PUBLIC COMMENT SYNOPSIS. Department of Health & Social Services, Division of Behavioral Health; Proposed Changes to Regulations; *7 AAC 70, 7 AAC 105 – 160. Services for Behavioral Health, Medicaid Coverage & Payment, Autism Services*; JU2016200132.

COMMENTER/ AGENCY	COMMENT RECEIVED	RESPONSE
Carlene Boden	Dear Mr. Calcote - I am excited to have reviewed the publication from yesterday on the states plan to provide ABA services within our community. I find an important piece of information missing from the public draft and I am hopeful this is just "yet to be decided". There is a listed definition for "adaptive behavior treatment" but there is not a section for this under the proposed payment rates for this service as provided by a BCBA. There are certainly some clients that the BCBA is the most appropriate service provider. Adaptive behavior treatment (and needed program modification) is typically billed under a 368T/369T CPT code. BCBA oversight of services is a requirement for both RBT and BCaBA providers. I am concerned that ABA services will have many of the same difficulties the HCBW program struggle with if there is not a set process to bill for BCBA supervision/direct services. Thanks in advance for reviewing my concern. Looking forward to your response. Best, Carlene Boden MSPAS, BCBA Alaska Behavior Consultants	The Dept. determined the need to add the service "adaptive behavior treatment with protocol modification" billed as 368T code, to the list of autism services.
ABA	September 8, 2017 Commissioner Valerie Davidson Alaska Department of Health and Human Services 3601 C Street, Suite 902 Anchorage, AK 99503 **Re: Formal Request for Direct Collaboration and Time Extension re: Proposed Changes on Behavioral Health Services, Medicaid Coverage & Payment: Autism Services in the Regulations of Department of Health and Social Services** Dear Commissioner Davidson: First, let us extend a warm thank you for taking the time to consider our formal request for direct collaboration and	Letter answered by Commissioner's office under separate cover (see cop of Commissioner letter below Pg. 28-29).

	time extension re: DHSS proposed changes on Behavioral Health Services, Medicaid Coverage & Payment: Autism Services. It is our sincere hope that our request will be received in the spirit in which it is intended: to best serve Alaska's under 21 Medicaid eligible children and young people with high quality and best practice autism services. We make our request based on the following: **1)** Lack of Collaboration: As the Proposed Changes on Behavioral Health Services, Medicaid Coverage & Payment: Autism Services in the Regulations of Department of Health and Social Services were crafted in complete absence of collaboration or consultation with the Alaska Association for Behavior Analysis (AK-ABA) and its membership (whose mission is "to promote the science and theory of behavior analysis through the support of research, education and practice") throughout the Department's two years of draft regulation development, there are a resulting broad and complex range of vital issues within the currently proposed draft that we strongly believe will preclude ability for effective and best practice service provision. 2) Unrealistic Present Timeline: We are formally requesting more time (at least 60 additional days), as well as face-to face collaboration with the Department to work together on the development of a comprehensive and functional system for providing services to Medicaid eligible children with autism. At this stage, AK-ABA has requested feedback and involvement from national organizations, including the Association for Professional Behavior Analysts (APBA) and the Legal Resource Center for Autism Speaks, to assist in ensuring a comprehensive and effective set of Alaskan regulations and we have been able to convene a single AK-ABA work group session since the regulations draft were recently released (generally released, however not directly to BCBA's in our State nor AK-ABA nor its broad membership of practitioners). It is AK-ABA's firm belief that feedback and guidance from national organizations who have been involved in the implementation of EPSDT and Applied Behavior Analysis (ABA) services in other areas of our country are advised so that Alaska can create a system that works well;	

	however, coordination with national organizations and our local membership will take time. It is our understanding that the goal of currently proposed regulations is to expand services to meet the needs of Medicaid eligible children with autism in the state of Alaska. AK-ABA does not believe the current draft will create a system able to meet those needs and therefore we are making formal request to work directly with the Department as well as an extension of the comment period in order to thoroughly review all the relevant regulations and develop a system that will allow for the provision of behavior analytic autism services to Medicaid eligible children in our state. We look forward to the opportunity to work collaboratively toward our mutual goal of helping Alaska's Medicaid eligible children with autism receive the quality services they so desperately need, and deserve. Sincerely, Alaska Association for Behavior Analysis Cc: Randall Burns, Director, Alaska Department of Health and Human Services Division of Behavioral Health Rick Calcote, Alaska Department of Health and Human Services Division of Behavioral Health Christie Reinhardt, Governor's Council on Disabilities and Special Education Alaska State Legislature Senate and House Health and Social Services Committee Members Dan Unumb, JD, Executive Director, Autism Speaks Gina Green, PhD, BCBA-D, Association for Professional Behavior Analysts Membership & Board, Alaska Association for Behavior Analysis	
CARD Comments	Re: Notice of Proposed Changes-Services for Behavioral Health, Medicaid Coverage & Payment: Autism Services	

	Dear Mr. Calcote: 1. The Center for Autism and Related Disorders (CARD) respectfully submits these comments in response to the above referenced proposed regulations regarding services to treat Medicaid beneficiaries under age 21 who are diagnosed with autism spectrum disorder (ASD). CARD is among the world's largest organizations treating ASD and the nation's third largest non-governmental organization contributing to autism research. CARD provides services at over 150 locations throughout the United States and at international locations in Africa, Asia, and the Middle East, employing a workforce of over 3,000 dedicated professionals. CARD commends the efforts of the Department of Health and Social Services to comply with the CMS requirement to include autism treatment in its EPSDT coverage. Given the proposed regulation in its current form, CARD has significant concerns. In its current form, the proposed regulation includes provisions that have the effect of hindering and/or limiting access to medically necessary treatment in direct violation of EPSDT requirements. Additionally, the proposed regulation incorporates certification requirements that may have the effect of limiting access to autism treatment so severely as to make the CMS-mandated benefit proposed herein illusory for some underserved populations. **Eligible Medicaid Providers-7AAC105.200 (b)(12) and Autism Services; Provider Qualifications-7 AAC 135.300 (c)(3)** **Concern:** The proposed regulation specifies that the paraprofessional implementing a treatment plan under the supervision of a behavior analyst or other licensed professional must be a *Registered Behavior Technician (RBT)* certified by the Behavior Analyst Certification Board (BACB). Historically, state programs that have mandated a credential at the frontline technician level have encountered significant delays in securing access to medically necessary treatment. CARD has significant concerns that this requirement will hobble any effort to develop an adequate network of autism treatment providers with the capacity to meet the needs of Alaska's Medicaid-eligible children, especially if DHSS limits the accepted certification to the RBT. The RBT requirement	The Dept. has determined the need to maintain that behavior technicians be certified as required in the proposed regulations. The requirement that a behavior technician also be supervised by a licensed behavior analyst will also remain. However, Medicaid does not pay for "supervision" though it does include a billable code for the service "adaptive treatment with protocol modification" that will be added to the list of autism services. The Dept. has determined that the "fail-first" requirement is an impediment to treatment access, and will be removed from regulation.

	creates two significant problems that would severely limit access to autism treatment for Alaska's Medicaid-eligible children. First, in order to become and RBT, one must pass and exam. In Alaska, that exam is only available at one test site in Anchorage. Second, the RBT must be supervised by a Board Certified Behavior Analysts (BCBA), which would preclude other licensed professionals from using the tiered delivery model to supervise paraprofessionals who implement the treatment plan. That is, psychologists and others working within the scope and competency of their license (and included as eligible Medicaid providers in the regulations) are not permitted to supervise RBTs under the Behavior Analyst Certification Board rules. (Although the BACB includes language to allow a psychologist to meet criteria to supervise and RBT, a very limited number of psychologists meet that criteria and **no psychologist in Alaska meets that criteria.)** Moreover, the RBT is not the only certification available for frontline paraprofessionals. In fact, the only behavior analytic autism-specific credential accredited by the NCCA (the same entity that accredits the BCBA and BCaBA) for the entry –level technician role is the Board Certified Autism Technician (BCAT), which is administered by the Behavioral Intervention Certification Council, a nonprofit that also maintains ongoing background checks on all of its certificates. BCATs can be supervised by BCBAs and by licensed professionals acting within the scope of their licensure, including psychologists. Additionally, BICC allows providers that meet specific requirements to host the BCAT exam using independent and trained proctors. This option reduces the cost of certification and eliminates the barrier created by minimal test locations. **Recommendation:** CARD urges DHSS to consider delaying this requirement and /or offering a grace period to newly hired technicians, so they may be able to provide services once they have completed training and passed a background check but prior to completing the certification process. CARD also urges DHSS to include the BCAT certification as an option in the final regulation to ensure that other licensed professionals can continue to provide services, minimize the cost of the certification, and ensure access to the exam for individuals who do not reside in Anchorage. ***Recipient Eligibility – 7 AAC 135.020 (e)(3)(D)***	All Medicaid behavioral health services have annual limits. Providers may request extension of service limits through the service authorization process noted in regulation. All service authorization requests must be based on medical necessity. The Dept has determined to increase the number of hours for the annual service limit for "adaptive behavior treatment by protocol." The Dept has also determined the need to increase the annual limit for "family adaptive behavior treatment guidance." The restriction on providing community based services to recipients receiving care through an acute care facility, etc. is a Medicaid rule, and will be observed as written in regulation. The autism services rates for Alaska Medicaid are established as a flat fee-for-service rate. Services

	Concern: This language appears to impose a " fail-first" provision in which documentation is required that " confirms that other recommended EPSTD (sic) services listed in 7 AAC 110.210 have previously been provided or are presently being provided to the recipient and those services have not resulted in measurable improvement in the recipient's behaviors." Applied behavior analysis (ABA) is the single treatment recommended by the American Academy of Pediatrics and the U.S. Surgeon General as it has been empirically proven to be the most effective method for treating the deficits and behaviors associated with ASD. To impose a "fail first" requirement to demonstrate the ineffectiveness of another treatment prior to accessing the appropriate treatment contradicts the intent of the EPSDT mandate and may result in a child's permanent loss of function and/or an increased need for services across the lifespan. No other state imposes a fail-first requirement on its coverage of ABA for its Medicaid EPSDT population. Fail-first policies have also been recognized by CMS as non-quantitative treatment limitations subject to the prohibitions of the federal Mental Health Parity and Addiction Equity ACT (MHPAEA)	must be provided by qualified individuals as outlined in regulation, but the service is not variably reimbursed according to the rendering provider's credentials (i.e. Licensed BA, Lic. Asst. BA, RBT).
	Recommendation: Delete this section The EPSDT mandate requires the provision of medically necessary services to treat conditions that are revealed in a screen. The Medicaid Act also prohibits discrimination of benefits based on diagnosis. Therefore, treatment of ASD cannot be limited to those individuals exhibiting "the presence of maladaptive behavior or developmental skills deficits' that significantly interferes with home, school, or community activities." Other states have considered and rejected nearly identical language, and we urge Maryland to follow suite and reject language that limits access autism treatment. All deficits and conditions arising from a child's diagnosis of ASD must be treated. **Recommendation:** Eliminate any language that limits autism treatment, and clarify that a diagnosis of ASD is sufficient to access treatment for all deficits and conditions forming the basis of the diagnosis of ASD. ***Service Authorization and Limitation- 7AAC 135.040(c)(19)(A-D)*** **Concern:** This language appears to impose a soft cap on services, limiting adaptive behavior treatment by protocol (i.e., the 1:1 ABA hours typically delivered by a	

	behavior technician) to 520 hours per six-month period and limiting parent training to four sessions per year unless the provider receives "specific authorization by department." Such a cap is confusing and unwarranted since a child must already demonstrate medical necessity and obtain prior authorization to receive any level of services. To the extent that this cap is intended as a hard cap, hard caps on treatment are not permitted under EPSDT. Although it is clear that DHSS/DBH understands that all medically necessary treatment must be delivered under EPSDT, soft limits have repeatedly caused confusion during the authorization process and when the benefit is administered by managed care organizations (MCOs). In fact, *every* soft limit we have encountered has been treated as a hard limit, which is a violation of the EPSDT mandate. That is, the soft cap serves as a chilling effect on medically necessary treatment. The EPSDT mandate requires the provision of medically necessary services to treat conditions that are revealed in a screen. To the extent that soft limits are not imposed on other EPSDT benefits, please note that the Medicaid Act also prohibits discrimination of benefits based on diagnosis. Other states have considered and rejected nearly identical language and we urge Alaska to follow suit and reject language that limits any aspect of autism treatment. All deficits and conditions arising from a child's diagnosis of ASD must be treated. Any arbitrary limit imposed on EPSDT services violates the EPSDT mandate and the federal Mental Health Parity and Addiction Equity Act. The soft limit proposed in these regulations would limit ABA to 20 hours per week. Research has consistently demonstrated that "intensive" ABA such as that required to ameliorate the deficits and behaviors associated with ASD is defined as 30-40 hours per week, e.g., Eldevik, Eikeseth, Jahr, & Smith, 2006; Eikeseth2009; Reichow & Wolery, 2009; Remington, Hastings, Kovshoff, degli Espinosa, Jahr, et al.,2007; Rogers & Vismara, 1998. Indeed, the seminal study that first used ABA to treat ASD recommended that ABA be provided during "most…waking hours" Since that first study, thousands of studies published in peer-reviewed journals have demonstrated that outcomes are maximized only when a child receives sufficient hours of ABA. For many children, their ability to become adults	

	who function independently in the community depends on early intensive behavioral intervention (EIBI) of 30 - 40 hours per week of ABA. Recently, Linstead and colleagues conducted a retrospective review of over 700 children with autism, ranging in age from 1.5 to 12 years, in which they determined that the single-most influential variable in the treatment of children with ASD is the number of hours of treatment they received each week. Children who receive fewer hours are likely to require services over the course of their lifetime, the cost of which has been estimated at $3.2 million per capita. Sections 7 AAC 135.350 (f) (1)-(2) of the regulations state, "The department will pay for family adaptive behavior treatment guidance… to (1) instruct recipient guardians and caregivers on the recipient's identified problem behaviors and deficit skills; and (2) teach recipient guardians and caregivers to use planned treatment protocols to intervene with the recipient to reinforce change and to maintain treatment progress." However, Section 7 AAC 135.050 (19) (B) limits family adaptive behavior treatment guidance to "four family adaptive behavior guidance sessions in one year." When it is clinically appropriate to involve the parents/caregivers in the treatment plan, four sessions would rarely be sufficient to provide the information, training, and support that are critical to ensure effective participation of the parent/caregiver. **Recommendation:** Eliminate any and all hour and /or visit/session limits from the proposed regulation to avoid confusion and ensure that Alaska's Medicaid-eligible children have access to autism treatment based on individualized determinations of medical necessity. ***Autism services 7 AAC 135-350 (k) (9) (C)*** Medicaid eligible children who are receiving treatment from an outpatient hospital, general acute care hospital, inpatient psychiatric hospital, residential psychiatric treatment center, skilled nursing facility, and/or intermediate care facility should not be precluded from receiving treatment if it will benefit them. Other states, including California and Colorado, have eliminated this exclusion to comply with EPSDT. Treatment should be individualized and not categorically excluded. **Recommendation:** Eliminate this exclusion.	

