THERAPY-1-16 Update

Response to Public Comments

Approximately 9,000 comments and/or petition signatures were submitted between September 14th – November 14th in response to Therapy 1-16. The majority of those comments were from parties stating their concerns if the proposed therapy thresholds are initiated and a Prior Authorization is implemented. Many of the comments were in support of the proposed changes. The comments are addressed in the responses below.

Comment: Several parties, submitted comments stating the proposed 90 minute threshold is inadequate for the majority of children who qualify under Medicaid guidelines and 120 minutes would be more appropriate as most "outliers" are over the 120 minute range. Many stated a 120 minute threshold would be a good compromise; there would be fewer Prior Authorizations resulting in less administrative costs. "I believe that to arbitrarily limit services to 90 minutes (without prior authorization) harms the children that desperately need those services. It also takes patient care decisions away from the doctor and therapist (where they should be) and places them in the hands of "decision makers" that neither know the patient, nor the severity of their condition. If a limit must be written into the new rules, I would ask that you seriously consider making that limit 120 minutes per week. I feel that this would most appropriately reflect the needed amounts of therapy for the most patients".

Response: DHS has proposed rule changes that would alter how Medicaid therapy is currently paid for individuals receiving OT, PT, or Speech at a CHMS or a DDTCS, those individuals receiving these types of therapy at a stand alone, private clinic and those children receiving school based OT, PT, or Speech therapy provided at the school during school hours. The proposed rule allows Medicaid eligible recipients, in the categories listed above, who qualify for services and have a prescription to get (without the need for prior authorization): 90 minutes a week of speech therapy, 90 minutes a week of occupational therapy, and 90 minutes a week of physical therapy. Anything above the 4.5 hours total per week would require the provider to get prior authorization, which is a common practice for other Medicaid services and among private insurance carriers. If an individual needs these services, there will be an easy and quick way for the provider to get additional services approved. We are working with pediatric health clinicians who are experts in these fields to develop the prior authorization process.

Comment: Several parties commented about having a third party vendor perform the evaluations. They stated that the therapist that has been working with the individual would be better suited to perform the evaluations because they are familiar with the individual. A third party is inadequate because they do not have regular contact, thus leading to inconsistent evaluations.

Response: Please see other responses.

Comment: Several parties submitted comments voicing concern that a reduction in minutes to 90 minutes per week per therapy will cause the individuals to require therapeutic services for a longer period of time, thus being a greater expense in the long term.

Response: Please see other responses.

Comment: Several parties submitted comments concerning individuals not receiving services during the Prior Authorization process.

Response: Please see other responses.

Comment: Several parties submitted comments exclaiming the progress that their loved one has made with therapy and the 90 minute threshold will hinder the individual's progress and cause the individual to regress causing further delay.

Response: Please see other responses.

Comment: Several parties commented on specific procedures being spelled out in legislation. "After a period of time, this legislation will be reversed (Texas is a recent example) creating a "black hole" of sorts in which roles, responsibilities, policies, and procedures are not clearly defined". "We should have what records and documentation will be required to make any kind of determination outlined within the legislation, itself. So, if this moves forward, I ask that you please include these guidelines".

Response: The proposed changes will NOT be state statutory law. State law mandates the DHS have proposed policy changes reviewed and approved by the Arkansas General Assembly.

Comment: Several parties echoed the following comment; "Research has shown time and time again that early intervention is not only the most effective approach for a child to make progress with rectifying a speech/language disorder, but it is also very cost effective. Early intervention will help to prevent more expenses that would come about later in the child's life if *sufficient* therapy was not conducted at the earliest age possible".

Response: Please see other responses.

Comment: Several parties submitted comments stating that the proposed change is concerned with short-term savings and has not considered the long-term implications. Where is the value in reducing these services when you are looking at the long-term value associated with it?

Response: Please see other responses.

