ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

SENT VIA EMAIL: courtney.king@alaska.gov

December 4, 2017

Courtney O'Byrne King, MS
Medicaid State Plan Coordinator
Division of Health Care Services
Alaska Department of Health and Social Services
4501 Business Park Blvd., Suite 24, Bldg. L
Anchorage, AK 99503

Dear Ms. King:

The Alaska Native Tribal Health Consortium (ANTHC) is a statewide tribal health organization that serves all 229 tribes and more than 158,000 Alaska Native and American Indian (AN/AI) individuals in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center, the tertiary care hospital for all AN/AIs in Alaska. ANTHC also provides a wide range of statewide public health, community health, environmental health and other programs and services for Alaska Native people and their communities.

Thank you for the opportunity to comment on the Department's proposed Medicaid State Plan changes regarding coverage and payment for Durable Medical Equipment, Prosthetics and Orthotics, and Supplies (DMEPOS).[1] While ANTHC and other tribal health organizations (THOs) are not currently enrolled as providers of these services, we prescribe them for our patients and are very interested in ensuring that they have reasonable and timely access to them—even if they live in remote villages hundreds of miles from the nearest DMEPOS provider or manufacturer. Reasonable and timely access requires that:

- reimbursement must be sufficient to cover the added cost of delivering DMEPOS items to far-flung villages, and should not discourage THOs from enrolling as DMEPOS providers in regional hubs;

- restrictions on the number of items that may be supplied at a time and on the frequency of refills must recognize that many villages lack daily flight service and that flights are often delayed or cancelled in bad weather; and
- prescription requirements must accommodate the unique characteristics of THOs, which not only serve Alaska Natives throughout the State, but are also the sole health care providers for Native and non-Native residents in the vast majority of Alaska's communities.

[1] Although the public comment and tribal consultation processes are separate, we are combining our comments in this letter and ask that you consider it in both contexts. Combining our comments in one letter is especially appropriate here, because there is as yet no draft State Plan Amendment (SPA) for us to review and the proposed regulations are thus the best indication of changes the Department is considering for the SPA.

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ANTHC believes that the SPA and regulation as drafted could potentially result in patients experiencing difficulty in obtaining medically-necessary DMEPOS equipment or services from local providers. This would only result in patients having few choices when selecting equipment or suppliers that will result in a reduction in the quality of DMEPOS items and services received. In order to avoid these circumstances, we respectfully request the following changes to the proposed regulations, and corresponding changes to the proposed State Plan Amendment:

1. Reimbursement Rates and Shipping Costs.

We understand that the proposed adoption of Medicare rates is essentially required by federal law starting January 1, 2019. However, as we read the federal rule, it allows States a modicum of discretion to tweak the Medicare rates, so long as reimbursement does not exceed the "aggregate amount" that would be paid by Medicare for each "class" of items.[2] Further, because the federal rule addresses amounts expended by the State "on the basis of a fee schedule for [DMEPOS] items," we believe it does not apply to shipping costs at all, and that the State may establish its own reasonable rules for reimbursing shipping costs. 42 U.S.C. § 1396b(i)(27). Indeed, 42 U.S.C. § 1396a(a)(30)(A) likely requires the State's program to cover DMEPOS shipping costs, to ensure adequate Statewide access to these vital services.

To be sure, the proposed regulations would allow reimbursement for "the reasonable and necessary direct costs of delivery or shipping" of DMEPOS items to recipients. But they impose conditions and restrictions that are so wildly inappropriate for Alaska, they almost seem to have been copied from some other State that is mostly urban and whose communities are interconnected by well-maintained roads. They also, we assume unintentionally, incentivize DMEPOS providers to locate exclusively in Alaska's largest cities, and discourage THOs and others from becoming DMEPOS providers in Alaska's regional hubs.

The proposed language at **7 AAC 120.200(i)** (regarding DME) and at **7 AAC 120.300(i)** (regarding Prosthetics and customized Orthotics) is a bit garbled, but appears to allow payment of shipping costs only when the recipient resides more than 50 air miles outside the municipality in which the enrolled DMEPOS provider is located.[3]

We understand that most of Alaska's DMEPOS providers, and certainly its largest, are located in Anchorage, Wasilla, Juneau, Ketchikan, and other urban centers. Under the proposed rule, those providers, if enrolled in Medicaid, would be reimbursed for shipping items to recipients in Bethel, Nuiqsut, Utqiagvik, Kotzebue, Kivalina, Akhiok, Sand Point, and dozens of other remote villages and rural hubs located more than 50 air miles from their own "municipalities."[4] So far, so good. But those providers would receive no compensation for shipping to other communities, some of them even less

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[2] *See* 42 U.S.C. § 1396b(i)(27).