	Behavioral Health Services Payment Rates- 7AAC 145.580 **Concern:** No rate is listed for the behavior analyst or licensed professional who conducts the clinical case management, including supervision of the behavior technician. If providers cannot be reimbursed for these services, the Medicaid benefit for autism treatment is *de facto* illusory. All commercial coverage of ABA includes reimbursement rates for the behavior analyst and/or qualified health professional. Given a choice between providing coverage for commercial plans that include rates for the behavior analyst and a Medicaid plan that does not, providers are unlikely to choose to participate in Medicaid plans. CARD's mission includes a social justice initiative to provide services across all populations, so we make every effort to participate in Medicaid, even when the rates are considerably lower than those offered by commercial plans. CARD would be unable to participate in a Medicaid plan that did not include reimbursement of the behavior analyst service. This tiered delivery model in which the behavior analyst oversees the behavior technician who implements the 1:1 ABA has been demonstrated to be extremely effective from the earliest days of evidence-based autism and is critical in state, such as Alaska, where the number of BCBAs is insufficient to meet the needs of the autism population. CARD commends DHSS/DBH for recognizing tiered-delivery model by including the behavior technician in its list of eligible Medicaid providers. Please note that the Behavior Analyst Certification Board allows the Board Certified Assistant Behavior Analyst (BCaBA) to provide some supervision duties under the broader supervision of the BCBA, Reference regarding the missing rate for the assistant behavior analyst, as well. ***E. (2) Services shall be discontinued when the…Participant is not demonstrating progress towards treatment goals and objectives and measurable functional improvement is no longer expected.*** This section requires that treatment end when "participant is not demonstrating progress toward treatment goals," but EPSDT requires services to *maintain* a child's functioning. While minimal progress is noteworthy and the treatment goals should be reviewed,	

	lack of progress is not the same as lack of medical necessity. Children with ASD may require medically necessary treatment to maintain function and prevent the loss of skills. **Recommendation:** Clarify that lock of progress should be addressed by the provider but is not a basis on which to discontinue services. Thank you for investing your time in considering these comments. Should you require additional information, please do not hesitate to contact me at J.Kornack@centerforautism.com. Respectfully submitted Julie Kornack Director of Public Policy (818) 345-2345, extension 1070	

Form letter submitted by 6 individuals	Mr. Rick Calcote Division of Behavioral Health 3601 C Street, Ste 878, Anchorage, AK 99503 (907) 269-3623 (fax) Dear Mr. Calcote: Thank you for the opportunity to comment on the Department of Health and Human Service proposed changes. I am the friend of a child under the age of 21 who requires Intensive Active Treatment (TAT) in the form of Applied Behavior Analysis (ABA) services. Some significant changes that these services have made for my friends child include increased verbal skills. The proposed changes to regulations will effectively prohibit any provider of ABA services in Alaska from accepting children covered by Medicaid, leaving some of Alaska's most vulnerable and needful Children without services. Specifically:	
	•The changes do not include a reimbursement rate for the Masters/Doctoral level professional (BCBNBCBA-D) who is responsible for ensuring fidelity and the successful programming for my child via supervision, assessment, and direct services with my child. •The proposed Medicaid rate is only 47% of the current	Autism services are reimbursed without regard to specific rendering provider credentials. (see above).

	rate paid for the same service 1:1s to my provider, who has been providing TAT/ABA services to families in Alaska for 7 years. •·Per the Tricare Medicaid' study, the proposed AK Medicaid rates are well below the national average ($65, 16/hr. for behavior technicians and $94.72/hr. for BCRAs). •Yet Fairbanks, AK has a cost of living rate that is 32% higher than the national average. •The proposed hourly AK Medicaid rates for ABA ($44) are not comparable to other professional; with similar educational requirements such as SLPs, OTs, and PTli. ($153.76, $181, $ l 81 respectively)	The autism services rates are established to be commensurate with other Medicaid behavioral health services.
	If implemented, the proposed Medicaid rates will force my provider, Step-in Autism Services of Alaska, LLC. to close its doors.	
Parent David Flynn	Dear Mr. Calcote: I would appreciate anything you and your office could do to assist with keeping the only ABA therapy option available to my son, that I am currently aware of, available to him. It is difficult enough for our family to deal with his disorder without further set-backs and we have finally got into a rhythm with getting him there and it is definitely helping him overcome some of his challenges. Please contact me if there is anything I can do to assist further! Best Regards, David Flynn (Father of Jake) 907-590-7775cell/text	The Dept is dedicated to providing Medicaid funded autism services to help meet the needs of eligible children statewide.
Rachel White	**Questions:** 1. Page 8: (D) "confirms that other recommended EPSDT services listed have previously been provided or are presently being provided to the recipient and those services have not resulted in measurable improvement in the recipient's behaviors." a. What are the criteria for "measurable improvement"? b. How long do services have to have been tried?	All publicly submitted questions were answered within a separate document posted on the On-Line Public Notice system.

	c. Can a newly diagnosed child get autism services right away? Or do they need to have a history of failure with other services first? d. What other disciplines is this required for? If this is the only one required, why? e. Whose responsibility is it to determine improvement? f. Is there a dollar cap for all EPSDT services combined? 2. Page 11: covered services a. What about coordination with other service EPSDT providers, school, etc.? Is there a way that BCBAs can attend or assist with coordination of behavior plans across environments? b. What about supervision of RBTs? RBTs are required to be observed 5% of their hours per month. At least half of those hours must be individual and must include observation while working directly with clients. For RBTs working full time (40 hours), they must be supervised at least 8 hours per month with at least 4 of those occurring while working with clients. c. Where are the codes for billing? Where is the table of rates per code, as with other service providers? d. Will BCBA recommendations for amount of treatment hours be considered, or will all consumers receive 20 hours per week? 3. Page 15: (C) "information on the recipient's skill deficits, deficient adaptive behaviors or maladaptive behaviors from the following sources: (i) in-person observation of the recipient; (ii) structured interviews with the guardian or caregiver; (iii) administration of standardized and non-standardized tests; (iv) a detailed behavioral history; (v) interpretation of test results;" a. Who will evaluate and approve these plans? b. Will a BCBA/BCBA-D be involved in the review process? c. Are all 5 items required, or a combination of any of them? d. Will the BCBA determine which interviews and assessments are	

	used? 4. Page 17: (h) "To receive payment for autism services a provider must develop an individual treatment plan that is updated as needed and includes:…" a. Who will evaluate and approve these plans? b. Will a BCBA/BCBA-D be involved in the approval process? 5. Page 18: (j) Autism services settings. a. Will the setting for autism services have to be declared in the authorization? b. Can the setting change throughout the authorization? 6. Will there be a grace period for RBT credentialing? a. Currently, there are only 75 RBTs in the state. The credential requires completion of 40 hours of ABA training, passing a skill fluency checklist, applying to the Behavior Analyst Certification Board (BACB), and passing a written exam. The time between application and exam is generally 2-4 weeks for local providers. The exam can only be taken in Anchorage or Fairbanks at this time, so providers outside of those areas may need more time scheduling their travel to take the exam. 7. Will any other credentials be recognized, such as BCAT and ABAT? 8. Will audits be conducted? a. What will be required for an audit? b. Who will be conducting audits? c. How frequently will audits be conducted? d. Are these in line with other disciplines? 9. How will this affect school? a. Will schools be able to bill as related service? b. What if schools are using all the authorized hours? c. Will there be a percent designated between school and home/community providers? 10. Are systems in place for providers to get enrolled? a. How do BCBAs get a Medicaid	

	number? b. Are there processes in place for implementation? 11. What is the rationale for this regulation being "autism services" rather than applied behavior analysis services (as other professions are referred to specifically within State regs)? 12. Can you please clarify if BCBAs will be allowed to hold and bill for social groups (as only RBTs and BCaBA are currently listed within the draft)? 13. Can you clarify the evidence/best practice and rationale behind prohibition of two services at the same time? 14. Can you clarify the evidence/best practice relied upon in specifically excluding the client from being present during family guidance sessions? 15. Can you clarify the evidence/best practice relied upon in limiting family guidance sessions to four per year? 16. Can you please explain the exclusion of foster parents and guardians within the draft definition of family (which would effectively preclude family guidance for those families of children in State's custody)? 17. Do you anticipate other service areas beyond autism services (such as FASD) that have demonstrated success through receipt of ABA services to be added to these regulations? 18. What percentage of ABA services do you estimate will be covered under this regulation through federal funds &/or federal funds received by the State? 19. The State's "fiscal crisis" was mentioned at the September 22nd hearing. In light of our State's "crisis" will the State be reducing the reimbursement rates for all Medicaid service areas or will ABA service reimbursement rates be the sole area looked at to help reduce overall costs? 20. Can you explain why the currently proposed rates are so far below those of other comparable disciplines? 21. On September 6th, in written formal request, and again at September 22's hearing, our State's Association made formal request for collaboration and extension of time to best assist in creation of best practice regulations, which has been denied. Do you anticipate this position to change?	

	a. If not, can you please explain the rationale for creation of draft regulations in the absence of collaboration with our State's professional organization and its members? b. Can you provide examples of other discipline's regulations that were crafted in the absence of collaboration with Alaskan practitioners and State and National Associations? c. Is this common practice for our State? 22. Can you explain how the currently proposed cap on service hours can meet EPSDT, BCBA ethical guidelines, the BACB's treatment guidelines and federal requirement to cover all medically necessary services for children including children with ASDs under EPSDT? 23. Can you explain why issuance of these draft regulations has taken over two years' time? 24. Can you clarify the evidence/best practice relied upon in requiring a "fail first" clause? a. Is this clause included in other discipline's regulations within our State? b. If yes, can you please provide example? c. Can you please explain how a "fail first" clause meets medical necessity? 25. Can you explain why additional criteria beyond clinical diagnosis such as the "fail first" clause and at page 8 (B)(i) is required to access ABA services? a. Are additional criteria required for other comparable disciplines or just ABA services? b. If others, can you please provide example? 26. Can you explain why ABA service provision oversight has been placed within the Division of Behavior Health? 27. Can you explain how the two year delay has allowed DBH to "vastly improve the Division's behavioral health delivery system, including the inclusion of a more integrated approach to the delivery of both primary and behavioral health care" and how "the adoption of ABA services are (were) incorporated into DBH's broader systems review" (as stated in director Burns' July 1, 2016 letter as reason for	

	further regulation delay)? 28. Can you please explain why the rate for a Licensed Assistant Behavior Analyst (who has an undergraduate degree) is the same as a Registered Behavior Technician (who does not need to have a degree)? 29. Can you give the rationale as to why the technician level staff would need to be an RBT when the state already has billing codes and regulations for a behavior health technician? 30. Can explain why the proposed regulations do not have codes for the supervision of the technician? a. This is in violation of BCBA ethical guidelines, the BACB's treatment guidelines. b. Will supervision codes be added for both Licensed Assistant Behavior Analyst and Licensed Behavior Analyst? 31. Why don't the regulations reference the Licensed Behavior Analyst and Licensed Assistance Behavior Analyst professions instead of BCBA/BCABA? 32. Why services are called "autism services" when they are actually "Applied Behavior Analysis services"?	
Diane Poage	October 5, 2017 Diane Poage, Executive Director FOCUS 11901 Business Blvd. Suite 209 Eagle River, AK 995 77 Focus is a non-profit agency serving individuals who experience developmental disabilities and their families. Our clients live in Eagle River, Chugiak and Peters Creek as well as parts of Anchorage and the Mat-Su area. We offer ABA services to children from age 2 through ages 8. As a result, we have been eagerly awaiting the issuance of the draft ABA Medicaid regulations. Now that they are available for review, we have some significant concerns.	
	•One area of concern about the proposed regulations relates to the supervision of Registered Behavior Technician (RBTs) by a Board Certified Behavior Analyst (BCBA). There is currently no provision for reimbursement for the appropriate supervision of RBTs in the regulations. Throughout the field, the standard for supervision is 5% of each	Please see comments above re: "supervision" and addition of the service: adaptive behavior treatment with

	RBTs hours per week (e.g., a 40-hour week= 2 hours of supervision per learner.) It is considered unethical and unprofessional to fail to provide appropriate levels of supervision to RBTs. Private insurance companies require this activity. We recommend that the Medicaid ABA regulations include language about RBT supervision by BCBAs and appropriate reimbursement rates for that activity. A second area of our concern relates to the reimbursement of a broad range of BCBA and BCBA-D services including not only RBT supervision but also family training, assessments, periodic reassessments, preparation of treatment protocols, data analysis and appropriate modification of treatment protocols based on the data gathered by the RBTs. Please note: It is not unusual for a learner to have 20 - 30 detailed programs for each session. These programs (or protocols.) which can be pages long are initially written by a BCBA and are revised weekly in response to learner achievement. BCBA services should be included in all appropriate phases of treatment from assessment, planning, program writing and on-going family training (twice a month for 1-2 hours) to RBT supervision by BCBAs for at least 5% of the time RBTs are delivering service. Industry-wide these services are billed at rates of $120-$160/hour. Finally, we are concerned about the reimbursement rates in the regulations for RBT services. The current rate ($44) is barely more than the rate at which the services of a direct service provider for Day Hab are billed at. RBTs are highly trained in the implementation of ABA plans and protocols, data collection, graphing and recording. They have 40 hours of required on line training and a rigorous hands-on competency evaluation based on the BACB's official task list (see below) as well as a comprehensive national examination to successfully pass. Accordingly, we recommend that the reimbursement rates for RBTs be $55/hour, the industry average corrected for cost of living, as opposed to the suggested $44/hour. Please be aware that the reimbursement rate of $44 is too low to fiscally sustain the service. We recommend $55 an	protocol modification. The Dept determined the need to adjust the originally proposed reimbursement rates for all autism services based on analysis of other insurance and other state's Medicaid rates.

	hour for the RBT service because it is consistent with New Mexico Medicaid ABA rates as of 5/1/15 and the Tricare $50 an hour rate adjusted for Alaska cost of living. We recommend that you refer to the array of CPT codes used by Tricare and other private insurances to reimburse for a broad range of ABA services. It is important to appreciate that RBT service is more intense, targeted and prescriptive and requires a higher level of training and supervision than a direct service provider delivering day habilitation. Not only will FOCUS need to pay the RBT staff a higher rate of pay then frontline Waiver direct service providers, we will need to pay them travel time, training time and more significant data recording and data-analytic time then we would for a Waiver direct service provider.	
	One of the hallmarks of FOCUS is providing person-centered services for young children and family-centered supports and training for their parents. A great number of our clients are on Medicaid and we have been waiting for two years for Medicaid regulations for ABA to be published so we can provide this critically important service to <u>all</u> our children. In planning to offer ABA to Medicaid recipients, we made our business plan assuming that Medicaid coverage would be similar to TRICARE and private sector insurance plans. We have been telling our families who have not been able to get ABA service for their children because they do not have private insurance but are covered under Medicaid that there will be the opportunity to access ABA through Medicaid soon. It is a source of profound disappointment to us that these proposed regulations will not allow us to provide that service. Sadly, we can serve children and families who are fortunate enough to have good jobs with good insurance or are a part of our military but not our most needy and economically challenged families. It is our sincere hope that we can continue to reassure these families that ABA <u>will</u> be available to them sooner rather than later and that the state of Alaska will provide appropriate regulations that will facilitate this desperately need service.	

