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Dear Tribal Health Leaders

As it moves forward in the amendment process, the Department of Health (the department) wishes to express appreciation for the time and attention tribal health organizations spent reviewing the proposed SPA language and drafting thoughtful and constructive comments for consideration.

The following information represents a record of tribal comments (verbatim where included) and department responses to tribal consultation regarding the proposed state plan amendment (SPA) revising preventive services, vision services, and therapies. The state received comments from the following entities and notes the source of each comment in the document below – Alaska Native Health Board (ANHB), Alaska Native Tribal Health Consortium (ANTHC), Aleutian Pribilof Islands Association (APIA), Hobbs, Straus, Dean & Walker LLP on behalf of Bristol Bay Area Health Corporation (BBAHC/Hobbs Straus), and Kenaitze Indian Tribe (KIT).

Tribal Comment #1 – (BBAHC/Hobbs Straus) Preventive Services Typographical Error

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.

Department Response –
Thank you for pointing out this awkward language; the state revises the text as suggested to ensure its clarity and accuracy.

Tribal Comment #2 – (BBAHC/Hobbs Straus) Therapy Services Typographical Error

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).

Department Response –
Thank you for pointing out this omission; the full citation was included in the draft SPA pages but was inadvertently omitted in the text of the tribal consultation letter.

Tribal Comment #3 – (ANHB, ANTHC, APIA, KIT) Habilitative & Rehabilitative Service Definitions

(Finally,) we wish to share a concern on the definition provided for "Habilitative Services" in the Occupational, Physical, and Speech-Language Therapy Services. The proposed definition is based on limitation, and includes the confusing phrase "attain, maintain, or prevent deterioration of skills and functioning for daily living never learned or acquired." This definition does not include the improvement

of existing skills, which is part of the definition provided by CMS in its "Glossary of Health Coverage and Medical Terms" and is also inconsistent with the recommended definition adopted by the National Association of Insurance Commissioners (NAIC), and then adopted by the respective therapists' associations.

> Habilitation Services
> Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.

We also note that there is a similar confusion to the definition proposed for "Rehabilitative Services", which does not include the improvement of regained skills. We recommend that the Department adjust these definitions to be more inclusive and better reflect the industry standard as shared by CMS in its Summary of Benefits and Coverage "Glossary of Health Coverage and Medical Terms".

> **Department Response –**
> Thank you for offering this comment and suggested language.
>
> To align with the National Association of Insurance Commissioners (NAIC), the American Occupational Therapy Association (AOTA), the American Speech-Language-Hearing Association (ASLHA), the American Physical Therapy Association (APTA), and the Department of Health and Human Services Glossary of Health Coverage and Medical Terms the department makes the following adjustments to the text in each category of therapy services (physical, occupational, and speech, hearing, and language disorder therapy services).
>
> > The proposed definition of habilitative services, "*…forms of treatment to help a beneficiary attain, maintain, or prevent deterioration of skills and functioning for daily living never learned or acquired*," is revised to read, "…forms of treatment intended to help a beneficiary attain, maintain, or improve skills and functioning for daily living."
> >
> > The proposed definition of rehabilitative services, "*…forms of treatment that help a beneficiary maintain, regain, or prevent a deterioration of skills and functioning for daily living lost or impaired because a person was sick, hurt, or disabled*," is revised to read, "…forms of treatment intended to help a beneficiary maintain, regain, or improve skills and functioning for daily living lost or impaired because the beneficiary was sick, hurt, or disabled."

Tribal Comment #4 – (BBAHC/Hobbs Straus) Therapy Services - Definitions

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. The State's proposed language does not extend to improving skills and 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. 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."

Department Response –

Thank you for offering this comment and suggested language.

The proposed language in this section includes the word "attain", which the department believes precludes the need to include the word "learn" in the definition.

The department removes the extraneous language "never learned or acquired" from the habilitation definition, removes "prevent a deterioration of," and adds "improve" to both the habilitation and rehabilitation definitions as detailed in the response to comment #4.

Tribal Comment #5 – (BBAHC/Hobbs Straus) Therapy Services – Devices

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.

Department Response –

In accordance with existing practices, the state intends to continue reimbursing rehabilitative and habilitative devices under the durable medical equipment benefit.

Tribal Comment #6 – (BBAHC/Hobbs Straus) Therapy Services - Exclusions

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.

Department Response –

Thank you for this comment expressing concerns about the service limitations in the therapy benefit sections. The department considered the points raised by Hobbs Straus/BBAHC and, in response, offers the following additional information.

The department intended the proposed revisions to the list of excluded services in the therapy sections of the state plan to reflect the removal of habilitation services from the list while

establishing a consistent declaration of coverage exclusions; it did not intend to revise other existing coverage practices and policies. As the state plan currently reads, the exclusionary language for occupational and physical therapy precludes reimbursement for swimming therapy and weight loss. Physical therapy additionally excludes coverage of fiscal fitness activities. The department intends that these exclusions remain in the state plan.

