with competence, compassion, and sensitivity

September 2, 2022

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The Bristol Bay Area Health Corporation offers the following comments on the proposed preventive, vision, and therapy services changes to the State Plan.

I. PREVENTIVE SERVICES

The state proposes to add the following language to the State Plan:

> 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.

We think there is a typographical error in the sentence beginning "[w]ith respect to infants, children,…" Specifically, the sentence should read "With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided based on current guidelines in the American Academy of Pediatrics Bright Futures periodicity schedule for screenings and follow-up visits." Otherwise, the section promises that guidelines will be provided, not the services themselves.

II. VISION SERVICES

A. OPTOMETRIST SERVICES

The state proposes to add and revise the following language in the State Plan:

> Vision services are provided to recipients experiencing significant vision-related difficulties or complaints ~~related to vision~~ or if an attending ophthalmologist or optometrist finds health reasons for a vision examination once per calendar year. ~~A second vision exam in a 12-month period must be prior authorized by the division or its designee.~~ 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.

At present, the State only provides optometry services if the recipient is experiencing significant difficulties or complaints related to vision or if an attending ophthalmologist or optometrist finds health reasons for a vision examination. This is not appropriate preventative vision care. According to the American Optometric Association, comprehensive eye exams are an essential part of preventative eye health and are recommended at least every two years for patients 18-64, or sooner for at risk patients, as recommended. For all patients 65 and older the AOA recommends examinations at least annually.[1] Accordingly, coverage of vision services should not be based solely on patients experiencing significant difficulties or complaints or if an attending doctor finds health reasons for a vision examination. Moreover, it is hard to see how an ophthalmologist or optometrist could find health reasons for a vision examination for patients who cannot see such a doctor, because the services are not covered. The State needs to revise the scope of optometric services covered to properly include annual, preventative eye exams for all age groups.

The State's proposed language to specify that recipients twenty-one years of age and older can receive additional vision provided that there has been authorization or a determination of medical necessity impermissibly limits the scope of preventive care. For those with changing vision, doctors may recommend appointments every six months or even sooner. For those with conditions

[1] American Optometric Association, *Comprehensive eye exams*, https://www.aoa.org/healthy-eyes/caring-for-your-eyes/eye-exams?sso=y.

like dry eye, doctors may recommend appointments biweekly or weekly until the condition resolves. It is hard to know what services and conditions will be covered under the 'medical necessity' standard, and under the proposed language the State forces patients to take a gamble when they receive care as to whether their appointments will be covered or not, often only finding out well after the fact.

The State's proposed language to specify that recipients twenty-one years of age and older can receive additional vision exams in a 12-month period provided that there has been authorization or a determination of medical necessity also appears to inappropriately foreclose the possibility of patients under the age of twenty-one from receiving additional vision exams when necessary. The State should clarify that patients under the age of twenty-one are eligible for additional vision exams.

The State's use of different measurements of time will cause confusion and complicate compliance. A calendar year is distinct from any 12-month period. By requiring prior authorization or a determination of medical necessity for additional vision exams in a 12-month period, the State limits scheduling flexibility for annual visits. For example, using a 12-month period would preclude a vision exam on September 1, 2022 from being followed by a yearly exam on August 30, 2023. This constraint may be particularly profound for seasonal employees or families dealing with changing school schedules. Consistent use of a calendar year standard would ensure that doctors and patients can have at least a few weeks of flexibility in scheduling their appointments, and would not undercut the State's intended limitation to yearly visits.

B. EYEGLASSES

The state proposes to add and revise the following language in the State Plan:

> ~~Eyeglasses are provided to recipients in response to an initial or change of prescription, or as a replacement of a lost or destroyed pair of glasses.~~ 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. ~~Tinted lenses are not covered unless medically necessary. Contact lenses are not covered except for specific medical conditions. Tinted lenses and contact lenses must be prior authorized.~~
>
> 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.