	Sincerely, Diane Poage	
Kimberly Dugas	Hello, I am an Occupational Therapist and a LEND fellow through Alaska's LEND Without Walls Program. I have been made aware of the EPSDT regulations that affect ABA therapy. As an OT, I value the interdisciplinary team, to provide holistic care to children with special needs. It is important all disciplines work together in collaboration, to provide the child with the best possible treatments that cover all aspects of his or her life. I have been made aware that the proposed regulations include a restriction that to be eligible for ABA services, the child has to fail another therapy, and if this doesn't "work" for the child, then he or she is eligible for ABA. This restriction would make it impossible to allow the child and his or her family, the concurrent services necessary to provide the best care for the child. Sometimes it is necessary for a child and his or her family, to learn to manage the behavior, before other therapies can be successful in helping the child gain skills. There have been some times that working in collaboration with an ABA therapist to help a child, has been helpful for me. With each of us being most knowledgeable in our own field, it is best practice to consult with other disciplines when a piece of the puzzle is missing and we need more tools to help a child. Please reconsider the "Fail First" eligibility requirement in the new EPSDT regulations. Thank you. Kim Dugas	Please see response above re: "fail first" requirement.
ABA Rachel White	Mr. Rick Calcote, The Alaska Association for Behavior Analysis and licensed Behavior Analysts in the state of Alaska were not	

	consulted in the formation of these regulations. We would appreciate more time (60 additional days) to work with the state on the development of a comprehensive and functional system for providing services to children with autism. With regard to the draft regulations proposed, we would like to thank the state for the time you have spent on this. Thank you for this proposal to cover ABA services for children with autism. We appreciate the time you spent putting this together. Thank you for recognizing Licensed Behavior Analysts and Board Certified Behavior Analysts (BCBAs) as providers for this service. The definition of "autism services" is well written to include the characteristics of Applied Behavior Analysis (ABA), the recommended treatment for individuals with autism. Thank you for recognizing the role of licensed Assistant Behavior Analysts (BCaBA s) and Registered Behavior Technicians (RBTs) in the delivery of ABA. We are grateful that individuals up to 21 years of age are eligible for these services. Thank you for including those individuals receiving ABA services under IAT, as well. We really appreciate the significant coverage for social skills groups. This wills our learners to better interact with their peers in the natural environment. Thank you for including parent training services. Parent training will help skills to generalize and for learners to need less support in the future. Thank you for requiring reassessment every 6 months. This will ensure that goals are updated and learners are making progress throughout treatment. Thank you for including language about the supervision of BCaBA s and RBTs. Supervision within service delivery is vital to the fidelity of the program. Thank you for recognizing the need for BCBAs to receive appropriate training in supervision prior to supervising others. We appreciate that autism services can be provided in multiple settings, as this will allow for better generalization of skills. In order to help the state provide the needed services to children with autism in the state of Alaska, the Alaska Association for Behavior Analysis (AKABA) offers the following comments and recommendations. On page 8 (D), the draft states "confirms that other recommended EPSDT services listed have previously been provided or are presently being provided to the recipient	All comments have a previous written response (please see above). One additional note: Medicaid rules prohibit the provision of more than one service to the same recipient in the same clock hour (with the exception of case management).

	and those services have not resulted in measurable improvement in the recipient's behaviors." Early intervention results in more improvements and reduced need for services in the future (see articles attached: "Cost Comparison…" & "Costs of ASD"). Delaying start of ABA is not beneficial to child (see article attached: "Effects of Age and Treatment…" & "Effectiveness of IBI"). An individual might still need ABA even if progress is being made in other areas. Other services provided might not be addressing the same skill deficits as "autism services". AKABA recommends that the referral comes from diagnostician for ABA or "Autism services". Diagnosis includes level of severity and providers must document coordination with other services providers. (See New Mexico ABA billing instructions, p8, Stage 1: Comprehensive Diagnostic Evaluation). This is better than waiting to let the child fail. On page 11 (A), the draft states "a total of 520 hours in a six month period for either (i), (ii), or (iii)". Medical necessity should determine the number of hours. (See article attached: Effects of Age and Treatment Intensity) Children under 7 years old make more progress with more hours. Additionally, BCBA direct work with client sometimes needed; both IAT and CBC are for clients with greatest needs, so there needs to be a similar option for EPSDT; in some locations, BCBA may only be available, so need to be able to bill. AKABA recommends that the BCBA recommendations should be considered when approving the amount of services per client based on assessment. Codes should be added so that BCBAs can provide direct services when needed to support the success of the child's program. On page 11 (B), the draft states "four family adaptive behavior treatment guidance sessions in one fiscal year". This would be only once per 3 months. Parent training needs to be on-going and related to the needs of the client and the parent, as well as changes in the environment (see article "Parent Inclusion in EIBI" attached). AKABA recommends increasing parent training to 1-2 sessions per month. On page 13 (d), the draft states "If a board certified behavior analyst provides supervision to an assistant behavior analyst or a registered behavioral technician the	Regarding the comment below about the potential confusing language in the proposed regulations referring to a BCBA: The Dept has determined the need to amend the proposed regulations to use the term "licensed" in all cases when identifying a behavior analyst or assistant behavior analyst.

	behavior analyst must complete the required supervisory certification as prescribed by the Behavior Analyst Certification Board." RBTs and BCaBAs require supervision (RBTs = 5% of hours [see https://bacb.com/responsible-certificants/]; BCaBAs = 2-5% of hours depending on number of post-certification hours [see Standards for Supervision of BCaBAs, attached]). While BCaBAs hold an undergraduate degree and do not need as much supervision, BCBAs need to observe RBTs working with clients to make programming decisions. BCBAs need to meet with the team of parents, caregivers, and multiple RBTs/BCaBAs to guarantee fidelity of program implementation (see "ABA Guidelines for ASD" and "Intensity of supervision and outcome", attached). AKABA recommends add supervision code and hours up to 20% of approved service hours (adaptive behavior treatment by protocol or group adaptive behavior treatment by protocol). This would be up to 4 hours per week for BCBA oversight in either observation of RBTs/BCaBA s or team meetings to coordinate with providers and family. On page 14 (a), the draft states "The department will pay for the following autism services…" As previously mentioned, AKABA recommends adding a supervision code and hours up to 20% of approved service hours (adaptive behavior treatment by protocol or group adaptive behavior treatment by protocol). This would be up to 4 hours per week for BCBA oversight in either observation of RBTs/BCaBA s or team meetings to coordinate with providers and family [see CPT® coding structure to report adaptive behavior assessment and treatment services]. On page 19 (6), the draft states "any two or more concurrent autism services by the same or different rendering individuals to the recipient at the same time". As previously mentioned, RBTs and BCaBA s require supervision RBTs (RBTs = 5% of hours [see https://bacb.com/responsible-certificants/]; BCaBA s = 2-5% of hours depending on number of post-certification hours [see Standards for Supervision of BCaBA, attached]. BCBAs need to observe RBTs working with clients to make programming decisions. BCBAs need to meet with the team of parents, caregivers, and multiple RBTs/BCaBA to guarantee fidelity of program implementation. AKABA recommends adding a supervision code and hours up to 20% of approved service hours (adaptive behavior treatment by protocol or group adaptive behavior	

Rachel White Good Behavioral Beginnings	treatment by protocol). This would be up to 4 hours per week for BCBA oversight in either observation of RBTs/BCaBA or team meetings to coordinate with providers and family. The way these regulations are written, we believe this will limit the number of providers who would enroll with Medicaid and therefore would limit services to children. Thanks again for the opportunity to submit comments. We look forward the revisions of this draft. Rachel L White, PhD, BCBA-D Past-President On behalf of the Alaska Association for Behavior Analysis members October 9, 2017 Re: MEDICAID COVERAGE & PAYMENT: AUTISM SERVICES Mr. Rick Calcote, My name is Rachel White and I am a Board Certified Behavior Analyst – Doctoral level and a Licensed Behavior Analyst in Alaska. I am the CBAI Behavior Analysis Services Director at the Center for Human Development at UAA and the Past-President of the Alaska Association for Behavior Analysis, but today I am writing to you as the owner of Good Behavior Beginnings, an agency providing ABA services to children with autism. Thank you for your work to provide evidence-based services to children with autism and thank you for the opportunity to comment. As someone who works with children with autism and their families, my focus is on the provision of quality services so that these children can gain the skills they need to be as independent and successful as possible as they grow up. Quality services start with verifiable, qualified providers; and include effective services to improve functioning, address core symptoms of the disorder, and prevent regression. I am concerned that "fail first" language is being used to prevent children with autism from accessing ABA services as early as possible.	

	This is contradictory to the goals of EPSDT and scientific evidence, guaranteeing that children will be deprived of medically necessary services, which will make it more challenging to make progress later. Second, the services provided should be based on medical necessity for that child and individualized to their specific needs. To put a cap on the number of hours covered negates the role of the professionals on the child's treatment team. Guidelines and research cite 30-40 hours per week for comprehensive ABA services. Even if proposed as a soft cap for services, this is too low. Hours provided should be based on the analysis, experience, and expertise of the Licensed Behavior Analyst evaluating and providing the ABA services. More hours will also be needed for ongoing case supervision, protocol review and modification, and the supervision of RBTs as required by the Behavior Analyst Certification Board. Additionally, I strongly recommend that language in the regulations be changed to be consistent with our state license laws and the BACB. References to Board Certified Behavior Analysts should be changed to Licensed Behavior Analysts; references to the RBT as a certification should be changed to a credential; supervision of LABAs/BCABAs and RBTs is required, not optional; and "autism services" should be changed to "Applied Behavior Analysis services" to reflect the actual service provided, not the diagnosis required. The Association for Professional Behavior Analysts and Autism Speaks Legal Resource Center have Model Language for Medicaid State Plan Amendments and I recommend adopting their wording to best reflect the services provided by Licensed Behavior Analysts. Also, the covered services listed do not cover the full range of ABA services necessary to effectively make progress. Covered services should match the CPT codes for reporting ABA services. Services that are currently not listed include Observation Behavioral Follow-Up Assessment, Exposure Behavioral Follow-Up Assessment, Adaptive Behavior Treatment with Protocol Modification, Adaptive Behavior Treatment Social Skills Group, and Supervision of RBTs. The current services presume that the Licensed Behavior Analyst would only conduct the assessment and that RBTs would be providing all other services. However, that can vary based upon the severity of challenging behaviors and the needs of the client. This also doesn't take into account the role of the Licensed	

	Assistant Behavior Analyst and their education and experience beyond the level of the RBT. Instead, modifiers should be used to identify which level provider performs the service. Finally, the rates proposed on page 23 (36) – (40) are significantly below the national average reimbursable rates. Tricare conducted an Applied Behavior Analysis Benefit Comparison with Medicaid and Commercial Benefits in 2014 and found that "the mean national reimbursement rate … was $65.16 per hour for therapeutic behavioral services from a BCaBA, Behavioral Technician, or other unspecified-level provider, or $94.72 per hour for master's- or doctoral-level providers." Taking into account the additional cost of living in Alaska, the way these regulations are written, I believe this will limit the number of providers who would enroll with Medicaid and therefore would limit services to children. With regard to billing rates and codes, there are additional concerns that need to be addressed. Assessments can take 10+ hours if dealing with severe challenging behavior or complicated skill repertoires. The rate for assessment should be the same whether an initial or follow-up assessment because the level of detailed analysis that goes into quality programming and analysis does not change decrease after the first assessment. RBTs and BCaBAs require supervision (RBTs = 5% of hours [see https://bacb.com/responsible-certificants/]; BCaBAs = 2-5% of hours depending on number of post-certification hours [see Standards for Supervision of BCaBAs, attached]). While BCaBAs hold an undergraduate degree and do not need as much supervision, BCBAs need to observe RBTs working with clients to make programming decisions. BCBAs need to meet with the team of parents, caregivers, and multiple RBTs/BCaBAs to guarantee fidelity of program implementation (see "ABA Guidelines for ASD" and "Intensity of supervision and outcome", attached). I recommend adding a supervision code and hours up to 20% of approved service hours (adaptive behavior treatment by protocol or group adaptive behavior treatment by protocol). This would be up to 4 hours per week for BCBA oversight in either observation of RBTs/BCaBAs or team meetings to coordinate with providers and family. Due to severity of need or complexity of program, it is	

	sometimes necessary for the BCBA to provide direct intervention services to the learner. I recommend adding a billing rate for BCBAs to provide adaptive behavior treatment and group adaptive treatment. BCBA-Ds and BCBAs perform the same tasks, but BCBA-Ds have more education and their rates should reflect that. BCaBAs are currently listed as performing the same tasks as RBTs in this draft, but BCaBAs have an undergraduate degree, while RBTs do not. Rates should be reimbursed at different levels based on the education and certification level of the provider. In summary, I appreciate your effort in putting these regulations together and I encourage you to make changes to these recommendations based on feedback from Licensed Behavior Analysts; national experts, such as APBA; and families with children with autism. Sincerely, Rachel L White, PhD, BCBA-D President, Good Behavior Beginnings --- Good Behavior Beginnings, LLC PO Box 771606 Eagle River, AK 99577 Rachel L White, PhD, BCBA-D, President 907.301.5471	
Jude Jenkins	My concern with the Medicaid proposal for ABA therapy is the reimbursement rates. I cannot afford to take Medicaid clients for ABA based on the proposed rates it would be impossible for me to pay my RBT's and I cannot take all Medicaid clients myself due to the low reimbursement rate for BCBA's as well. I have start-up packet ready to send but have held back due to low rate of reimbursement. When rates are raised to meet current levels of reimbursement I will send in my application to become a provider. Thank You, Jude Jenkins-Schrack, BCBA Autism and Behavior Solutions, LLC (907) 669-0123	The issue of Medicaid reimbursement rates for autism services is addressed above in a previous response.

Kristin Riall	Good morning, Mr. Calcote, I'm writing to express my concerns about the current draft proposal for Medicaid coverage for individuals who experience Autism. I am a special education teacher working with students with intensive needs in Nome, Alaska and am planning to sit my boards for my BCBA this February. Assuming I pass, I will be the only BCBA in my region. I would love to be able to provide ABA services through the school district or in collaboration with NSHC, but I need your help. The current wording in the draft proposal for Medicaid coverage for Autism services will not allow for the provision of ABA services in the Norton Sound region. Currently our region has zero BCBAs and zero RBTs. Once I obtain my credential, I would like to be able to provide services for people in Nome and the surrounding communities but would not be able to incorporate provision of services to Medicaid recipients using RBTs at the current rate. Furthermore, the provision that children must fail to progress under other therapies prior to receiving ABA will cause undue hardship to children who already face significant challenges, particularly in regions where there are no OT, SLP, and limited counseling services (especially for non-verbal individuals). It'd be great if they were also provided those therapies, but currently we barely have adequate services in place in order to allow them the opportunity to fail. Furthermore, what is a freshly minted LMSW going to do with a non-verbal child with significant self-injury and aggression towards others? How would that be an efficient use of already strained counseling resources? The ABA community in Alaska has worked so hard to cultivate BCBAs and RBTs for our rural regions. This proposal does justice to either the youth who need the services or the professionals who have worked so hard at their own expense to be able to provide them with the best evidence-based therapy to meet their significant needs. Thanks in advance for your consideration of my comments. September 14, 2017	All comments have a previous written response (please see above).
Val Davidson		

Commissioner	Alaska Association for Behavior Analysis RE: Notice of Proposed Changes to Regulations Related to Behavior Health Services, Medicaid Coverage & Payment - Autism Services. To Whom It May Concern: I am writing to follow-up on Alaska Association for Behavior Analysis' (AABA's) letter regarding the proposed regulations referenced above. After careful consideration, I am unable to agree to the AABA's request for special consultation and for an extension to the public comment period. I do, however, feel that the AABA's input is valuable and invite your organization to take part in the public comment period that is open through October 10, 2017. The Alaska Association for Behavior Analysis may comment on the proposed regulation changes, including the potential costs to private persons of complying with the proposed changes, by submitting written comments to Rick Calcote at the Division of Behavioral Health, 3601 C Street, Suite 878, Anchorage, AK 99503. Additionally, the Department of Health & Social Services will accept comments by facsimile at (907) 269-3623 and by electronic mail at hss.dbh.publiccomments@alaska.gov. The comments must be received no later than 5 p.m. on October 10, 2017. Oral or written comments also may be submitted at the public hearing that will be held on September 22, 2017, at Conference Room 890 & 896, 3601 C St., Anchorage, AK 99503. The hearing will be held from 9am to 1pm. If an AABA representative is unable to attend in person, but would like to comment during the oral public hearing, your representative can call the teleconference number (800) 315-6338 (Toll Free) and use the code 36171#. The AABA may also submit written questions relevant to the proposed action to Rick Calcote at the Division of Behavioral Health, 3601 C Street Suite 878, Anchorage, AK 99503. The questions must be received at least 10 days before the end of the public comment period. The Department of Health & Social Services will aggregate its response to substantially similar questions and make the questions and responses available on the Alaska Online Public Notice System at https://aws.state.ak.us/OnlinePublicNotices/ and agency website at http://dhss.alaska.gov/dbh/Pages/default.aspx.	

