EXHIBIT F

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: ARKids-2-16, CHMS-1-16, DDTCS-1-16, Hospital-1-16, Nursepra-1-16, Therapy-1-16, Physician 2-16, and Rehabhsp-1-16

DESCRIPTION: This establishes a limit on the weekly amount of Medicaid funded speech therapy, occupational therapy, and physical therapy that may be provided to an eligible individual without prior authorization.

PUBLIC COMMENT: A public hearing was held on October 5, 2016. The public comment period expired on November 13, 2016. The department received the following comments:

Over 9,000 comments were submitted between September 14th – October 27th 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.

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".

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.

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.

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

Comment: Several parties submitted comments voicing concern about a timely review process for the Prior Authorization.

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.

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".

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".

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?

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.

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".

Comment: Several parties 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.

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.

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

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

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 stated that a third party PA will erode the position of the Primary Care Physician and substitute administrative judgement in place of medical judgement.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

COMMENT:
Michael Harry, attorney for the Bureau of Legislative Research, asked how the department settled on placing the cap at 6 units per week.

RESPONSE:
Although the threshold changes were proposed by a Provider Workgroup made up of speech therapist, occupational therapist, physical therapist and early intervention providers, more information needs to be available to inform stakeholders on the intention of the proposed rule. I have attached a Fact Sheet we developed.

Currently, the Notice of Rule Change states (I'm paraphrasing a little here): All PT, OT, and ST billed under the Medicaid State Plan will allow 90 minutes per discipline per week with the appropriate prescription. However, if greater amounts of therapy is required, a prior authorization or extension of benefits process will be utilized. As for the prior authorization process, the same Provider Workgroup is drafting specs on how the PA process should ideally operate. That draft will go on our website for public comment as well, likely in early 2017. DDS is committed to ensuring that clinicians review the

documentation submitted for increased therapy hours. It is not our intention to deny therapy services for children who need them. The prior authorization process will also include clear guidance on how a therapist/PCP can appeal a decision.

All written comments, such as yours, will be logged. DHS will formally respond to the comments in writing following the end of the public comment period. The public comment period is the first step in any rule change process. The public comment period has been extended until November 13th. We will read all comments and make adjustments to the rule if warranted.

The proposed effective date is July 1, 2017.

CONTROVERSY: This rule is expected to be controversial. While the organizations representing the therapy providers have approved of the amendment, certain individual therapists may disagree with the rule.

FINANCIAL IMPACT: The total estimated savings for the current fiscal year is $56,235,645 ($16,544,527 in general revenue and $39,691,118 in federal funds) and the same amount in savings is projected for the next fiscal year.

LEGAL AUTHORIZATION: The Department of Human Services is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201 (12). Arkansas Code § 20-77-107 specifically authorizes the department to "establish and maintain an indigent medical care program."

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Medical Services

DIVISION DIRECTOR Dawn Stehle

CONTACT PERSON Melissa Stone

ADDRESS PO Box 1437, Slot S295, Little Rock, AR 72203

PHONE NO. 501-682-8662 **FAX NO.** 501-404-4619 **E-MAIL** melissa.stone@dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Tami Harlan

PRESENTER E-MAIL tami.harlan@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

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1. What is the short title of this rule? ARKids 2-16, CHMS 1-16, DDTCS 1-16, Hospital 1-16, Nurseprac 1-16, Therapy 1-16, Physicn 2-16 and Rehabhsp 1-16

2. What is the subject of the proposed rule? Establishes a limit on the weekly amount of Medicaid funded speech therapy, occupational therapy, and physical therapy that may be provided to an eligible individual without prior authorization.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒
   If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒
   If yes, what is the effective date of the emergency rule?

When does the emergency rule expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒
If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary? The purpose of the rule is to establish limits on the amounts of Medicaid funded therapy (PT, OT, ST) provided to an eligible individual without seeking prior authorization. The rule is necessary to monitor utilization of Medicaid funded therapies.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
https://www.medicaid.state.ar.us/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
If yes, please complete the following:

Date: October 5, 2016
Time: 4:30 pm
Arkansas Central Library
100 Rock Street
East Room
Place: Little Rock, AR

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
November 13, 2016

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
July 1, 2017

12. Do you expect this rule to be controversial? Yes ☒ No ☐

If yes, please explain. While the organization representing the therapy providers have approved of the amendment, certain individual therapists may disagree with the rule.

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

Individual occupational, speech and physical therapists might argue that the proposed rule is ineffective, cumbersome, or potentially harmful.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Melissa Stone

TELEPHONE NO. 501-682-8662 **FAX NO.** 501-404-4619 **EMAIL:** Melissa.stone@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE **ARKids 2-16, CHMS 1-16, DDTCS 1-16, Hospital 1-16, Nurseprac 1-16, Therapy 1-16, Physicn 2-16 and Rehabhsp 1-16**

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	

Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total _____ Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	($ 4,789,911)	General Revenue	($ 4,789,911)
Federal Funds	($11,491,229)	Federal Funds	($11,491,229)
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	($16,281,140)	Total	($16,281,140)

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ (4,789,911)

Next Fiscal Year
$ (4,789,911)

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.