We are supportive of the increased coverage of contact lenses and specialty lenses, but urge the State to permit contact lenses more liberally than upon a finding of medical necessity. The presumption should not be that glasses are the more convenient or healthy option for most people, particularly for those who do manual labor or live other active lifestyles.

In addition, a two-year time frame for glasses and contacts is impractical, potentially dangerous, and wasteful. Prescriptions regularly change more often than once every two years, particularly in the young, the old, and those with greater optical needs. The State's proposed eyeglasses and contacts coverage, particularly when combined with the State's proposed coverage of optometry appointments, forces patients into potentially wearing the same prescriptions for two years, regardless of whether the prescriptions properly corrects the patients' vision. Moreover, without clarification of what constitutes medical necessity for a new pair of glasses, it is hard to see how this standard would be uniformly applied. A correction to 20/20 may be medically necessary for certain doctors, but a change in vision that leaves a patient with vision corrected only to 20/32 may not warrant a new prescription according to other doctors. The State's current standard, covering eyeglasses in response to a change in prescription, is more appropriate. That way, a patient can always decline a new prescription if the change is minimal. The State should also support replacement of lost or destroyed glasses, as it does under the current standard. In addition, requiring the purchase of contacts in two-year quantities is wasteful for populations with eyes that change more often than that, as they will be forced to throw out the outdated prescription as they are prescribed a new set.

The State's proposed prohibition on coverage for aspherical lenses, progressive or no-line multi-focal lenses, polarized lenses, and anti-reflective or mirror coating is likewise absurd and would have a devastating impact on specific populations. Aspherical lenses—or toric lenses—are commonly designed for those with astigmatism. Astigmatism afflicts approximately 40% of adults worldwide.[2] Multifocal lenses are commonly required for people who need vision correction to see multiple depths. Multifocal lenses are commonly required for populations afflicted with presbyopia, which may be in excess of 60% of adults over the age of 40.[3] Likewise, polarized lenses and anti-reflective lenses are designed to improve vision by reducing glare. The State's proposed language deliberately withholds necessary optical corrections for entire, not insubstantial, groups of people. Moreover, given the degree to which people are operating heavy machinery these days—from cars to machines far larger—operating with incompletely corrected vision is extremely dangerous.

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[2] H. Hashemi, A. Fotouhi, A. Yekta, R. Pakzad, H. Ostadimoghaddam & M. Khabazkhoob, *Global and regional estimates of prevalence of refractive errors: systematic review and meta-analysis*, Journal of Current Ophthalmology, 30(1): 3-22 (2018) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5859285/.

[3] Ilesh Patel & Sheila K West, *Presbyopia: prevalence, impact, and interventions*, Community Eye Health, 20(63): 40-41 (2007) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2040246/.

C. VISION SERVICES

The State also proposes to add the following language:

> 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.

At present, the State's proposed language limits coverage for annual examinations to circumstances in which an annual examination is medically necessary, but it is unclear whether the State considers annual examinations themselves to be medically necessary. At a minimum, the American Optometric Association recommends that school age children (6 to 18 years) *with healthy and nonchanging vision* receive a comprehensive eye exam each year.[4] Children with changing vision often need more frequent exams and, most importantly, need for the cost of those exams, fitting fees, glasses, and contacts to be covered for every appointment. The State should clarify that at least one examination is covered for each patient under twenty-one, each year. This would be consistent with medical recommendations, and would not require patients to carry the burden of proving that an annual eye examination is medically necessary.

Additionally, between the State's proposed eyeglasses and vision services language, it is not clear that patients under twenty-one are eligible for contact lenses in the same way that patients over twenty-one are. Children and young adults need the flexibility to wear contacts for the same reasons as outlined above—needing them to maintain a healthy and active lifestyle and, for the older among them, to operate machinery like cars and other heavy vehicles and machinery. The State needs to extend coverage for contact lenses (as well as to aspherical lenses, progressive or no-line multi-focal lenses, polarized lenses, and anti-reflective or mirror coating) to patients under twenty-one.