	If the AABA representative is a person with a disability who needs a special accommodation in order to participate in this process, please contact Rick Calcote by e-mail at rick.calcote@alaska.gov or by telephone at (907) 269-3617. The request for accommodation was required by today's date, but feel free to contact Mr. Calcote no later than Friday, than September 15, 2017, to ensure that any necessary accommodations can be provided. Sincerely, Valerie Davidson Commissioner	
Kim Burnett	October 9, 2017 Mr. Rick Calcote Division of Behavioral Health Alaska Department of Health and Human Services 3601 C Street, Suite 878 Anchorage, AK 99503 RE: COMMENTS ON DHSS AUTISM SERVICES DRAFT REGULATIONS Thank you for the opportunity to provide written comment. For the record, my name is Kim Burnett. I've owned Every Child Matters, a consulting practice based in Anchorage since early 2010 and I've had the privilege of living and working in our great state for over 30 years. I'm a Board Certified and State of Alaska licensed Behavior Analyst and am a current Alaska Association for Behavior Analysis Board member. To begin, I believe it's important to take a moment to remember that we're all firmly focused on the common goal of providing Alaska's under 21 Medicaid eligible children and young people with high quality and best practice applied behavior analysis services. To that end, I'd like to recognize the tremendous efforts to date of those who have crafted the current draft regulations as well as our State's practitioners and advocacy groups, especially those at the national level, who have taken time to offer their support and ideas for turning this current goal into effective reality, a reality I wholeheartedly believe would stand the greatest opportunity for achievement with reconsideration of our Association's September 6, 2017 (attached) request for direct collaboration with the Department and an additional 60 days with which to develop a comprehensive and functional system of service provision within our State. The extremely disappointing September 14, 2017 Departmental rejection (attached) of AK-ABA's request notwithstanding, I'd like to echo many of the public	All comments addressed in previous written responses and the Commissioner's letter (please see above). All publicly submitted questions were answered in a separate document posted on the On-Line Public Notice System.

	concerns and those of my colleagues previously expressed at September 22, 2017's public comment hearing and would especially like to highlight the following: • Need for direct collaboration between the Department and our State's professional organization and its practitioners to address the broad and complex range of issues within the currently proposed draft that is highly likely to preclude ability for effective and best practice service provision; • Recognition that the Department's denial of collaboration and limited time extension was made following an additional two years' time taken by the Department to issue its current draft before us today; • Concern expressed at the first (and last) stakeholders meeting held in July of 2015, more than 2 years ago today, that if there was no allowance for BCBAs to work with clients, effectively supervise and bill at a professional level (as other comparable disciplines such as psychologists, Speech Language Pathologists, Occupational Therapists, Physical Therapists are able to within our State), BCBAs are understandably highly unlikely to sign up as Medicaid providers; • Acknowledgement that current draft requirement of failure of a myriad of services before ABA services are to be approved is arbitrary, not research based and would result in critical loss of time, especially for young children; • Understanding that extension of time for collaboration would also allow Departmental response to the following (as yet unanswered) previously submitted questions: 1. Page 8: (D) "confirms that other recommended EPSDT services listed have previously been provided or are presently being provided to the recipient and those services have not resulted in measurable improvement in the recipient's behaviors." a. What are the criteria for "measurable improvement"? b. How long do services have to have been tried? c. Can a newly diagnosed child get autism services right away? Or do they need to have a history of failure with other services first? d. What other disciplines is this required for? If this is the only one required, why? e. Whose responsibility is it to determine improvement? f. Is there a dollar cap for all EPSDT services combined? 2. Page 11: covered services a. What about coordination with other service EPSDT providers, school, etc.? Is there a way that BCBAs can attend or assist with coordination of behavior plans across environments?	

	b. What about supervision of RBTs? RBTs are required to be observed 5% of their hours per month. At least half of those hours must be individual and must include observation while working directly with clients. For RBTs working full time (40 hours), they must be supervised at least 8 hours per month with at least 4 of those occurring while working with clients. c. Where are the codes for billing? Where is the table of rates per code, as with other service providers? d. Will BCBA recommendations for amount of treatment hours be considered, or will all consumers receive 20 hours per week? 3. Page 15: (C) "information on the recipient's skill deficits, deficient adaptive behaviors or maladaptive behaviors from the following sources: (i) in-person observation of the recipient; (ii) structured interviews with the guardian or caregiver; (iii) administration of standardized and non-standardized tests; (iv) a detailed behavioral history; (v) interpretation of test results;" a. Who will evaluate and approve these plans? b. Will a BCBA/BCBA-D be involved in the review process? c. Are all 5 items required, or a combination of any of them? d. Will the BCBA determine which interviews and assessments are used? 4. Page 17: (h) "To receive payment for autism services a provider must develop an individual treatment plan that is updated as needed and includes:" a. Who will evaluate and approve these plans? b. Will a BCBA/BCBA-D be involved in the approval process? 5. Page 18: (j) Autism services settings. a. Will the setting for autism services have to be declared in the authorization? b. Can the setting change throughout the authorization? 6. Will there be a grace period for RBT credentialing? a. Currently, there are only 75 RBTs in the state. The credential requires completion of 40 hours of ABA training, passing a skill fluency checklist, applying to the Behavior Analyst Certification Board (BACB), and passing a written exam. The time between application and exam is generally 2-4 weeks for local providers. The exam can only be taken in Anchorage or Fairbanks at this time, so providers outside of those areas may need more time scheduling their travel to take the exam. 7. Will any other credentials be recognized, such as BCAT and ABAT? 8. Will audits be conducted?	

	a. What will be required for an audit? b. Who will be conducting audits? c. How frequently will audits be conducted? d. Are these in line with other disciplines? 9. How will this affect school? a. Will schools be able to bill as related service? b. What if schools are using all the authorized hours? c. Will there be a percent designated between school and home/community providers? 10. Are systems in place for providers to get enrolled? a. How do BCBAs get a Medicaid number? b. Are there processes in place for implementation? 11. What is the rationale for this regulation being "autism services" rather than applied behavior analysis services (as other professions are referred to specifically within State regs)? 12. Can you please clarify if BCBAs will be allowed to hold and bill for social groups (as only RBTs and BCaBAs are currently listed within the draft)? 13. Can you clarify the evidence/best practice and rationale behind prohibition of two services at the same time? 14. Can you clarify the evidence/best practice relied upon in specifically excluding the client from being present during family guidance sessions? 15. Can you clarify the evidence/best practice relied upon in limiting family guidance sessions to four per year? 16. Can you please explain the exclusion of foster parents and guardians within the draft definition of family (which would effectively preclude family guidance for those families of children in State's custody)? 17. Do you anticipate other service areas beyond autism services (such as FASD) that have demonstrated success through receipt of ABA services to be added to these regulations? 18. What percentage of ABA services do you estimate will be covered under this regulation through federal funds &/or federal funds received by the State? 19. The State's "fiscal crisis" was mentioned at the September 22nd hearing. In light of our State's "crisis", will the State be reducing the reimbursement rates for all Medicaid service areas or will ABA service reimbursement rates be the sole area looked at to help reduce overall costs? 20. Can you explain why the currently proposed rates are so far below those of other comparable disciplines? 21. On September 6th, in written formal request, and again at September 22's hearing, our State's Association	

	made formal request for collaboration and extension of time to best assist in creation of best practice regulations, which has been denied. Do you anticipate this position to change? a. If not, can you please explain the rationale for creation of draft regulations in the absence of collaboration with our State's professional organization and its members? B .Can you provide examples of other discipline's regulations that were crafted in the absence of collaboration with Alaskan practitioners and State and National Associations? c. Is this common practice for our State? 22. Can you explain how the currently proposed cap on service hours can meet EPSDT, BCBA ethical guidelines, the BACB's treatment guidelines and federal requirement to cover all medically necessary services for children including children with ASDs under EPSDT? 23. Can you explain why issuance of these draft regulations has taken over two years' time? 24. Can you clarify the evidence/best practice relied upon in requiring a "fail first" clause? a. Is this clause included in other discipline's regulations within our State? b. If yes, can you please provide example? c. Can you please explain how a "fail first" clause meets medical necessity? 25. Can you explain why additional criteria beyond clinical diagnosis such as the "fail first" clause and at page 8 (B)(i) is required to access ABA services? a. Are additional criteria required for other comparable disciplines or just ABA services? b. If others, can you please provide example? 26. Can you explain why ABA service provision oversight has been placed within the Division of Behavior Health? 27. Can you explain how the two year delay has allowed DBH to "vastly improve the Division's behavioral health delivery system, including the inclusion of a more integrated approach to the delivery of both primary and behavioral health care" and how "the adoption of ABA services are (were) incorporated into DBH's broader systems review" (as stated in director Burns' July 1, 2016 letter as reason for further regulation delay)? 28. Can you please explain why the rate for a Licensed Assistant Behavior Analyst (who has an undergraduate degree) is the same as a Registered Behavior Technician (who does not need to have a degree)? 29. Can you give the rationale as to why the technician level staff would need to be an RBT when the state	

Hope Greer	already has billing codes and regulations for a behavior health technician? 30. Can you please explain why the proposed regulations do not have codes for the supervision of the technician? a. This is in violation of BCBA ethical guidelines, the BACB's treatment guidelines. b. Will supervision codes be added for both Licensed Assistant Behavior Analyst and Licensed Behavior Analyst? 31. Why don't the regulations reference the Licensed Behavior Analyst and Licensed Assistance Behavior Analyst professions instead of BCBA/BCABA? 32. Why are services called "autism services" when they are actually "Applied Behavior Analysis" services? In summary, I would again like to express my sincere belief that the process of creating draft regulations in the absence of collaboration with Alaska's behavior analysis professional organization, its practitioners and in a way that precludes knowledge of the process or professionals that may or may not have been utilized throughout the two years of regulation formation is at best troubling and at worst completely heartbreaking as election of this path is likely to ultimately result in direct harm to those the regulations are mandated and intended to serve, young Medicaid eligible Alaskans with autism who research consistently demonstrates receive direct and immeasurable benefit from ABA services, especially in the earliest years of life. I urge the Department to reconsider its position and allow extension of time to collaborate with AK-ABA and national groups with extensive prior experience in creation of regulations that will provide greatest opportunity for meaningful, quality provision of services rather than pushing through the draft in its current state for the sake of checking the box "Complete". Our state's Medicaid eligible children in need of behavior analytic services and our state's behavioral analytic professionals deserve more. Again, thank you for the opportunity to provide written comment and supporting attachments today, Kimberley Burnett, M.Ed., BCBA, LBA Every Child Matters LLC 2019 Brandilyn Street Anchorage, Alaska 99516 (907) 522-2163	

Christie Reinhardt (HSS) Dean Gates Chair Medicaid Ad Hoc Committee	DHHS, I am writing to express my concern over the proposed changes to our state's Medicaid coverage and payment rates related to Autism Services. I live in Fairbanks with my husband and our two sons (age 4 and 8) who both experience autism and are non-verbal. Both of our children also receive ABA therapy on a daily basis which is currently covered under IAT through Medicaid. Our boys are both very sweet, but as is common with children with autism and particularly those who are non-verbal, they have some serious behavioral issues that are difficult for our family to deal with. My older son can be very aggressive towards others in the form of scratching/clawing, punching, and kicking. He also frequently goes after our younger child who now has several scars on both sides of his cheeks (a sight that breaks my heart every time I see it). Our younger son has difficult fits where he kicks and bangs his head on the ground. We try to deal with all of these issues the best that we can as parents and there are many days where we honestly don't know how to handle something or where we become despondent. We have some help from our sons' teachers through the school district who try their best to help in any way that they can, but they are not BCBA's and they don't have the extensive training needed to deal with intense and aggressive behavioral issues and methods to decrease them. To say that we depend on ABA therapy for our sons is a serious understatement. They both receive ABA through Step-In Autism Services in Fairbanks who have a wonderful and amazing community/family orientated environment. Step-In is very dedicated to its clients and they go above and beyond almost every day. I have had hour plus long conversations with techs and with the two owners, far past the billable time for our children. Some of the other ways in which they have helped us as a family is by providing after hours holiday activities for the kids and coming to do sessions at our home in order to address issues specific to that environment. Most importantly, my younger son is beginning to use words (I can't tell you how much this means to us). I have no doubt that this is the result of the daily efforts of the Step-In techs who tirelessly work on	

	sounds and words with him using the ABA model; they have given us a gift that truly cannot be quantified. The two owners of Step-In are both BCBA's and they train and supervise their staff very carefully which gives the best and most quality therapy for their clients. In your proposal you set a reimbursement rate which is unrealistic for therapists at this level of training and expertise. If your proposed changes go through and the reimbursement rates for these therapists go down so significantly, Step-In will likely not be able to maintain their business and will have to close down. This would have a tremendous negative impact on my family and on our community. In Alaska we often don't have the resources that other states do or the resources available to us are hundreds of miles away. Without the therapy that our sons receive at Step-In we will be stranded and isolated from services that our children desperately need. Sincerely, Hope Greer Rick Calcote Division of Behavioral Health Alaska Department of Health and Social Services 3601 C. Street, Suite 878 Anchorage, Alaska 99503 Re: Proposed Changes on Behavioral Health Services, Medicaid Coverage & Payment: Autism Services in the Regulations of Department of Health & Social Services Dear Mr. Calcote, The Governor's Council on Disabilities and Special Education (the Council) fills a variety of federal and state roles, including serving as the State Council on Developmental Disabilities (SCDD) under the Developmental Disabilities Assistance and Bill of Rights Act. In 2007, the Council convened a Five-Year Autism Initiative to assess needs and provide action steps for the improvement of diagnosis and treatment of Autism Spectrum Disorders (ASD) in Alaska. As part of this work, the Council was key in	

	the passage of SB 74, an autism insurance bill which required private insurance carriers in Alaska to cover Applied Behavior Analysis (ABA), an intensive evidence-based treatment for ASD. The Council has also actively advocated for the development of a workforce of Board Certified Behavior Analysts (BCBA) at the Center for Human Development (CHD) as well as the licensing needed by these therapists for billing public and private insurance for ABA. In 2015, the Council was tasked in the final report from the Comprehensive Autism Early Diagnosis and Treatment Task Force established by the Alaska State Legislature to work on several fronts to improve diagnosis and treatment ASD, and as part of this mandate developed a second Five Year Autism Initiative. An important objective of this legislative mandate is advocating and assisting the state in expanding coverage of ABA. It is in this capacity that we offer these comments on the proposed changes to Medicaid regulations for Services for Behavioral Health, Medicaid Coverage & Payment: Autism Services. The Council is very pleased by the recognition of licensed Board Certified Behavior Analysts (BCBAs), Assistant Behavior Analysts (BCaBAs) and Registered Behavior Technicians (RBTs) as providers for this therapy. The Council along with our partner boards has actively advocated for the development of a workforce of Board Certified Behavior Analysts (BCBA) at the Center for Human Development (CHD) as well as the licensing needed by these therapists for billing public and private insurance for ABA. The Council approves the proposal to cover children up to 21 and that several very beneficial services including social skills groups and crucial parent training are also included for coverage. The Council agrees with the Department that coverage of telepractice is of great benefit for families in Alaska and has the potential for cost savings and increased availability of service. We join our professional stakeholders in applauding the Department for a strongly written definition of “autism services” that clearly lays out the difference between ABA and other behavioral treatment practices.	