Comment: Several parties submitted comments regarding the Prior Authorization process, and the belief that there is one in place. Arkansas essentially has a prior authorization (PA) process in place. Therapists conduct an evaluation and create a plan of treatment with a recommendation for the weekly minutes needed for therapy. The report, plan of treatment, and recommendation for minutes are submitted to the primary care physician (PCP) for review. The severity of the disorder guides the therapist in recommending the number of minutes needed to address the areas of deficit based on

medical necessity. (Please refer back to the chart listed above to verify the range of minutes prescribed per discipline.) The PCP then confirms medical necessity and approves the recommended number of minutes. The PCP has the ability to decrease the number of minutes recommended or decline services completely. Therapy cannot be initiated until the PCP has returned a DMS-640 form which includes the specific number of minutes prescribed for the client. Therefore, the PCP acts as a PA for services.

Response: Please see other responses.

Comment: Several parties comments reflected the following sentiment; "the changes proposed have been discussed and created with little to no input from treating therapists, families, or physicians in Arkansas. Although the total financial savings was reported to the Arkansas Democratic Gazette, details regarding the specific changes were not shared. Medicaid has not disseminated this information to current providers. Our national organizations are not aware of these significant changes. The discussions have occurred in such a vacuum that groups throughout the state such as the "Down Syndrome Network" and "Autism Involves Me" have not been given the opportunity to formulate a response and are currently working to gather details regarding these proposed changes".

Response: A third party vendor will NOT perform the evaluations. The evaluations (diagnosis and prognosis and treatment plan) will remain the responsibility of the therapist selected by the individual or family.

Response: Data shows that 74,704 individuals received OT, PT, or Speech at a CHMS, a DDTCS, a stand alone private clinic, or in a school setting in CY 2014. Total spend from those 74,704 recipients was approximately $140,182,731.

School Based: Data shows that 23,211 children received school based therapy in CY 2014. Of those, 1,536 children received more than 90 minutes in one of the three disciplines per week. Data shows that out of the school based clients, 2% of those receiving OT will be affected, 4% of those receiving PT will be affected, and 1% of those receiving ST will be affected.

Stand Alone: Data shows that 25,024 children received therapy in a stand alone clinic setting in CY 2014. Of those, 12,489 children received more than 90 minutes in one of the three disciplines per week. Data shows that out of the stand alone clients, 14% of those receiving OT will be affected, 14% of those receiving PT will be affected, and 22% of those receiving ST will be affected.

CHMS: Data shows that 16,327 children received therapy in a CHMS setting in CY 2014. Of those, 5,831 children received more than 90 minutes in one of the three disciplines per week. Data shows that out of the CHMS clients, 9% of those receiving OT will be affected, 9% of those receiving PT will be affected, and 15% of those receiving ST will be affected.

DDTCS: Data shows that 10,142 individuals received therapy in a DDTCS setting in CY 2014. Of those, 3,763 individuals received more than 90 minutes in one of the three disciplines per week. Data shows that out of the DDTCS clients, 9% of those receiving OT will be affected, 12% of those receiving PT will be affected, and 15% of those receiving ST will be affected.

Response: Below is a list of the meetings I attended or hosted regarding the proposed therapy changes to OT, PT, and Speech.

6/28/16 Workgroup (representatives from ARPTA, AROTA, ArkSHA, CHMS, DDTCS, DDPA, and Early Intervention Providers) presented data and proposal for inserting 90 minute thresholds per discipline per week

8/17/16 Large Stakeholder meeting was held at the UALR Cooperative Extension Service Auditorium

8/22/16 Health Reform Task Force Meeting; TSG presented that looking at the units was being discussed between DDS and Stakeholder groups

9/6/16 Workgroup Meeting (representatives from ARPTA, AROTA, ArkSHA, CHMS, DDTCS, DDPA, and Early Intervention Providers)

9/14/16 TAC Meeting made up of therapist

9/23/16 Workgroup Meeting (representatives from ARPTA, AROTA, ArkSHA, CHMS, DDTCS, DDPA, and Early Intervention Providers)

10/25/16 TAC Meeting Scheduled at AEDD

10/31/16 Discussed therapy rule changes at Public Health

11/17/16 Discussed therapy rule changes at Public Health

Comment: Several comments reflected the following sentiment; I am pro limiting therapy minutes to a general guideline of 90 minutes a week per discipline, per child (what most of my kids get anyways). I believe this will cut down on the cost of billing for unnecessary treatment time for children who are currently receiving too much therapy. We all know how expensive therapy services are, and I believe establishing a limit will save money and shift focus from unnecessary billing to treating more clients who actually NEED services. HOWEVER, there needs to be a plan in place that makes it EASY for therapists to "prove" and qualify those clients who need MORE than 90 minutes per week.