[3] The proposed regulations read identically, as follows:

> "(1) To be eligible for payment, the following conditions must apply
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> (A) the recipient resides outside the municipality where the business of the enrolled dispensing provider is located, 50 air miles.
>
> (B) the item or service is unavailable from a provider enrolled under this section in the municipality in which the recipient resides, defined as within 50 air miles."

Proposed 7 AAC 120.200(i)(1) and proposed 7 AAC 120.300(i)(1).

[4] Neither the current nor proposed regulations define "municipality," but Alaska statutes generally define the term to include home rule and general law cities, boroughs, and unified municipalities. AS 29.71.800.

accessible and even more costly to ship to, simply because they are either "in" or "within 50 air miles" of the DMEPOS provider's municipality. A provider in Anchorage, for example, would receive no reimbursement for items shipped to Tyonek and Ketchikan providers would receive nothing for shipping costs to Metlakatla. It simply does not make sense to tie shipping cost reimbursement to municipal boundaries and air mile distances, in a State where most "municipalities" are huge and include dozens of communities that are accessible only by small plane, boat, or snow machine.

Worse still, tying reimbursement to municipal boundaries effectively guarantees that DMEPOS providers will never be established outside Alaska's largest cities, in regional and health care hubs like Utqiagvik or Kotzebue. Even though it would likely be cheaper, quicker, and more efficient to ship to Ambler from Kotzebue than from Anchorage, for example, an Anchorage DMEPOS provider's shipping costs would be covered by Medicaid and a Kotzebue provider's would not, simply and arbitrarily because Kotzebue and Ambler are in the same "municipality," the Northwest Arctic Borough.

We do not suggest that DMEPOS providers should be separately reimbursed for costs of shipping and delivering items to all recipients. As we understand it, CMS generally regards routine delivery costs as an integral part of a DMEPOS provider's business, and assumes that they are taken into account when the items are priced. That makes perfect sense for much of the lower-48 and within and between Alaska's road-connected communities, where shipping costs are typically modest and predictable. But shipping to Alaska's distant communities is costly and unpredictable, and it is not reasonable to expect such variable costs to be covered by an item's price. We could support other ways of differentiating shipping costs that must be included in an items' reimbursement from those that may be separately reimbursed. For example, the Department could establish an included-costs limit, and provide separate payment for costs that exceed it; or it might differentiate deliveries to locations on and off the road system; or it could allow separate reimbursement for items that must be delivered by plane or boat. But we think it is not reasonable to allow political boundaries—rather than geography, mode of transit, and actual costs—to dictate which costs will be separately reimbursed and which must be included in an item's price.

With regard to the proposed rates for the DMEPOS items themselves, we cannot judge whether they are adequate, or whether some should be increased to reflect higher costs in Alaska. But we understand that Alaska's few DMEPOS-enrolled providers are very concerned that some rates are inadequate and, if adopted, would make some items and services completely unavailable to some eligible Alaskans. We ask the Department to seriously consider their concerns and address them to the fullest extent possible under applicable federal laws.

2. Number and Frequency Limits.

The proposed regulations impose limits on the number of DMEPOS items that may be prescribed or shipped at a time, and allow for only a few days' extra supply between refills. Specifically, under proposed **7 AAC 120.200(l)** the Department would only pay "for up to a 30-day supply within each 25 day period," and under **7 AAC 120.200(m)** providers would be allowed to "supply no more than the difference between what the recipient needs and what still remains, except an allowance of a 5 day on-hand emergency overlap supply may be permitted."

The proposed limits might suit Alaska's largest communities, but they are unreasonable and inadequate for much of Alaska, and particularly for remote Alaska villages, where flights or barges do not arrive daily or on a scheduled basis at all, and where the State's size, weather, terrain, and limited transportation infrastructure conspire to cause frequent transportation delays. Just last year, for example, the village of Quinhagak was completely cut off for more than two weeks, and running low on food and other necessities due to bad weather, a damaged runway, and other factors. While that is an extreme

example, going six days or more between flights is not uncommon. We also question whether the proposed limits make fiscal sense: where shipping costs will be separately reimbursed, we expect that it would cost less to ship more items at a time and less frequently.

We suggest the Department cover up to a 60-day supply within each 45 day period, and allow a 15 day on-hand overlap supply. (Note that this would also require a conforming change to proposed **7 AAC 120.310(b)(2)**, which would now require a service authorization for medical supplies that exceed a 30-day limit set by the Department.) We also recommend that that larger quantities be permitted subject to service authorizations for all covered supplies, and not just for incontinence supplies as proposed by **7 AAC 120.200(p)(6)**.