	Many of the Council's concerns about the proposed regulation have been voiced by stakeholders already, in both written and oral comments and we join with them in some of their concerns, such as: • A "fail first" requirement, as described in 7 AAC 135.020 (D) is contrary to the mandate Early Periodic Screening Diagnosis and Treatment (EPSDT) which ensures that "eligible children receive the health care they need, when they need it". The proposal would require that other expensive and time consuming therapies be tried first. It makes the access to a medically necessary treatment dependent on an assessment from a provider who may not have in-depth knowledge of the child or the therapy. This not only wastes valuable time and money, it stands the potential of causing rivalry and miscommunication among a treatment team that runs contrary to the idea of coordinated wraparound services. No other EPSDT covered services have this additional hurdle for coverage, and similar proposals have been seen as red flags by CMS and rejected in other states. • The intensity of the therapy would not be determined by the needs of the child as decided by their licensed provider, but would be established as a bi-annual hourly cap. By statute, private insurance providers in Alaska are not allowed to place a cap on ABA services. Limiting ABA therapy intensity does not naturally lead to cost savings. The biggest behavioral changes are usually seen by intensive early treatment that fades as the skill is learned. The authorized therapy intensity should be based on a comprehensive assessment and regular re-assessments and not a proscriptive bi-annual hourly cap. There will be questions about whether this is a hard or a soft cap and how that reflects the EPSDT requirement to provide service based on medical necessity. Because of this confusion, most states have	

	chosen not to cap intensity. We recommend Alaska do the same. • There is no provision for the payment of supervision of RBTs by BCBAs. A BCBA must professionally and ethically supervise a RBT 5% of the time and this supervision must happen with the consumer, the RBT and the BCBA. Without this necessary supervision, a BCBA will not be able to provide the service they are trained and licensed to do. BCBAs in Alaska have made it very clear that they will not be able to enroll as EPSDT Medicaid providers without payment for supervision. BCBAs would continue to be able to be paid by Medicaid for RBT supervision if they work with Alaskans over 21 with an I/DD waiver through Intensive Active Treatment (IAT) and BCBAs would likely continue to provide adult services. This would mean that Alaska would only have Medicaid providers of ABA for adults and not for young children. This runs completely contrary to everything we know about the lifelong benefit of early intervention, especially with children with autism. The proposed ABA service payment rates are substantially lower than the EPSDT payments to other therapists and providers working with children with autism, such as speech or occupational therapists, even though they have similar education and licensing requirements. In addition, RBTs must have considerably more training and required supervision than behavioral health aides, yet their proposed rate is considerably lower. The estimates are that a BCBA currently receiving Medicaid payments for ABA under IAT, will be expected to provide the exact same service to the exact same child for about half the payment. These rate inequities need to be addressed by the department, or as we see in other specialty fields, there could be no providers willing to enroll.	

	The proposed EPSDT regulations will have a huge impact in the availability of ABA services for the children and families of Alaska. Half of the children in Alaska rely on Medicaid for their health coverage. With far fewer ABA providers who accept Medicaid, ABA will be available only to those families who have private insurance or can privately pay for services. This is clearly contrary to the intent of children's EPSDT Medicaid coverage. While other states are actively luring these scarce professionals, we will be driving ours away at a time when we are implementing a Medicaid redesign that boldly changes behavioral health services "to provide greater system flexibility and offer a broader range of alternative services to fill existing service gaps and reduce Alaska's reliance on crisis services". For the past decade, the State of Alaska has funded The Capacity Building for Autism Interventions (CBAI) at UAA, to increase the level of professional ABA expertise. The program which is in its 8th cohort trains Masters Level BCBAs and has a grant to train RBTs. In addition, UAA has also launched a BCABA Bachelors Level program. In the past we relied on other universities to help us, but we now have the capacity to train BCBAs and RBTs entirely in state. Alaska has recognized the need for effective behavior therapy and has invested in meeting that need. We now have the opportunity to finish this important job. While we fully understand the need to contain costs, we think we do not need to belabor the extreme costs to the state of reliance on acute and residential treatments and the lifelong supports that will be needed by the needed by the ever increasing numbers of Alaskans with autism. With an average increase of 100 new school age children in Alaska being identified as having autism per year, these costs and numbers are only going to increase. It is the recommendation of the Council that the Division, as requested in their September 8 letter, directly collaborates with the Alaska Association of Behavior Analysts (AKABA) as well as a representative from the Council Autism Ad Hoc Committee to make sure these regulations meet the needs of the state, ABA	

	professionals and most importantly, families in Alaska. As Alaska's Developmental Disability Council we provided the state with meaningful stakeholder input and expertise on these regulations two years ago. Since then, we have offered input on these regulations and have provided opportunities for the Division of Behavioral Health to meet with stakeholders to discuss their development, which were not availed. The Council knows that there has been a lot of written and oral testimony on concerns with the proposed regulation and the negative impact there will be on professionals and families in Alaska as they are currently written. The Council appreciates the time put forward to get these regulations out, including the notation of telepractice, and stands ready to assist the Division with enhancements to ensure that this regulation fully meets the needs of our state. In addition, we look forward to assisting the state in the rollout and implementation of this important and long awaited autism regulation. Thank you for this opportunity to comment and we look forward to assisting in any way we can on this important work. Sincerely,  Dean Gates Chair Medicaid Ad Hoc Committee  Patrick Reinhart Executive Director	
Rebeka Edge Behavior Matters	October 9. 2017 Mr. Rick Calcote Division of Behavioral Health Alaska Department of Health and Human Services 3601 C Street, Suite 878	All comments address in

	Anchorage, AK 99503 Thank you for the opportunity to provide written comment. I am Rebeka Edge and I own Behavior Matters, a Behavior Analytic practice serving clients in Eagle River, Mat Su valley, Juneau and Kenai. We have served clients in AK since 2010 when the military brought my husband to Alaska. I'm a Board Certified and State of Alaska licensed Behavior Analyst and also a current Alaska Association for Behavior Analysis (AK-ABA) member. Behavior Matters is also a Medicaid provider in Alaska and in two other states. I had hoped the committee that worked so hard to draft this regulation would have considered the AK-ABA's September 6, 2017 request for direct collaboration with the Department and the additional 60 days with which to develop a comprehensive and functional system of service provision within the state of Alaska. It was extremely disappointing when on September 14, 2017 the Departmental rejection of AK-ABA's request for this collaboration and extension. I'd like to state many of the concerns from professional like myself and of those expressed at September 22,2017's public comment hearing. • Need for direct collaboration between the Department and the State's professional organization and its practitioners to address the broad and complex range of issues within the currently proposed draft that is highly likely to preclude ability for effective and best practice service provision; • Recognition that the Department's denial of collaboration and limited time extension was made following an additional two years' time taken by the Department to issue its current draft; • Concern expressed at the first (and last) stakeholders meeting held in July of 2015, more than 2 years ago today, that if there was no allowance for BCBAs to work with clients, effectively supervise and bill at a professional level (as other comparable disciplines such as psychologists, Speech Language Pathologists, Occupational Therapists, Physical Therapists are able to within our State), BCBAs are understandably highly unlikely to sign up as Medicaid providers; • Acknowledgement that current draft requirement of failure of a myriad of services before ABA services are to be approved is arbitrary, not research based and would result in critical loss of time, especially for young children;	previous written responses above, and within the Commissioner's letter, copy above. All questions were answered in a separate document posted on the On-Line Public Notice System.

	• Understanding that extension of time for collaboration would also allow Departmental response to the following unanswered questions: 1. Page 6: (10) "Autism services…" What is the rationale for this regulation being "autism services" rather than behavior analysis services (as other professions are referred to specifically within State regs? 2. Page 8: (D) "confirms that other recommended EPSDT services listed have previously been provided or are presently being provided to the recipient and those services have not resulted in measurable improvement in the recipient's behaviors." a. What are the criteria for "measurable improvement"? b. How long do services have to have been tried? c. Can a newly diagnosed child get autism services right away? Or they need to have a history of failure with other services first? d. What other disciplines is this required for? If this is the only one required, why? e. Whose responsibility is it to determine improvement? f. Is there a dollar cap for all EPSDT services combined? 3. Page 11: covered services a. What about coordination with other service EPSDT providers, school, etc.? Is there a way that BCBAs can attend or assist with coordination of behavior plans across environments? b. What about supervision of RBTs? RBTs are required to be observed 5% of their hours per month. At least half of those hours must be individual and must include observation while working directly with clients. For RBTs working full time (40 hours), they must be supervised at least 8 hours per month with at least 4 of those occurring while working with clients. c. Where are the codes for billing? Where is the table of rates per code, as with other service providers? d. Will BCBA recommendations for amount of treatment hours be considered, or will all consumers receive 20 hours per week? 4. Page 15: (C) "information on the recipient's skill deficits, deficient adaptive behaviors or maladaptive behaviors from the following sources: (i) in-person observation of the recipient; (ii) structured interviews with the guardian or caregiver; (iii) administration of standardized and non-standardized tests; (iv) a detailed behavioral history; (v) interpretation of test results;"	

	a. Who will evaluate and approve these plans? b. Will a BCBA/BCBA-D be involved in the review process? c. Are all 5 items required, or a combination of any of them? d. Will the BCBA determine which interviews and assessments are used? 5. Page 17: (h) "To receive payment for autism services a provider must develop an individual treatment plan that is updated as needed and includes:…" a. Who will evaluate and approve these plans? b. Will a BCBA/BCBA-D be involved in the approval process? 6. Page 18: (j) Autism services settings. a. Will the setting for autism services have to be declared in the authorization? b. Can the setting change throughout the authorization? 7. Will there be a grace period for RBT credentialing? a. Currently, there are only 75 RBTs in the state. The credential requires completion of 40 hours of ABA training, passing a skill fluency checklist, applying to the Behavior Analyst Certification Board (BACB), and passing a written exam. The time between application and exam is generally 2-4 weeks for local providers. The exam can only be taken in Anchorage or Fairbanks at this time, so providers outside of those areas may need more time scheduling their travel to take the exam. 8. Will any other credentials be recognized, such as BCAT and ABAT? 9. Will audits be conducted? a. What will be required for an audit? b. Who will be conducting audits? c. How frequently will audits be conducted? d. Are these in line with other disciplines? 10. How will this affect school? a. Will schools be able to bill as related service? b. What if schools are using all the authorized hours? c. Will there be a percent designated between school and home/community providers? 11. Are systems in place for providers to get enrolled? a. How do BCBAs get a Medicaid number? b. Are there processes in place for implementation? 12. Can you please clarify if BCBAs will be allowed to hold and bill for social groups (as only RBTs and BCaBAs are currently listed within the draft)? 13. Can you clarify the evidence/best practice and rationale behind prohibition of two services at the same time? 14. Can you clarify the evidence/best practice relied upon	

	in specifically excluding the client from being present during family guidance sessions? 15. Can you clarify the evidence/best practice relied upon in limiting family guidance sessions to four per year? 16. Can you please explain the exclusion of foster parents and guardians within the draft definition of family (which would effectively preclude family guidance for those families of children in State's custody)? 17. Do you anticipate other service areas beyond autism services (such as FASD) that have demonstrated success through receipt of ABA services to be added to these regulations? 18. What percentage of ABA services do you estimate will be covered under this regulation through federal funds &/or federal funds received by the State? 19. The State's "fiscal crisis" was mentioned at the September 22nd hearing. In light of our State's "crisis", will the State be reducing the reimbursement rates for all Medicaid service areas or will ABA service reimbursement rates be the sole area looked at to help reduce overall costs? 20. Can you explain why the currently proposed rates are so far below those of other comparable disciplines? 21. On September 6th, in written formal request, and again at September 22's hearing, our State's Association made formal request for collaboration and extension of time to best assist in creation of best practice regulations, which has been denied. Do you anticipate this position to change? a. If not, can you please explain the rationale for creation of draft regulations in the absence of collaboration with our State's professional organization and its members? b. Can you provide examples of other discipline's regulations that were crafted in the absence of collaboration with Alaskan practitioners and State and National Associations? c. Is this common practice for our State? 12. Can you please clarify if BCBAs will be allowed to hold and bill for social groups (as only RBTs and BCaBAs are currently listed within the draft)? 13. Can you clarify the evidence/best practice and rationale behind prohibition of two services at the same time? 14. Can you clarify the evidence/best practice relied upon in specifically excluding the client from being present during family guidance sessions? 15. Can you clarify the evidence/best practice relied upon in limiting family guidance sessions to four per year?	

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Kathleen Karimi	25. Can you explain why additional criteria beyond clinical diagnosis such as the "fail first" clause and at page 8 (B)(i) is required to access ABA services? a. Are additional criteria required for other comparable disciplines or just ABA services? b. If others, can you please provide example? 26. Can you explain why ABA service provision oversight has been placed within the Division of Behavior Health? 27. Can you explain how the two-year delay has allowed DBH to "vastly improve the Division's behavioral health delivery system, including the inclusion of a more integrated approach to the delivery of both primary and behavioral health care" and how "the adoption of ABA services are (were) incorporated into DBH's broader systems review" (as stated in director Burns' July 1, 2016 letter as reason for further regulation delay)? 28. Can you please explain why the rate for a Licensed Assistant Behavior Analyst (who has an undergraduate degree) is the same as a Registered Behavior Technician (who does not need to have a degree)? 29. Can you give the rationale as to why the technician level staff would need to be an RBT when the state already has billing codes and regulations for a behavior health technician? 30. Can you please explain why the proposed regulations do not have codes for the supervision of the technician? a. This is in violation of BCBA ethical guidelines, the BACB's treatment guidelines. b. Will supervision codes be added for both Licensed Assistant Behavior Analyst and Licensed Behavior Analyst? 31. Why don't the regulations reference the Licensed Behavior Analyst and Licensed Assistance Behavior Analyst professions instead of BCBA/BCABA? 32. Why are services called "autism services" when they are actually "Applied Behavior Analysis" services? In summary, the process of creating draft regulations without the collaboration with Alaska's behavior analysis professional organization, its practitioners and in a way that precludes knowledge of the process or professionals that may or may not have been utilized throughout the two years of regulation is likely to result in direct harm to those the regulations are mandated and intended to serve, young Medicaid eligible Alaskans with autism who research consistently demonstrates receive direct and immeasurable benefit from ABA services, especially in the earliest years of life.	