III. THERAPY SERVICES

Since the State's propose amendments to the physical therapy, occupational therapy, and speech-language therapy sections are substantially the same, we provide a few comments of general applicability for the three sections, as well as some specific comments.

For ease of illustration, the State proposes the following amendments for occupational therapy:

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[4] American Optometric Association, *Evidence-Based Clinical Practice Guideline: Comprehensive Pediatric Eye and Vision Examination*, Guideline Brief 2017, https://www.aoa.org/AOA/Documents/Healthy%20Eyes/For%20Teachers/AOA%20Executive%20Summary%20Pediatric%20Eye%20Exam%20Guidelines%20Revised%2003.05.18.pdf.

Occupational therapy services are provided upon the order of a physician, ~~advanced nurse practitioner~~, 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: ~~maintenance of bodily function~~, swimming therapy, ~~habilitation,~~ 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.

The State's drafting of the Habilitative and Rehabilitative sections throughout the Therapy Services sections makes it difficult to understand what is covered. Moreover, the generally understood meaning of habilitative services includes services to keep, learn, or improve skills and functioning for daily life.[5] The State's proposed language does not extend to improving skills and

[5] HEALTHCARE.GOV, Habilitative/Habilitation services, https://www.healthcare.gov/glossary/habilitative-habilitation-services/ (accessed Aug. 18, 2022).

functioning (at least as we understand the State's language), but it should. We think it best if the State redrafted the Habilitative sections to read:
"(1) Habilitative—limited to forms of treatment to help a beneficiary attain, maintain, learn, or improve skills and functioning for daily living, or to prevent the deterioration of those skills and functioning."
The use of "attain" and "learn" will make the phrase "never learned or acquired" unnecessary.

Likewise, the State's proposed language for the Rehabilitative sections omits coverage for the improvement of skills and functioning.[6] We think it best if the State redrafted the Rehabilitative sections to read:
"(2) Rehabilitative—limited to forms of treatment to help a beneficiary maintain, regain, or improve skills and functioning for daily living that have been impaired because the beneficiary was sick, hurt, or disabled, or to prevent the deterioration of those skills and functioning."

In addition, as the State notes in its Dear Tribal Health Leaders letter, 42 U.S.C. § 18022 includes "rehabilitative and habilitative services and devices" as an essential health benefit. Unfortunately, however, the State's proposed definitions do not make clear that such devices are covered. We suggest that the State incorporate language to make clear that prescribed devices with habilitative and/or rehabilitative uses are covered by the state Medicaid program.

The State should not categorically exclude coverage for swimming therapy, physical fitness, and weight loss activities conducted pursuant to therapy services. First, weight loss is a critical component for health for many different demographics, including those classified as obese and those with diabetes. Moreover, swimming therapy can be essential to restoring and improving health, particularly those who have trouble with other types of exercise, like those suffering from arthritis or who cannot put a lot of weight on certain body parts. Each of these activities, including a physical fitness regime, carried out as part of a healthcare provider's course of therapy services, should be covered by the State. Ensuring the healthcare of all Medicaid beneficiaries is not only the mission of the program, but covering preventative and maintenance services reduces the ultimate cost to the program.

Otherwise, we believe the State's omission of the current language limiting the types of covered physical therapy services from the proposed language appropriately broadens the scope of coverage.

For the occupational therapy language, we believe there is an inadvertent omission in the second sentence. The citation should read 42 C.F.R. § 440.110(b), not 440(b).

IV. CONCLUSION

Thank you for your time and consideration of these comments.

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[6] HEALTHCARE.GOV, Rehabilitative/Rehabilitation services, https://www.healthcare.gov/glossary/rehabilitative-rehabilitation-services/ (accessed Aug. 18, 2022).