Alaska Medicaid delineates between swimming therapy and hydrotherapy or aquatic physical therapy. Swimming therapies range from self-conducted to minimally supervised swim sessions that may or may not be administered by a credentialed physical therapist. By contrast, hydrotherapy and aquatic physical therapy are administered by a credentialed physical therapist in an aquatic environment. These services are covered when provided in alignment with a patient's physical therapy treatment plan. These services remain covered with the implementation of this proposed SPA.

Weight reduction and fitness services are also activities that may be self-conducted and are not reimbursable through Medicaid programs, even with a healthcare provider's recommendation. Exercises performed in conjunction with a physical or occupational therapy treatment plan in the presence of a credentialed physical or occupational therapist are covered services.

Please note that these exclusions apply only to individuals 21 years of age and older, individuals not subject to the provisions of EPSDT.

Tribal Comment #7 – (ANHB, ANTHC, APIA, KIT) Vision Services Schedule & Prior Authorization (comments divided and enumerated for clarity)

(1) Although we appreciate all of these improvements, we do wish to draw your attention to some concerns with the proposed changes. Our concerns are focused on vision services and therapy services. First the Department proposes to institute a two-year requirement on eyeglasses and contact lenses for beneficiaries 21 years of age or older. There is an allowance for a more frequent dispensing of eyeglasses and contacts, but it is subject to both a review of medical necessity and Departmental prior authorization. Frequently, patients with vision conditions and impairments or other medical conditions may experience a medical need to have whole eyeglasses, lenses, or contact lenses replaced more frequently than every two years. Additionally, the proposed SPA and ABP amendment do not clearly establish that a change in prescription would qualify a beneficiary to a new pair of eyeglasses, lenses, or contact lenses, if the new prescription were to fall in the off-year of the two-year cycle. The necessity of these replacements, including changes in prescription, are best left between doctors and patients.

(2) The burden of a determination of medical necessity and prior authorization for such new eyeglasses, lenses, or contact lenses not only puts a burden on providers, it can also harm beneficiaries' vision health if requests are denied and they must continue using out-of-date prescription eyeglasses and lenses. Vision services also have a real impact on the socio-economic wellbeing of beneficiaries in the working world. Many modern jobs require extended work on computer screens, requirements for vehicular operation, or work in rough conditions in rural Alaska. Without appropriate vision corrective lenses or the ability to replace eyeglasses, lenses, or contact lenses more frequently, beneficiaries may experience more limited economic opportunities due to impaired vision. We recommend that the language in the SPA continue to allow for annual replacement of eyeglasses, lenses, or contact lenses for beneficiaries 21 years of age or older.

Department Response –

(1) The proposed change from a one-year to a two-year cycle for eyeglasses and contact lenses occurs concurrently with regulatory revisions intended to align Alaska Medicaid coverage more closely with other payors. As noted in the text of this comment, beneficiaries are eligible for more frequent glasses or contact lenses as determined medically necessary via a prior authorization process, which does not change with this SPA.

(2) Beneficiaries 21 years of age and older continue to be eligible to receive annual vision examinations. The provider submits a prior authorization request if the off-year examinations reflect the medical necessity for updated glasses or contacts. Alaska Medicaid must reimburse only for clinically appropriate and medically necessary services; prior authorization processes are inherent to ensuring compliance. The prior authorization process does not change with this SPA.

Tribal Comment #8 – (ANHB, ANTHC, APIA, KIT) Vision Services Exclusions

Our concern extends to the limitations described in excluded vision products, including aspherical lenses, progressive or no-line multi-focal lenses, vision therapy services, polarized lenses, and anti-reflective or mirror coating. While we recognize that these products are not always part of standard care, they may be required by beneficiaries based on medical necessity. Unfortunately, the current language of the proposed SPA and ABP amendment does not allow for such medically necessary approval. We believe that such products should be available through medical necessity and prior authorization in a similar manner to ultraviolet coating, prism lenses, specialty lenses, specialty frames, and tinted lenses.

Department Response –

The addition of language describing excluded services and products intends to facilitate transparency regarding coverage and align the state plan with other vision services payors, existing practices, and state regulatory updates. Noncoverage of aspherical lenses, progressive or no-line multi-focal lenses, polarized lenses, and vision therapy services for beneficiaries 21 years of age and older is a long-standing policy of the department that aligns Alaska Medicaid with other payors, including other states' Medicaid programs.

These non-covered items listed in the proposed SPA are considered enhancements throughout the vision industry, and there are other *standard* lens options available to meet an individual's medical needs. Alaska Medicaid covers, and will continue to cover, lined multifocal and high-index lenses where medically necessary.

Examples:

National vision insurers, including Vision Service Plan (VSP), EyeMed, and MetLife, categorize aspherical lenses, progressive or no-line multi-focal lenses, polarized lenses, and anti-reflective or mirror coating as enhancements to standard available lenses.

Washington and California don't cover eyewear for adults and only standard eyewear for Medicaid beneficiaries under 21 years of age.