Response: DHS is working to develop a prior authorization process that is easy and clinically sound.

Comment: Several parties submitted comments voicing concern over the cost/expense of employees having to keep up with all of the Prior Authorizations for extended therapy. The changes in the above stated bill will negatively impact several of our patients' progress and future success. Currently, 50% of our patients receive skilled therapy services for 120 minutes/week. If we were required to request Prior Authorization for each of these children (in addition to the physician approving visits) it would add costs all around…administrative costs for the providers, increased expense for Medicaid to handle Prior Authorization requests and a delay the child's therapy services during this process.

Response: DHS is working to develop a prior authorization process that is quick and easy so if additional services are needed they will be approved. DHS has committed to utilizing pediatric

clinicians to review the evaluations and has committed to requiring the vendor to complete the process within 72 hours.

Comment: Several parties submitted comments that the proposed 90 minute thresholds will compromise individual's ability of achieving critical milestones and benchmarks.

Response: DHS agrees that early intervention as well as ongoing therapeutic services are extremely important for those with developmental and intellectual disabilities or delays. We are working to develop a prior authorization process that is quick and easy so if additional services are needed they will be approved. DHS has committed to utilizing pediatric clinicians to review the evaluations and has committed to requiring the vendor to complete the process within 72 hours.

Comment: Several comments stated that a third party PA is redundant when the Primary Care Physician already writes the prescription.

Response: While many PCP's work with individual therapist to set therapy units, some do not.

Comment: Several parties agree with the proposed changes; "Therapists are over identifying kids and over serving them. Request 180 min regardless of the severity of the diagnosis".

Comment: Several parties submitted comments stating if an effective PA system is established with a third party, the recipients will receive the same number of minutes at an increased cost to the State.

Comment: Several parties agree the proposed changes will cut cost of billing for unnecessary treatment time for children receiving too much therapy, if there is a simple component in place to get additional therapy minutes for those that need it.

Comment: Several parties submitted comments stating that the State needs to re-examine DDTCS make it more difficult to qualify for DDTCS, as they are costly to Medicaid program.

Response: DHS is examining both DDTCS and CHMS services at this time.

Comment: Several parties submitted comments agreeing with the proposed changes to avoid managed care.

Comment: Several parties submitted comments stating that when the State had Prior Authorizations in the past they did not work, caused delays and back-log.

Response: DHS has heard feedback regarding a previous prior authorization process. Many clinicians on the workgroup who are helping to develop the new PA process provided services at that time. DHS is reviewing the former PA process to avoid practices that made the previous system complicated or ineffective.

Comment: Several parties submitted comments stating; the tests used for qualification for therapy services have to be examined as well.

Comment: Several therapists submitted comments stating that proposed changes limit the therapist's abilities to exercise clinical skills which they spent years working towards. It is difficult to understand how the trustworthiness and integrity of highly educated therapists could be called into question and be told they have completed all those years of education yet they are not trusted to conduct unbiased and ethical evaluations on patients. This is how this is being perceived by the Speech, Occupational, and Physical Therapy communities. DO NOT punish the honest therapists by taking away their educational rights to prescribe the amount of minutes their clinical judgement justifies.

Response: It is not the intention of DHS to punish or take away a therapist's clinical judgement.

Comment: DDPA supports the original proposal for a threshold of 90 minutes of therapy per week per discipline for children and adults with a prior authorization process in place prior to implementing the thresholds that have approved guidelines, credentials of reviewers, and timelines for any recommendations for therapy that are above the threshold. An appeal process must be in place prior to implementing the threshold also. The projected savings would be $13,000,000 net.