	I humbly urge the Department to reconsider its position and allow extension of time to collaborate with AK-ABA and national groups with extensive prior experience in creation of regulations that will provide greatest opportunity for meaningful, quality provision of services rather than pushing through the draft in its current state for the sake of checking the box "complete". Our state's Medicaid eligible children in need of behavior analytic services and our state's behavioral analytic professionals deserve more. Again, thank you for the opportunity to provide written comment and supporting attachments today, Rebeka Edge, M.A., BCBA, LBA Dear Behavioral Health Division, Thank you for your time and consideration of our public comments regarding the proposed changes to Medicaid coverage and payment of Applied Behavior Analysis (ABA) treatment for children with autism. As an ABA provider serving families in Alaska, our mission is to enhance access to specialty behavioral healthcare for children with autism, including those in rural and traditionally underserved communities. The purpose of our commentary is to encourage further development of the proposed ABA practice regulations and reimbursement rates. **Guidelines for Best Practice Applied Behavior Analysis** In 2014 the Behavior Analyst Certification Board issued a second edition of ABA practice guidelines for healthcare funders (please see attached). The standards presented in the document reflect the consensus of a number of subject matter experts and should be considered when refining the proposed Medicaid regulations. We are respectfully requesting your consideration of the following: **Assessment** The assessment process required for the initial development of a comprehensive treatment plan may take 20 hours or longer (BACB, 2014). Further, the functional assessment process for severe challenging behavior (e.g., self-injurious behavior, aggression) is often complex and may require considerably longer durations. The following list represents essential components of the assessment process: • Interview with client/parents/caregivers	

	• Observation of client across environments • Comprehensive records review • Analysis of data • Treatment plan development and modification • Individualized behavior intervention plan • Development and modification of crisis plan • Discharge planning The proposed reimbursement rate of $309 for the initial behavior assessment does not cover the full cost of a comprehensive evaluation. Reimbursement rates should be adjusted to align with rates offered to BCBA providers under Alaska's Complex Behavior Collaborative. The rate offered under this program for Maladaptive Behavioral Analysis and Development of a Behavioral Intervention Plan is $200.00 per hour, not to exceed $2800.00 (including a comprehensive review of available assessments, analysis of the individual's behavior, skills, abnormalities, in the context of their medical/psychiatric and developmental diagnosis and functioning). Further, the time requirement to complete the initial assessment and 6-month reevaluation should be similar and should therefore be reimbursed at the same level. Other State Medicaid Programs, like New Mexico's have designated separate codes and rates for extended assessments; including procedural codes 0360T and 0361T (please refer to attached NM Medicaid Billing Guidelines). Addition of the extended assessment codes are recommended to ensure the additional time is utilized and reimbursed only as needed. **Case Supervision** The proposed fee schedule does not include a procedural code for supervision of a Registered Behavior Technician or Board Certified Assistant Behavior Analyst. Supervision is an essential component of ABA treatment and per BACB guidelines, is critical to producing beneficial treatment outcomes. Case supervision begins with assessment and continues through discharge. ABA treatment requires comparatively high levels of case supervision to ensure effective outcomes because of (a) the individualized nature of treatment, (b) the use of a tiered service-delivery model, (c) the reliance on frequent collection and analysis of client data, and (d) the need for adjustments to the treatment plan (BACB, 2014). Essential supervision activities include both direct	

	(services with client present) and indirect activities (services where client is absent) and are routinely covered by health insurance funders. Standard supervision procedures include: BCBA Directly observing treatment implementation and child's response to treatment for potential revision. BCBA monitoring treatment integrity to ensure satisfactory implementation of treatment protocols. BCBA directing staff and/or caregivers in the implementation of new or revised treatment protocols. BCBA developing treatment goals, protocols and data collections systems. BCBA's evaluation of progress towards treatment goals. BCBA reviewing client progress with staff without the client present to refine treatment goals. It is recommended that BCBA clinicians be required to directly supervise a minimum of 10% of all therapeutic services rendered by a Registered Behavior Technician. Additional 10% indirect case supervision activities should be included to meet the minimum 20% supervision requirements, as outlined by the BACB. **Exhaustion of Alternative Forms of Treatment** Page 8, Section D of the proposed regulations reads that coverage of ABA treatment will only be approved after verification that other recommended EPSDT services have previously been provided or are presently being provided to the recipient and those services have not resulted in measurable improvement in the recipient's behaviors. We are respectfully requesting removal of this requirement based on the widely accepted body of research suggesting that delaying treatment early in life could be detrimental to a child's development and that ABA intervention is most effective when delivered early in life and intensively. To this point, the American Academy of Pediatrics recommends that behavior analytic interventions should begin as early as possible for children with a confirmed or strongly suspected diagnosis of ASD (Meyers & Johnson, 2007). Further, ABA treatment should not serve as a replacement for any other service covered under EPSDT. To this point, the BACB Code of Ethics directs Behavior Analysts to refer out to professionals from other disciplines when there are client conditions that are beyond the training and competence of the Behavior Analyst. Examples would include but are not limited to,	

	a suspected medical condition or psychological concerns. To avoid duplicative or conflicting treatments, providers should be required to coordinate care and demonstrate coordination efforts within the consumer's ABA treatment plan. **Limitations on Dosage of Medically Necessary Treatment** Page 11, Section A of the proposed regulations reads that Medicaid beneficiaries will be eligible for coverage of up to 520 hours in a six-month period, equating to approximately 20 treatment hours per week. We urge policymakers to amend the maximum dosage levels to meet medical necessity criteria. The proposed limitation risks compromising developmental gains that can be achieved through a comprehensive ABA program, routinely recommended (based on medical necessity) and proven most effective for early learners. Comprehensive treatment involves an intensity level of 30-40 hours of 1:1 direct treatment per week, not including caregiver training, supervision, and other critical services (BACB, 2014; Meyers & Johnson, 2007; Roane, Fisher, & Carr 2016). Without access to medically necessary dosage, consumers may fall further behind typical developmental trajectories, resulting in increased cost and greater reliance on more intensive services across the lifespan. **Direct Services by BCBA** The proposed fee schedule does not include a procedural code for direct ABA therapy provided by a BCBA. Due to severity of need and complexity of programming, it is sometimes necessary for the BCBA to provide direct intervention services to the consumer. We respectfully request that a procedural code be added for BCBAs to provide adaptive behavior treatment and group adaptive treatment. **Differential Rate for BCBA-Ds and BCaBAs** Doctoral-level Board Certified Behavior Analysts possess more education and expertise in the field of Behavior Analysis than Master's Level Analysts and should therefore be reimbursed at a differential rate. Based on industry standards, we are requesting a differential reimbursement rate for doctoral level behavior analysts. Additionally, Bachelor's Level Board Certified Assistant Behavior Analysts (BCaBAs) possess more education and expertise in the field of Behavior	

	Analysis than Registered Behavior Technicians (a credential that requires a minimum of a high school diploma). BCaBAs should therefore be reimbursed at a rate that is higher than that offered to RBTs. **Grace Period for RBT Credentialing** Given ABA is such an intensive service, providers are constantly building capacity. Within our industry, provider organizations are commonly required to hire and train a new technician for nearly every new consumer enrolled in services. Presently, there are only 75 RBTs statewide and a majority are operating at full capacity. Once a technician has been hired, they are required to complete a minimum of 40-hours of ABA training, pass a skills fluency checklist, apply for registration with the BACB and pass a competency examination. The time between the application and examination is generally 2-4 weeks for local providers and testing locations are only available in Anchorage and Fairbanks at this time. Without consideration of added provider credentialing time, families can reasonably be expected to wait in excess of 2 full months prior to accessing care. Recognizing that limited RBT capacity is a barrier to accessing treatment for families nationwide, funding sources like New Mexico's State Medicaid Program have offered a grace period during which the behavior technician is authorized to render direct therapy services after meeting minimum training requirements and while actively working toward his/her RBT credential. We are respectfully requesting the proposed regulations be revised to include a six-month grace period for behavior technicians. **The Cost of Outpatient Specialty Care:** We at Behavior Change Institute recognize the importance of providing community based services to families in rural areas. In an effort to enhance access and build capacity in Alaska's rural communities, provider organizations are relying on advanced technology to deliver treatment via a researched-based telemedicine model. While the model has proven effective in addressing health access disparities in Alaska, scalability of the solution will rely heavily upon the state's ability to adequately fund it. Research indicates that the cost of providing care in remote locations is substantially higher than in large urban areas. Beyond the cost of building professional capacity, provider organizations like Behavior Change	

	Institute are required to secure additional insurance coverage; offer reimbursement for travel & technology; absorb the cost of high-level supervision and quality assurance; utilize costly Practice Management Solutions to transmit and store electronic health records; supervise clinicians around the country; and manage complex telehealth clinical and administrative workflows that are paramount to the model. While the initial cost to provide treatment may be higher, the long-term cost of care is lowered when behavioral challenges that impede a child's ability to functionally engage with their community are addressed. We at Behavior Change Institute are concerned about our ability to build capacity throughout the state due to the fact that state Medicaid rates significantly undercut those of industry standard. While we understand that state reimbursement rates will not likely match those of commercial plans, we would like to respectfully request that the proposed reimbursement rates be increased, minimally to cover the cost of care in the Medically Underserved Areas. **Reimbursement for Telemedicine Services** In addition, we are requesting reimbursement under the procedural code Q3014 to help cover the high cost of telehealth technology and transmission. **Reimbursement for Other Specialty Care Providers Far Exceeds ABA Treatment:** An evaluation of state reimbursement rates indicate that other mental health providers earn up to 346% higher than the rates currently quoted for Applied Behavior Analysis Therapy. As an example, consultants specializing in intellectual disabilities under Alaska's Complex Behavior Collaborative earn **$200-225** per hour in addition to covered travel costs. Overall, the proposed reimbursement rates for ABA services are lower than averages across the country. Per the attached Tricare ABA Comparison, "The mean national reimbursement rate, derived from this commercial data and Medicaid information, weighing the state-level results by the number of children diagnosed with ASD in each state, was $65.16 per hour for therapeutic behavioral services (H2019) from a BCaBA, Behavioral Technician or unspecified level provider, or $94.72 per hour for master's or doctoral level providers." Further, it should be noted that when Tricare released its regional reimbursement rates for ABA providers, providers in the state of Alaska were	

	offered reasonably more due to the added cost of living. Specifically, published AK regional rates cite reimbursement as follows: **Doctoral Level BCBA:** $147.36-149.98 per hour **Master's Level BCBA:** $125-141.74 per hour **Bachelor's Level BCaBA:** $80.93-112.50 per hour **Registered Behavior Technician:** $64.03 per hour By providing a reimbursement rate that is consistent with the quality of care requirements and sufficient to enlist enough providers, it will help ensure that these specialized services are available at least to the extent that they are available to the general population in Alaska's more populated areas, thereby meeting the ***equal access provision in the Medicaid Stature.*** We are respectfully requesting that the reimbursement rates be increased as follows: **Doctoral Level BCBA:** $140.00 per hour **Master's Level BCBA:** $125.00 per hour **Bachelor's Level BCaBA:** $75.00 per hour **Registered Behavior Technician:** $65.00 per hour An increase to the above amounts is essential to covering the cost of outpatient behavioral specialty care services and ensuring adequate capacity for Alaska's children with autism. Thank you for your time and consideration of our request to increase the reimbursement rate for this specialty service to assist with improving access to care for families in rural areas. Please do not hesitate to call or e-mail with any questions or concerns. Respectfully Joy Pollard and Kathleen Karimi	
Daniel Unumb, Esq. President Autism Legal Resource Center LLC	Dear Mr. Calcote: I am writing to confirm that my oral comments provided at the public hearing held on September 22, 2017 with respect to the above-referenced proposed regulations are being considered by the Department as part of the public comment process. Among the points I addressed are: 1. The need to ensure that there is access to treatment for all deficits and conditions relating to the Autism Spectrum Disorder (ASD) diagnosis which is made on the basis of clinically significant deficiencies in social interaction, communication and behavior. Additional requirements that would limit treatment to subsets of these deficiencies should not be imposed. The autism	All comments have been addressed in previous written responses (see above).

	diagnosis should be sufficient to access treatment. Also, general exclusions such as prohibiting payment for increasing a beneficiary's social activity or addressing antisocial behavior should be eliminated or redefined in light of ASD which is based on social and behavioral deficiencies. 2. The "fail first" requirement that other therapies must be used first and shown to not result in measurable improvement should be eliminated. Prompt, appropriate treatment based on individualized clinical determinations is critical in the treatment of ASD. Forcing a child to first undergo other types of un recommended and even potentially contraindicated treatment in place of the treatment recommended by his or her treating professional based on evaluation of relevant circumstances and professional judgment contravenes the EPSDT mandate to promptly provide necessary care based on individualized determinations and threatens to worsen the child's prognosis through delay in needed treatment. It is also improper to relegate a child to achieving merely "some" measurable benefit from an alternative, less-effective treatment, in place of generally-accepted treatment recommended to substantially correct or ameliorate a child's ASD deficits and conditions. No other state imposes this requirement on its EPSDT coverage of ABA, and the few states that considered such a provision (e.g. Florida, Nevada, and Colorado) ultimately withdrew it after stakeholder input. 3. Case management and clinical direction by the BCBA, including analyzing data, modifying treatment protocols, advancing treatment targets, and professional supervision and oversight of behavior technicians is a critical part of Applied Behavior Analysis (ABA) services and therefore, as is the case with all other states' EPSDT coverage, additional available codes should be adopted to provide for reimbursement of these necessary professional services. 4. The nature and extent of parent or caregiver support of treatment is a matter of professional judgment of the behavior analyst based on individualized circumstances and care must be taken to ensure that a child access to treatment is not conditioned on any mandatory parent/caregiver participation requirements. 5. The 520 hours per 6 months figure referred to in the proposed regulations cannot, consistent with the EPSDT mandate, be imposed as a hard cap on services. It also should not be imposed as a soft cap requiring further approval. First, the guideline is not based on professional	

	standards which in the case of comprehensive ABA programs typically require hours well in excess of this. Second, it appears that the medical necessity of any level of treatment hours must already be demonstrated and therefore adding an additional check point requiring the same information is unnecessary and confusing. On the other hand, if the intent is to only require a pre-authorization demonstration of medical necessity for amounts in excess of this, the regulations should be amended to reflect this. Also, in accordance with the EPSDT mandate and the urgent needs of Medicaid eligible Alaska children, I urged the Department to take immediate steps to allow children access to medically necessary care, including applied behavior analysis services, to correct or ameliorate deficits and conditions of Autism Spectrum Disorder based on individualized determinations during the pendency of the regulatory review and amendment process. Pursuant to the EPSDT mandate, state Medicaid agencies are required to provide all coverable medical assistance to Medicaid eligible children less than 21 years of age based in individual determinations of medical necessity regardless of whether such services are currently in the state plan. 42 U.S.C. § 1396d(r)(5). This obligation extends to all EPSDT eligible children and not just those currently receiving such services pursuant to a state waiver. Indeed, children in states such as Colorado, North Dakota and South Carolina have been receiving ABA services under EPSDT even as waivers providing these services to a limited group of other children have been in the process of being phased out. I commend the Department for its work on the proposed regulations SPA as part of its commitment to ensuring that Medicaid eligible North Carolina children get the care they need as required by EPSDT. Thank you for the opportunity to provide and comments and recommendations. If there is any additional information, please do not hesitate to contact me. Respectfully submitted	
Barbara Nath Paralegal Hope Community Resources, Inc.	Dear Mr. Calcote, Hope would like to thank you for the opportunity to review and make comments on the proposed changes to regulations for Autism Services. While we had input from several sources, we would like to acknowledge and thank Dr. Chuck Lester for reviewing these regulations. Dr. Lester is a practicing psychologist in Alaska and is the Clinical Director at Hope Community Resources. His input is invaluable and reflects 30 years of	The current regulations do not restrict the concurrent provision of any medically necessary behavioral health clinic