Oregon only covers standard eyewear; all enhancements are excluded.

Tribal Comment #9 – (BBAHC/Hobbs Straus) Vision Services Benefit – Optometrist Services

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. 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.

Department Response –
The language the commenter references above is included in existing CMS-approved language and does not intend to reflect a new restriction on annual or preventive vision services. The state revises the relevant language to reflect annual examinations and prevention coverage.

Tribal Comment #10 – (BBAHC/Hobbs Straus) – Vision Services – Prior Authorization

(comments divided and enumerated for clarity)

(1) 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 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.

(2) 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.

(3) 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.

Department Response –

(1) Thank you for your perspective. However, Federal Medicaid laws require the state to reimburse only for clinically appropriate and medically necessary services; prior authorization processes are routinely allowed and are intrinsic to ensuring compliance with these parameters. Even under EPSDT, states may utilize the prior authorization process to ensure services requested are medically necessary and clinically appropriate for a given beneficiary.

An individual's change in vision, or the treatment of conditions such as dry eye, are not preventive; these situations would be considered as actively diagnosing and/or treating a condition, covered by medical (not vision-specific) benefits. The department requires medical justification when a provider seeks to provide a beneficiary with preventive services more frequently than annually.

As evidenced by the proposed SPA language, Alaska Medicaid intends to continue coverage and reimbursement for annual vision examinations and preventive services, during which a provider would determine whether grounds for additional medically necessary appointments or services exist and would at that time request prior authorization for coverage. Thus, the department is not impermissibly limiting the scope of preventive services.

(2) The section the comment references applies only to individuals over 21. The state describes vision services for beneficiaries under the age of 21 under the EPSDT provisions, and therefore it should not be confusing to the reader. EPSDT benefits are as follows:

> Vision Services:
> Medically necessary eye examinations, refractions, eyeglasses, and fitting fees 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 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.

(3) Thank you for pointing out the confusion created by the inconsistent use of calendar year and 12 months in this section. The department revises the proposed text to reflect coverage based on a calendar year.

Tribal Comment #11 – (BBAHC/Hobbs Straus) Vision Services (comments divided and enumerated for clarity)

(1) 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. 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.

(2) 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.

Department Response –

(1) Please see the department response to tribal comment #9 and response (2) to tribal comment #10. Vision examinations are included in well-child exams. Alaska Medicaid adopted, by regulation, the American Academy of Pediatrics Bright Futures Periodicity Schedule, which includes annual vision examinations for Medicaid beneficiaries between 3 – 21 years old.

(2) Please see the department response (2) to tribal comment #10. Pursuant to EPSDT, beneficiaries under 21 years of age receive all services, subject to medical necessity and prior authorization by the Medicaid agency or its designee.

Tribal Comment #12 – (BBAHC/Hobbs Straus) Vision Services – Eyeglasses (comments divided and enumerated for clarity)

(1) 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.

(2) 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.

(3) 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. 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.

Department Response –

(1) The department appreciates the commenter's perspective regarding the request to expand coverage of contact lenses in the Alaska Medicaid program. However, the inclusion of language regarding the coverage of contact lenses, subject to a determination of medical necessity, reflects longstanding policy and practices and does not represent a change in coverage parameters.

(2) The Alaska Medicaid state plan does not, and has never, included a provision allowing the department to replace a pair of lost or destroyed glasses. This provision is instead described in the Vision Services Billing Manual, and aligned with a corresponding regulatory package which adds a new 7 AAC 110.705(b)(4)(A), which confirms this policy and practice for individuals under 21 years of age.

Medicaid recipients whose prescriptions change during off years are eligible for new lenses subject to a determination of medical necessity.

Please note that a beneficiary is not required to receive two years of contact lenses at a time. The two-year limitation is best described as follows, "In lieu of a pair of glasses every two years, an eligible individual may opt for contacts for the same length of time but may not receive both benefits in that timeframe." Each year with the annual vision exam, prescriptions for contacts will be validated and then ordered. If the prescription changes, the contacts for the year would as well, but a beneficiary can't then change and opt for glasses if they opted for contacts the year prior.

The department notes this policy is in alignment with other states' Medicaid programs.

(3) Alaska Medicaid covers standard high-index lenses for all conditions where aspherical lenses could also be used. High-index lenses are designed to minimize the weight of a lens for individuals with high corrective needs. Aspherical lenses are considered a cosmetic enhancement for lenses. They perform the same function as high-index lenses but in a different manner to make the lenses more aesthetically pleasing to the consumer by appearing flatter and thinner.

Tribal Comment #13 – (BBAHC/Hobbs Straus) Vision Services (comments divided and enumerated for clarity)

(1) 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. 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.

(2) 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.

Department Response –

(1) Please see the department response to tribal comment #9 and response (2) to tribal comment #10.

(2) Please see the department response (2) to tribal comment #10. Pursuant to EPSDT, beneficiaries under 21 years of age receive all services, subject to medical necessity and prior authorization by the Medicaid agency or its designee.