3. Prescription Authority and Requirements.

We were concerned to see that Occupational Therapists, Physical Therapists, and Speech-Language Pathologists would be removed from the list of practitioners authorized to order DMEPOS services. (*See* proposed **7 AAC 120.200(b)(1)** and **7 AAC 120.300(b)(1)**.) If this change is not required by federal law, we ask the Department to reconsider and continue to allow these highly-qualified professionals to order services within the scope of their professional training and licensure. Alaska as a whole, and especially rural parts of the State, already have a shortage of qualified health providers and limiting the Medicaid services that can be authorized by non-physician practitioners exacerbates that problem and drives up care costs.

If the change is required, then we strongly support the mitigating change proposed by 7 AAC 115.110(e), which would allow therapists to be paid for "select" medically necessary DMEPOS they furnsh in the standard course of therapy and within the scope of the professional's license. We suggest the Department make it clearer that this is an exception to the DMEPOS enrollment requirement, by inserting the following language immediately after the reference to 7 AAC 160.900: "<u>,without separately enrolling as a provider under 7 AAC 120.200(a)</u>."

We also believe that prescribing certain DMEPOS items would fall within the scope of practice of Community Health Aides and Practitioners. THOs and the Native and non-Native people we serve rely on CHA/Ps to deliver a wide array of health services in villages where they are the only health providers, and if CHA/Ps may order DMEPOS, village residents will have better and faster access to them. As you know, CHA/P services are considered to be "physician services" under the State Plan, so it may be that an explicit reference to CHA/P authority to order DMEPOS is not required in the State Plan or regulations. We ask the Department to add such references, however, if you think they are needed, and if not to make their authority clear in the Tribal Providers Billing Manual.

Finally, we suggest the Department more specifically identify in **7 AAC 120.220(s)** the federal regulation that states the "face-to-face examination" requirements, with which ordering providers will need to comply. We believe it to be 42 CFR § 440.70(f)(3) which, we were pleased to note, allows these visits to occur via telehealth.

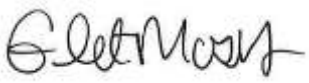
4. The "Repeal and Replace" Style of the Regulations Public Comment Draft.

Finally, we would like to lodge a mild complaint about the extensive use of the "repeal and replace" format in the regulations public review draft, which complicated our review. That format was used even when only a few words were proposed to be changed and could easily and more properly have been indicated by underlining the proposed additions and bracketing the proposed deletions. We do not suggest this was the Department's intention, but the effect was to obscure some potentially important changes, both good and bad. It also resulted in a public comment draft that was very lengthy, and more

daunting and time-consuming to analyze. For example, the repeal and replace style was used to propose changing "the department will pay a provider" to "providers … may request payment" in no fewer than twelve subsections—an important and potentially alarming change for enrolled providers, which would have been much more obvious using the underline/bracket style.[5] Similarly, the proposal to remove prescription authority from Physical Therapists, Occupational Therapists, and Speech-language pathologists in 7 AAC 120.200(b) would have been more apparent if brackets had shown the proposed deletions, as would a more welcome change in the same paragraph removing the requirement that prescriptions be by the patient's "attending" practitioner. As recognized by Alaska's Legislative Affairs Agency, "the [repeal-and-replace] technique should be used with restraint because it deprives the reader of the opportunity to see what changes are being made to the law."[6] Alaska's *Drafting Manual for Administrative Regulations* also instructs that the more transparent underline/bracket style should be used except where a regulation "is being amended so extensively that the underlining and bracketing method … would be more confusing than helpful," or when a new subsection is being added in the middle of existing regulations," which was not the case here.[7] We encourage the Department, in the future, to use the underline/bracket style whenever possible, and to limit the "repeal and replace" technique to those situations when it is clearly required or preferred under the *Drafting Manual*.

Thank you again for the opportunity to comment. If you should have any questions, please contact me directly at (907) 729-1908 or at gmoses@anthc.org.

Sincerely,



Gerald Moses
Senior Director of Intergovernmental Affairs

[5] *See* proposed changes to 7 AAC 115.110(e), 7 AAC 120.200(b), 7 AAC 120.200(c), 7 AAC 120.200(d), 7 AAC 120.200(e), 7 AAC 120.200(f), 7 AAC 120.200(g), 7 AAC 120.200(h), 7 AAC 120.200(i), 7 AAC 120.200(p), 7 AAC 120.220(a), and 7 AAC 120.220(c). In many of these, that was the only proposed language change.

[6] Alaska Legislative Affairs Agency, *Manual of Legislative Drafting* (2017), p.18.

[7] State of Alaska, Department of Law (August 2015), Chapter 7, page 61.