	practice and experience. The following are our comments/concerns for your consideration: ***CONCERN # 1 (7AAC 135-Eligibility re: Concurrent Services*** *Existing research very clearly and consistently show that an extremely high percentage (not all) of the individuals who are diagnosed with an ASD, ALSO experience and are diagnosed with one or more co-occurring mental health challenges (e.g., ADHD, anxiety, depression , etc.) and/or an intellectual disability.* 1. Given the above reality, it is therefore very important to ensure that the proposed regulations explicitly specify: **a.** That an individual who is diagnosed with both an ASD and a co-occurring mental health disorder can concurrently obtain under proposed regulations both "autism services" **AND** needed mental health treatment for the diagnosed mental health disorder from an appropriately qualified and licensed mental health provider, e.g. Psychologist, LPC, LPA, LCSW, etc., who is providing mental health treatment within an organization meeting the requirements of 7 ACC 70.030, and **b.** That an individual diagnosed with an ASD w/0 co-occurring mental health disorder and not needing mental health treatment is clearly eligible for "autism services" under the proposed changes. 2. In reading the proposed changes, it appears that neither #1a nor #1b (especially #1a) above are explicit or clear in the proposed regulations. For example, one of the proposed changes, 7 ACC 135.020 (e)(3)(D), specifies that an eligibility requirement for "autism services" is that other recommended EPSTD treatment services have been tried in the past, but did not produce a significant behavior change; OR other recommended EPSTD treatments are presently occurring, but failing to produce a significant behavior change. <u>Concern #1 (7AAC 135- Eligibility) *continued*</u> a. Given #2 above, it opens the door to some questions and some possibly false conclusions: i. Must an individual diagnosed with an ASD and a co-occurring mental health disorder have to first fail at other treatments (including mental health treatment?) to	service when autism services are being provided. The Dept has determined that the proposed regulations should be amended to clarify that all other EPSDT services are available to a child diagnosed with ASD. By Medicaid rules children are defined as "under 21" and the proposed autism services regulations will observe that rule. Individuals 21 years of age and older may be eligible for other Medicaid or other waiver services. The proposed regulations were developed to specifically address the needs of children diagnosed with autism services. The chapter title accurately reflects this intent and purpose. The Dept intends to retain this focus. The Dept has determined that the text referring to care-givers should reference "non-relative" care givers, and the regulations will be amended appropriately.

	qualify for "autism services"? ii. It seems clinically sensible and research-endorsed that an individual diagnosed with an ASD and a co-occurring mental health disorder may be more effectively treated with a concurrent treatment regimen of "autism services" and mental health treatment, as well as possibly OT/SI treatment. iii. Additionally, it seems evident that an individual diagnosed with an ASD who also has severe behavioral challenges and/or severe social impairments that do not fit into a diagnosis of mental health disorder, would still undoubtedly benefit from "autism services" Would such a person have first fail at other treatments? iv. Furthermore, there are many individuals who are diagnosed with both an ASD and co-occurring mental health disorder(s), who also have severe expressive/receptive language delays and /or a significant intellectual disability. Sometimes, certainly not always, an individual with such a clinical presentation may not be able to participate successfully in and benefit from mental health treatment, even if significantly adapted. Must that person first fail at mental health treatment before eligibility for "autism services"? **Recommendation:** a. Make it explicitly clear that "autism services" can occur concurrently with other treatments being paid by Medicaid. The term "concurrently" is used to mean that the individual can be actively engaged in more than one treatment regimen, including "autism services'. It is not being suggested that the proposed regulations allow the individual to receive "autism services" during the exact same moment in time that the individual is receiving individual psychotherapy. However, the individual could receive "autism services" and individual psychotherapy on the same day, unless clinically contraindicated. b. Delete 7 ACC 135.020 (e)(3)(D) because it opens the door to the type of misunderstanding illustrated in the body of this specific concern. ***CONCERN #2 (7 AAC 135-020 (b)(4) and 7 ACC 135.020 (e)(1)*** ***Eligibility re-AGE***	

	It is unclear if an individual over the age of 21 is eligible for "autism services" 1.Several specific examples are provided in the proposed regulations that affirm "autism services" for individuals over 21 with specific circumstances. However, that logically leads on to question eligibility for an individual over the age of 21, when the individual does not meet those circumstances. 2.Current research is showing that transition to adulthood for individuals who experience autism is a national problem, i.e., most are not transition well or successfully at all. 3.It is not completely uncommon to first learn of someone over the age of 21, who due to familial circumstances and numerous decisions by the parent/guardian, was only recently diagnosed in adulthood with an ASD and other rental health disorder. I can think of several people in my clinical career with such a story, and they all needed "autism services" as a young adult. 4.Therefore, excluding any individuals within this age group from "autism services" seems counterproductive for young adult Alaskans experiencing autism. **Recommendation:** **Remove the age specification for eligibility (i.e., remove the "under the age of 21" language). "Autism services" really has no age boundary…nor does ABA support and treatment.** ***CONCERN #3 (Throughout the Regulations-use of "Autism Services")*** *The regulations have an extremely broad conceptualization of "autism services". The rationale behind that broad conceptualization is probably good, but it is potentially confusing and problematic. In addition, the operational conceptualization intentionally limits "autism services" to ONLY ABA and nothing else (which Hope supports). However…* 1. In reality, it appears that what you are conceptualizing as "autism services' is rally application of ABA, as well as needed case management for effective ABA application. 2. There will be push-back from the public with your term choice of "autism services". I strongly suspect that there are numerous parents who will request/demand that their child receive the other non-ABA "autism services" under these regulations that they believe are effective	

	treatments for their child's autism. The amount of misinformation on the internet relating to autisms is truly problematic, and many times parent are desperately grabbing what they can to help their child and unfortunately parents are often vulnerable to the voluminous false information that exists. A Google search for "autism" just now yielded 119,000,000 hits; "autism treatments" yielded 24,600,000. Therefore, while I think it is wise that you are only permitting ABA services; your broad conceptualization "autism services" opens the door to very strong push-back from the consuming public. **Recommendation:** **That the broad conceptualization "autism services" not be used; instead, call it like it really is, "ABA autism services".** ***CONCERN #4 (7aac 135.50-Inclusion of Foster Parents/Non-Relative Caregivers)*** *It is unclear as to whether or not foster parents or other non-relative caregivers are included in the definition of family.* In the response to questions received, your response indicates that the Department of Health and Social Services will determine the need to revise the regulations to include foster parents or other non-relative caregivers. **Recommendation:** **Hope would support the revision of regulations to include foster parents or other non-relative givers as eligible for these services.** Thank you again for the opportunity to provide input. If you have any questions, please feel free to contact me at (907) 433-4981 Sincerely, Barbara Nath	

	Association of apba Professional Behavior Analysts **San Diego, CA 92108** Dear Mr. Calcote: We are writing to comment on the above-referenced draft regulations at the request of our Affiliate organization, the Alaska Association for Behavior Analysis (AK-ABA). As context, the Association of Professional Behavior Analysis (APBA) is a nonprofit membership organization whose mission is to promote and advance the science-based practice of applied behavior analysis (ABA). A major component of that mission is working on public policies that affect practitioners and consumers of ABA services. To that end, we have worked or are working on Medicaid State Plan Amendments and rules, autism insurance laws and regulations, and laws to license behavior analysts in many jurisdictions around the U.S. and in some other countries. We are committed to supporting the development of laws and regulations that are consistent with the best available scientific evidence and widely accepted standards and best practices in professional credentialing in order to protect the public. The comments and recommendations that follow are offered respectfully in the spirit of helping to ensure that Alaska Medicaid EPSDT recipients with autism receive medically necessary ABA services that are designed and overseen by qualified professionals. Recommendation 1: Incorporate input on the proposed regulations from the Alaska Association for Behavior Analysis. We understand that AK-ABA has asked to be given the opportunity to collaborate with the Division on revising the regulations, and respectfully urge you to accept that request.	
	As the professional organization for behavior analysts in your state, AK-ABA has a wealth of knowledge about ABA research, professional standards, and services in general as well as the delivery of those services in Alaska specifically. No doubt many AK-ABA members serve – or would like to serve – EPSDT recipients with autism and	The Dept will amend the proposed regulations to correct spelling of service terminology.

	their families. Thus they are not only important stakeholders vis a vis the regulations, but also a valuable source of insight on how to structure the ABA benefit. Recommendation 2: Change "autism services" to "applied behavior (not "Behavioral") analysis services" and make the definition of the latter consistent with the state behavior analyst licensure statute throughout the regulations. The description of "autism services" on p. 3 and elsewhere is actually a brief definition of the practice of ABA, almost mirroring the definition in the state's behavior analyst licensure statutes (AS 08.15, Sec. 08.15.090(1)). As you're no doubt aware, ABA interventions are effective for individuals with diagnoses other than autism and individuals with no specific diagnosis. Additionally, "autism services" may encompass others in addition to ABA, including other empirically supported behavioral health services. Changing the definition of "autism services" as recommended here is essential to avoid confusion and misunderstandings. On a related note, if behavioral health services other than ABA are going to be covered, it will be important to expand the regulations to include clear definitions of those services as well as qualifications of providers. Recommendation 3: Replace "Board Certified Behavior Analyst" with "Licensed Behavior Analyst" and "Board Certified Assistant Behavior Analyst" with "Licensed Assistant Behavior Analyst" throughout the document. Because AS 08.15 requires a state-issued license to practice behavior analysis in Alaska, the regulations should make it clear that ABA providers must be licensed in the state. Although certification by the Behavior Analyst Certification Board (BACB) is required to obtain a state-issued license, those certifications are not the same as state licenses. Therefore, to avoid confusion and be consistent with the licensure statute, the regulations should refer to licensees as Licensed Behavior Analysts and Licensed Assistant Behavior Analysts. Recommendation : Make it clear that Licensed Assistant Behavior Analysts (LABAs) and Registered Behavior Technicians (RBTs) must be supervised in accordance with the BACB's standards for both supervisors and those supervisees. We applaud the requirement for paraprofessionals to hold the Registered Behavior Technician credential (not "certification") issued by the BACB. However, the language in 7 AAC 135.300(d) implies that supervision of those personnel and LABAs is optional	The Dept understands that a BCBA, like all health care professionals, is obligated to observe licensing or other professional standards. However, Medicaid service criteria cannot be written to conform to these widely variable standards. The Dept has determined that the proposed regulations may have provided conflicting service information within Chapter 135, and will amend regulations accordingly. All other comments have been addressed in previous written responses (see above).

	("If a [board certified behavior analyst] provides supervision…"). In fact supervision of a specific type and quantity is required for personnel in both categories to maintain the credentials issued by the BACB (and in turn for LABAs, their state license). Their supervisors must also provide supervision of a specific type and quantity in order to maintain their BACB certifications and therefore their state licenses. That is, it is not just that the supervisor must be approved (not "certified") by the BACB to provide supervision; they and their supervisees must also meet other specific requirements. Requirements for supervisors may be found here: https://www.bacb.com/supervision-requirements/ Requirements for supervision of LABAs (BCaBAs) are at this link: https://www.bacb.com/wp-content/uploads/2017/09/161216-standards-for-supervision-of-BCaBAs.pdf Supervision requirements for RBTs are at this link: https://www.bacb.com/rbt/ Instead of replicating all of the BACB requirements in the regulations, we recommend simply making it clear that supervision is required and that all supervisors and supervisees must adhere to the BACB supervision standards that apply to them. Recommendation 5: Clarify which ABA services will be reimbursed, and make the descriptions of those services consistent throughout the regulations. As written, the regulations seem to reference some of the Category III CPT codes for "Adaptive behavior" services that were issued in 2014, but the definitions of some of those codes differ from the actual definitions of the codes as approved by the AMA CPT Editorial Panel. Additionally, there are discrepancies within the rules regarding which services/codes will be reimbursed. For instance, 7 AAC 70.990 (C) lists only three services/codes, but some additional services/codes are included elsewhere in that section (Definitions). Others that do not appear in section 70.990 are listed in 7 AAC 145.580, and some of the codes in that code set are not listed at all. Recommendation 6: Consult with knowledgeable attorneys as to whether the cap on services at 520 hours per 6-month period and the provision that recipients cannot receive ABA services unless and until they have received other services and failed to show "measurable improvements" violate EPSDT requirements. It is our understanding that the EPSDT program must cover all services that qualified professionals deem	

	medically necessary for each individual recipient. The blanket hour cap and "fail first" requirement would seem to violate that mandate, but we are not qualified to render legal opinions so recommend checking that with attorneys who are familiar with EPSDT. If they confirm our understanding, those two provisions should be deleted from the regulations. Thank you in advance for considering these comments. If I can answer any questions or provide any additional information, please do not hesitate to contact me. Gina Green, PhD, BCBA-D Chief Executive Officer.	
Teresa Cook-Guercio. M.S. BCBA. LBA Jerseyville, IL	Dear Mr. Calcote, The Behavioral Intervention Certification Council (BICC) was established in 2013 to promote the highest standards of treatment for individuals with autism spectrum disorder through development, implementation, coordination, and evaluation of all aspects of the certification and certification renewal processes. BICC Is an independent and autonomous governing body for the Board Certified Autism Technician (BCAT) certification program. The mission of the BICC is to enhance public protection by developing and administering a certification program consistent with the needs of behavior analysts to recognize individuals who are qualified to treat the deficits and behaviors associated with autism spectrum disorder using the principles and procedures of applied behavior analysis. BICC's Board Certified Autism Technician (BCAT) was the first NCCA accredited paraprofessional certification for ABA therapy providers. It remains the only autism-specific paraprofessional certification for ABA therapy providers. I commend the efforts of Alaska's Medicaid coverage to extend to autism services. It is a daunting task to define a program that meets the needs of individuals with an autism diagnosis as well as stakeholders providing services. BICC wishes to make you aware of the implications for the proposed changes as stated as well as our recommendations. We also want Alaska's Division of Behavioral Health to be aware that there are other nationally recognized certification boards credentialing professionals to deliver Applied Behavior Analysis services that have achieved NCCA accreditation in addition to the Behavior Analyst Certification Board. One significant limitation to the proposed Medicaid coverage for Autism services is the sole utilization of the Behavior Analyst Certification Board (BACB) credentials for therapists providing supervision (BCBA) of ABA	The Dept appreciates the information provided by BICC, but has determined at present to maintain the requirements as written in the proposed regulations.

services and paraprofessionals implementing ABA therapy (RBT). See the comparison chart below for features of the SCAT compared to the RBT.