Response: An appeal process will be put in place.

Comment: (UAMS KIDS FIRST) In general, we support the proposal as a method to ensure appropriate and efficient use of resources across the state. Our questions apply to the proposed PA process. We are primarily concerned with access to services for the types of children described, but also with minimizing the administrative time and effort burden.

Response: See responses above regarding DHS' commitment to make the PA process easy, as well as our commitment to require a 72 hour turn around and use pediatric clinicians.

Comment: Implementing arbitrary minutes on therapy limits our professional clinical integrity and what we and the dr feel is best for the patient. I know there are therapists that abuse the system. But instead of placing limitations on the children who need these services beyond 90 minutes, you should implement more in depth audits and consequences for those that lack professional judgment.

Response: Many states utilize the prior authorization process for therapuetic services paid by Medicaid. Some even require prior authorization before any access is allowed. This proposed change was developed with the support of Arkansas clinicians who currently serve this population.

Comment: Several parties submitted comments recommending flagging therapy companies that use the maximum amount of minutes on a higher percentage of clients, to identify possible abuse of the system. Once they have been identified as prescribing unusually high amounts of therapy, they could be reviewed under audit, instead of making cuts across the board.

Response: Please see response above.

Comment: It has come to my attention that a Workgroup consisting of representatives from ARPTA, AROTA, ArkSHA, CHMS, DDTCS, DDPA, and Early Intervention Providers, refused the proposal of reducing therapy reimbursement rates by 3-6%. By doing this it seems that they would rather reduce

the amount of time children with special needs receive therapy by placing a threshold of 90 minutes per week instead of taking a pay cut. If I have interpreted this incorrectly I apologize.

Response: DHS is unaware that the Provider Workgroup refused a different proposal. These proposed changes were recommended to DHS by the Workgroup.

Comment: DRA believes it is essential to establish a system that allows for careful monitoring and tracking of extended therapy benefits requests to ensure that the prior authorization process does not result in delays in accessing needed therapies and/or effectively results in hard cap limits on the amount of therapies available.

DRA is concerned about the lack of clarity in the proposed policy concerning whether the allowable amounts of therapies includes both individual and group therapies or individual therapy alone. Some individuals need both individual and group therapy.

DRA believes that further information and clarification regarding the impact of the unit limits on different types of therapy is necessary.

Recommendations:

1. DHS should amend the proposed policy to include a clear and timely authorization process for extended therapy requests, and
2. DHS should amend the proposed policy to clarify that individuals can receive up to six units (90min) weekly of individual therapy and six units of weekly group therapy.

Response: DHS appreciates the support from Disability Rights Arkansas and look forward to working with you on the prior authorization requirements.

Comment: I applaud you for working with the ARKSHA, AOTA, and APTA Representatives. We are opposed to a Managed Care Model as suggested by TSG. We desire to retain the ability to complete our own evaluations and make the subsequent therapy recommendations. We are opposed to a third entity performing our evaluations. This would significantly delay the timeliness of the evaluations and initiation of services. We are intimately acquainted with the children we serve and their idiosyncrasies. We are the skilled and nationally board certified professionals licensed by the State of Arkansas and ASHA, to do such.

Response: Thank you

Comment: Several parties submitted the following comment. Please accept this comment in opposition to the proposed rule change for speech, occupational, and physical therapy as it relates to public school. Districts are obligated by law (IDEA) to provide the above services. The proposed rule change could impact districts' ability to recoup funds for therapy provided. As it is, therapists charge well above the approved Medicaid Reimbursement rate, and districts must stretch every penny to make up the difference.

Additionally, public schools are the only providers required to pay state match. Therefore, public schools should be considered separately from private/for-profit providers.

Response: The Department of Education, Special Education Unit is in support of the proposed changes. DHS is working with them to develop a PA process that takes school therapy/IDEA/IEP into consideration.