Features of Credentials	BCAT	
NCCA-accredited program	X	X
Minimum of high school education	X	X
Must Pass exam	X	X
Must be supervised for 5% of Total hours of ABA delivered	X	X
Autism-specific credential see BCAT Task List for additional details	X	

Must attest to Code of Ethics	X
Must have 15 hours experience working with Individual (s) with autism	X
Must pass competency check	
Must have DOJ/FBI ongoing background check monitored by BICC	X
Requires primary source verification of education	X
Must accrue 12 CE's (3 related to ethics) During 2 year certification cycle	X
Certificant responsible for Documentation of Supervision	X
BCBA Responsible for documenting 5% supervision	
Can be supervised by a BCBA	X
Can be supervised by a BCBA, Licensed Psychologist, licensed/credentialed professional with ABA in scope of practice	X
Number of items on Exam	15
On-site testing	X

As stated, limiting the guideline to allow RBT as the only accepted paraprofessional credential will limit availability of paraprofessionals. The BACB partners with Pearson Vue to deliver all administrations of the RBT exam. Currently there are 2 locations serving all of Alaska located in Fairbanks and Anchorage. The BCAT partners with PSI AMP to administer the BCAT exam. Through our partnership with PSI, providers can offer on-site testing in their offices. This allows them to have their employees take the BCAT exam without the additional cost and burden of travel to the only 2 locations in Alaska that offer RBT testing. The BICC proposes that the Alaska Medicaid Coverage amend 7 AAC 105.200(b) which currently states "(12)

		a registered behavior technician", be changed to state "(12) a registered behavior technician or board certified autism technician." The BICC would also like to bring to your attention section 7 AAC 135.300 Autism services; provider qualifications (c) Autism services may only be provided by (1) a behavior analyst licensed under AS 08.15; (2) an assistant behavior analyst licensed under AS 08.15; or (3) a registered behavior technician certified by the Behavior Analyst Certification Board. As stated, the proposed regulation limits the availability of paraprofessionals as well as qualified supervisors. Applied Behavior Analysis does not fall under the sole purview of a Board Certified Behavior Analyst. The BICC definition of a qualified supervisor overseeing the implementation of ABA services to individuals with autism is a professional who possesses a license and/or certification by a national entity to practice applied behavior analysis (ABA) and who is acting within the scope and competency of his/her license or certification. Supervision is not limited to a BCBA, but also allows for licensed psychologists who are acting within their scope and practice to supervise ABA programs to individuals with autism. There is a serious shortage of BCBAs nationwide to meet the needs of individuals with autism. Limited the available professions allowed to practice ASA will surely limit services to Alaskans in need. Since the proposed Medicaid Coverage is specific to Autism services it is worth noting that the RBT Task List and exam do not cover autism specific content. Whereas, the BCAT Task List includes the following subdomains: Autism Spectrum Disorder, Principles of ABA, Treatment: Skill Acquisition, Treatment: Reduction of Problem Behavior, Behavioral Data Collection, and Ethical/Legal Considerations. Of the 150 items on the BCAT Exam, 10-12% of the exam questions are allocated to autism specific questions. The RBT exam ls limited to 75 questions and contains no questions specific to autism. The BICC respectfully requests that the regulations				

	concerning Medicaid coverage for Autism services elect to allow any professionals possessing a state license and/or an NCCA accredited certification that includes applied behavior analysis in their scope of practice be reimbursed for service. State Medicaid programs like California, New Mexico, Washington, and Texas already reimburse for BCAT professionals. The BICC is happy to partner with Alaska to assist in any way to help Alaskans receive quality ABA therapy for individuals with autism. Please let me know if I can provide additional assistance				
Oral Hearing	 NL17-255 - DHSS - Oral Hearing - Autism - 22Sep17.txt				
Kathleen Gottlieb	On behalf of Southcentral Foundation (SCF), I submit these comments on the Department's proposed changes to regulations regarding licensure and Medicaid coverage of applied behavior analysis serves (ABA). SCF supports and thanks the Department on its decision to recognize, regulate, and provide Medicaid coverage for these important and proven behavioral health services. 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 (HIS) pursuant to a contract with the 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 (A THS) which is comprised of 229 Federally Recognized Alaska tribes and tribal organizations who have all	All comments, with the exception of the recommendation to apply the tribal encounter rate, have been addressed in previous written response (see above). Application of the tribal encounter rate for autism services lies outside the scope of the proposed regulations. The Dept needs to further research the recommendations to amend regulation that addresses licensing of other State professionals working for Tribal health organizations. The Dept does not want to delay adoption of the proposed autism services			

	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 A THS 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 tribes have assumed such broad responsibility to own and manage our healthcare system and is shining example of how true Indian self-determination can work. 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 diagnosis 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 neurodevelopmental 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. We ask, however, that the proposed regulations be revised in several respects, to ensure that providers are able to furnish ABA services efficiently and effectively to all children for whom they are likely to be beneficial. I will comment below on a section-by-section basis. As you will see, we recommend changes that will ensure: • Medicaid reimbursement for services to children diagnosed with an Autism Spectrum Disorder (ASD) and for all diagnoses for which ABA services are shown to be effective, including Fetal Alcohol Spectrum Disorder, Traumatic Brain Injury, and	regulations to address these important issues. Although ABA Services may be applied with other disorders, the intent and purpose of the proposed regulations is to only address services for children diagnosed with ASD. The Dept will retain the specific focus of these regulations and currently not expand coverage of autism services to other potential populations. All other comments addressed in previous written responses (see above).

	any other diagnoses supported by current or future research. • Eliminate the requirement that children must first receive certain other services before Alaska Medicaid will cover their ABA services • Services furnished in a tribal clinic or tribal behavioral health center will be reimbursed at the encounter rate. • Increase the fees for the service to be at least in line with those for other comparable rehabilitative health services for children • Eliminate or modify service authorization requirements. • If service authorizations are required, increase to 30 hours per week the number of hours the Department will cover without specific authorization. • Clarify that foster families and guardians may be involved in "family and multiple-family group adaptive behavior treatment guidance" services. 1. 7 AAC 70.010 (4). This section exempts from the requirements of7 AAC 70 board certified behavior analysts and assistant analysts "licensed under AS 08.15." Under Section 221 of the federal Indian Health Care Improvement Act, health professionals working for tribal health organizations are not subject to the State's licensing laws, and Medicaid must cover their services if they are licensed by any State. This federal provision is partially recognized in 7 AAC 105.200 (c) and (d), but that regulation fails to state the full scope of the exemptions provided by the federal law, and suggest that professionals employed by tribal health organizations may be subject to State Licensure. Because the provision is in the Medicaid regulations, it also does not directly exempt such professionals from the separate requirements of 7 AAC 70. We ask that the Department dearly state that 7 AAC 70 also does not apply to professionals licensed in other States who are working for a tribal health organization. We also encourage the Department to amend 7 AAC 105.200 to reflect the full reach of the federal exemption afforded by the Indian Health Care Improvement Act and articulated in published opinions of the Alaska Attorney	

	General. 2. 7 AAC 70.030. This is the first of several of the proposed regulation changes reflecting the Department's intention to limit ABA services to individuals diagnosed with an Autism Spectrum Disorder. Although ABA services are now recognized as the gold standard for individuals with ASD, the service is also effective and appropriate for individuals with other conditions or pervasive developmental disabilities and their attendant behavioral challenges, including individuals with Fetal Alcohol Spectrum Disorders and Traumatic Brain Injuries. 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. We urge the Department to cover ABA for all diagnoses for which it is shown to be effective, as Washington's Medicaid program does, rather than arbitrarily limiting it to those with ASD. Extending the service to all children for whom it would be beneficial is, in our view, a moral imperative, and one the State should embrace. It may also be a legal obligation for the State which, under the mandatory EPSDT benefit, is 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."2 •••. As you may know, several courts have recently held that States must provide the benefit for children with ASD, but their rationale, and CMS's guidance on the subject, is equally applicable to children with other developmental disabilities and other conditions for which ABA may be an effective treatment. We thus recommend that the Department delete the reference in this provision to "autism services, "and replace it with "behavior analysis services." 3. 7 AAC 70.050. This provision would also needlessly limit ABA services to individuals with an ASD diagnosis. For the reasons stated above, we ask the Department to strike the reference to "autism services" and replace it with "behavior analysis services." 4. 7 AAC 70.990. This provision would add and	

	define the term "autism services." As defined, the service accurately describes behavioral analysis services which, as discussed above, are appropriate for a number of developmental disabilities in addition to ASD. We urge the Department to strike the reference to "autism services" and replace it with "behavior analysis services." 5. 7 AAC 105.200. We support the addition of the specified provider types to this list of eligible Medicaid providers. However, for the reasons discussed in paragraph 1 above, we ask that the Department revise the provision to recognize that practitioners who are working for a tribal health organization may hold such a license from any State, not only from Alaska. 6. 7 AAC 110.210. For the same reasons discussed above, the reference in paragraph (b)(IO) should be changed from "autism services" to "behavior analysis services." 7. 7 AAC 135.0lO(c). Again, the reference to "autism services" should be replaced with "behavior analysis services," to allow this important therapy to be provided to all individuals with any diagnosis for which it is shown to be effective. 8. 7 AAC 135.020 (e). This is another provision that should be revised to allow ABA services for individuals with diagnoses other than ASD. Alarmingly and inexplicably, the provision would cover behavior analysis services only if a child has already failed to see measurable improvement from other recommended EPSDT services. That is, even if the child's clinician concludes that other EPSDT services will not be effective, or would be effective only in combination with ABA services, the clinician would be required to order the other services, and the child would be required to receive them and fail to improve, before the ABA services could be ordered and provided. In other words, they would require clinicians and children alike to undergo a classic exercise in futility. This would waste Medicaid funds, subject children to a fruitless and potentially counter-productive round of therapies, deprive some children of the most appropriate treatment, and inappropriately substitute the Department's generalized judgment for the clinician's professional judgment of what is medically necessary for a particular	

	child. The requirement should be eliminated. Behavior analysis services (and all other behavioral health services) should be treated like physician and other "medical" health services, and covered in accordance with the professional assessment of a qualified health care provider. 9. 7 AAC 135.040. As we have said on other occasions and in many contexts, the Department should stop requiring service authorizations and extensive medical necessity documentation for behavioral health rehabilitation and other behavioral health services. In SCF's experience, each service authorization request typically consumes an hour of clinician time; time that could be much better spent actually treating our customer's 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 ask the Department to eliminate the prior authorization requirement for all behavioral health rehabilitation services, including behavior analysis services. If the Department declines to eliminate them, service authorizations should be required only for a level of service that is outside the norm, which is up to 30 hours per week for behavior analysis services. Setting the limit below average levels simply imposes a needless administrative burden on providers and the Department alike. It may also discourage some providers from requesting the additional services they know a child needs, simply to avoid the burden of requesting them. To avoid pointless burdens and ensure children receive the level of	

	services they require, if the Department retains the service authorization requirement, we urge the Department to substitute "800 hours" for "520 hours" in proposed 7 AAC 135.040(c)(19). Likewise, we urge the Department to substitute "18" for "4" family adaptive behavior guidance sessions per fiscal year in the same section. 10. 7 AAC 135.300. For the reasons discussed in paragraph two above, all references in this provision to "autism services" should be replaced with "behavior analysis services." This provision, like the one we discuss above in paragraph one, also refers to State-licensing requirements that are inapplicable to professionals working for tribal health programs, and we ask that the Department revise it (or 7 AAC 105.200(c) and (d)) to reflect the scope of the federal exemption. Finally, two provisions that would require prior authorization for services-7 AAC 135.300(a)(2)(B) and 7 AAC 135.300(a)(3)(C)-should be deleted for the reasons stated in paragraph nine. 11. 7 AAC 135.350. The many references to "autism services" in this section (including in its title) should be replaced with "behavior analysis services" for the reasons discussed in paragraph two above. Further, the detailed requirements for what must be included in assessments and treatment plans (in (b) and (h), respectively), and the prior authorization requirement (in paragraph (/)) should be eliminated or revised. As discussed above, the professional judgment of trained behavioral health clinicians deserves the same respect and deference as the professional judgment of physicians and other medical health providers, and the Medicaid agency should stop micro-managing these clinical judgments and professional practices. We also urge the Department to clarify that "family adaptive behavior treatment guidance" may properly include a recipient's family members, foster family members, and guardians, and is not limited to the "recipient's immediate family member" as defined at 7 AAC 135.990(34) (a term that does not seem to be used in any of the substantive regulations). Finally, children who require behavior analysis services often need to receive them in conjunction with other behavioral rehabilitation services, and multiple	

	rehabilitation services will typically be included in a child's treatment plan. We are concerned that the provision in this section that precludes payment for "any behavioral rehabilitation health service being provided concurrently with" behavior analysis services (7 AAC 135.350(k)(7)) could be read to preclude such a multiple-services approach. The impression that it might is increased by the slightly different language of the immediately preceding subparagraph, (k)(6), which precludes reimbursement for "any two or more concurrent autism services by the same or different rendering individuals to the recipient at the same time." We believe the Department's intent for both provisions is to decline payment for any two services that are provided to a recipient at the exact same time, and not to prohibit recipients from receiving different services during the course of a single day, week, month, or other time frame, but the currently proposed language leaves that in doubt. We ask that the Department clarify its intention and revise both (k)(6) and (k)(7) to preclude payment for services that are provided "simultaneously, at the same time of day." 12.7 AAC 135.990. The proposed definition of "autism services" is an accurate description of behavior analysis services, which are appropriate for autism and a number of other conditions. We urge the Department to cover the service for all appropriate diagnoses, and to substitute "behavior analysis services" for "autism services" here and throughout the regulations. 13. 7 AAC 145.580. While we applaud the Department's decision to cover behavior analysis services, coverage means nothing if the reimbursement rates are too low to support the service and to encourage qualified providers to furnish them. We believe the Department's rates for all rehabilitative services are far too low to support their true cost. But, at the very least, rates for behavior analysis services should be on par with those the Department pays for similar rehabilitative services that are furnished by providers with comparable qualifications. We attach a chart comparing them. As you will see, the Department's proposed fees for initial behavior identification assessments ($309) are identical to those for other	

	behavioral health assessments, and comparable for family psychotherapy and family adaptive treatment guidance. But they fall short for other comparable services: $22 for thirty minutes of adaptive behavior treatment by protocol, as compared to $35.02 for individual therapeutic behavioral health services for children; and $15 for group adaptive treatment by protocol, as compared to $18.54 for group therapeutic behavioral health services for children. We can think of no reason why payment should be lower for behavior analysis services than for other rehabilitative services, and any work the Department has done to support its fee schedule for the latter should reasonably support the former. At a minimum, the rates for adaptive behavior treatment by protocol should be increased to $35.02, and the rate for group adaptive treatment by protocol should be increased to $18.54. Further, when services are furnished in a clinic or community behavioral health center operated by a tribal organization, and thus qualify as tribal "clinic" services, they should be reimbursed at the OMB-approved tribal outpatient service encounter rate published annually by IHS in the Federal Register. 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, and the one most likely to ensure the services are available to recipients State-wide. The rate is based on cost reports and encounter data submitted by representative tribal facilities 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. We thus ask that the regulations be revised to adopt the encounter rate for all behavior analysis services furnished "on site" at a tribal facility. Thank you for the opportunity to provide comments	

	on this important proposal. Please feel free to contact me if you have any questions. I can be reached at (907) 729-4938 or by email, katherineg@scf.cc Sincerely, SOUTH CENTRAL FOUNDATION	