ARKANSAS
DEPARTMENT OF
HUMAN
SERVICES

Division of Developmental
Disabilities Services

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PUBLIC COMMENTS RECEIVED FROM APRIL 8, 2018—MAY 9, 2018

1. TOM MASSEAU, EXECUTIVE DIRECTOR, DISABILITY RIGHTS ARKANSAS, INC.

COMMENT: I am writing on behalf of DRA to submit a general comment that applies equally to each of the above-referenced proposed rulemakings. While we reviewed and commented on each of the proposed rules as appropriate, the information provided to the public for commenting does not indicate whether DHS followed the statutory requirements prior to a rulemaking. We recommend, in order to ensure transparency during this comment period, DHS should routinely provide the answers to the below questions in its transmittal letters to interested persons. The information elicited from the below questions could provide clarity to individuals regarding the motivation behind proposed rules, as well as the impact of the proposed rules on individuals.
As DHS is required to follow this process prior to a rulemaking, DRA recommends that DHS inform the public of the following, for each rulemaking proposed:
1. Why is DHS is engaging in this rulemaking? (See Ark. Code Ann.§ 25-15-204(a)(3)(A))
2. a. Is the proposed rule to resolve a problem?
b. If so, please provide, describe, or cite to any studies, statistics, or other data upon which DHS relies in identifying or resolving the cited problem. (See Ark. Code Ann.§ 25-15-204(a)(3)(A))
3. a. What is the anticipated impact of the new assessment on the delivery of services to DHS 's beneficiaries?
b. How has DHS, outside of the notice of this proposed rulemaking, attempted to contact its known beneficiaries who it expects will be impacted? (See Ark. Code Ann.§ 25-15-204(a)(3)(A))
4. a. Has DHS considered the specific nature and significance of the problem the agency is addressing with this proposed rule, including:
(1) the nature and degree of the risks the problem poses;
(2) the priority of addressing those risks as opposed to other matters or activities within the agency's jurisdiction;
(3) whether the problem warrants agency action; and,
(4) the countervailing risks that may be posed by alternative rules for the agency?
b. If so, for (I)-(4), above, please describe how DHS came to its conclusion regarding the specific nature and significance of the problem the agency is addressing with this proposed rulemaking. (See Ark. Code Ann.§ 25-15-204(a)(3)(A)-(C))

5. Has DHS considered whether existing rules have created or contributed to the problem the agency is addressing with the proposed rule, and whether those rules could be amended or repealed to address the problem in whole or in part?
(See Ark. Code Ann.§ 25-15-204(a)(3)(0))
6. What consideration did DHS give to other reasonable alternatives to the proposed rule, including:
(1) adopting no rule;
(2) amending or repealing existing rules; and
(3) other potential responses that could be taken instead of agency action?
(See Ark. Code Ann.§ 25-15-204(a)(3)(E))
7. a. Is the proposed 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?
b. What scientific, technical, economic, or other evidence did DHS use to identify the need for, consequences of, and alternatives to the proposed rule?
c. What scientific, technical, economic, or other evidence did DHS reject when identifying the need for, consequences of, and alternatives to the proposed rule?
(See Ark. Code Ann.§ 25-15-204(b)(I))

RESPONSE: Please see attached the Questionnaire and Financial Impact Statement filed for each Rule, which addresses the statutory requirements of rulemaking. *Attachment 1*. To engage stakeholders, DDS put on two Facebook Live informational sessions and a series of town halls. DDS also addressed the EIDT and ADDT program changes at all presentations leading up to the rule promulgation, those presentations included all DDS transformation efforts, which would include independent assessment, developmental screens, PASSE, EIDT, ADDT, etc. To promote beneficiary engagement, DDS has set up and utilized a family email portal, where families can sign up to receive all correspondence that is sent to providers.

PUBLIC COMMENTS ON TRANSPORTATION MANUAL AMENDMENTS

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1. DAVID IVERS, DEVELOPMENTAL DISABILITIES PROVIDER ASSOCIATION (DDPA)

COMMENT: The rate for transportation has not been increased in eight years. Providers lose significant amounts of money providing transportation. No transportation broker provider would provide the transportation for the full EIDT rate, let alone as a subcontractor. This will create an access issue soon if not addressed.

RESPONSE: No transportation broker is needed. DDS will pay the rate directly to EIDT and ADDT providers to transport their own clients. We are currently engaging stakeholders in non-emergency transportation (NET) discussions. We are happy to discuss a future change of eliminating EIDT/ADDT transportation and putting everyone on the NET rate, if eligible.

COMMENT: *272.200 Mileage Calculation: The route taken when transporting the clients must be reasonable and must be planned to minimize the beneficiaries' time spent in route to and from the facility (i.e. must pick up the beneficiary farthest from the facility first and drop him or her off last). The provider must not take unnecessary extended routes to increase the mileage.*
Why is the new language inserted? Providers lose money and only get paid for the client who lives the farthest, so what is the purpose of adding this?

RESPONSE: The purpose of this additional language was to clarify that the rule is the provider is paid for the client who lives the farthest, not the client who spends the most amount of time in transport. In doing so, we want to ensure that clients, both children and adults with developmental delays and disabilities, do not spend more time than necessary in route to the day treatment program.

COMMENT: Page 8aa at 23.a.(3) The statement that: "The route must be planned to ensure that beneficiaries spend the least amount of time being transported" is ambiguous. Considering the financial status of the program, this concept would have to be balanced with the economic realities.

RESPONSE: Please see response above.

PUBLIC COMMENTS ON ADULT DEVELOPMENTAL DAY TREATMENT (ADDT) PROGRAM

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1. DAVID IVERS, DEVELOPMENTAL DISABILITIES PROVIDERS ASSOCIATION

COMMENT: The proposed rule, which creates a new program (ADDT) and ends licensure under DDTCS, puts at risk the state's "grandfather" status under OBRA 1989.

RESPONSE: The Omnibus Budget Reconciliation Act of 1989 (OBRA '89), which you cite, is a prohibition on the Secretary of the U.S. Department of Health and Human Services (DHHS) to defund an *old* program until such time as the Secretary finalized regulations addressing the issue of habilitation services. That legislation in no way presents a limitation on the Secretary's ability to approve alteration or fund a *new* program. A great deal has changed in the Medicaid program in the past 29 years which has provided states with new options that did not exist in 1989. DHS will not sunset DDTCS or CHMS without having CMS approval of the new programs.

COMMENT: Also, creating a new licensure would place the managed growth statute and rules under state law in question. The managed growth statute at 20-48-105 references "existing operations," which are defined as DDTCS at 20-48-101(3).

RESPONSE: Because of the state statute, the expansion rules will apply to the new EIDT and ADDT models, as successor programs; and the same standards will apply.

COMMENT: 201.200 ADDT Providing Occupational, Physical, or Speech Therapy
It is inconsistent to state that speech, physical, and occupational therapies are an "essential component" of an individual program plan and then to state that they are optional, not included as a core service, and can only be provided if the individual is eligible for day habilitation. Most adults in DDTCS do not receive therapy so it is hard to understand how it can be an "essential component."

RESPONSE: The language was meant to indicate that, when therapy is needed, it is an essential component of that individual's IPP. However, the word "essential" will be deleted from this sentence to clarify that occupational, physical, and speech therapy are not required for all clients attending an ADDT.

COMMENT: 211.100 Developmental Disability Diagnosis
A.1.a. Intellectual Disability. Did you mean to use language regarding infants/preschool here?

RESPONSE: This language is in the definition of intellectual disability used in DDS Policy 1035; however, it is not applicable to ADDT programs and will be removed.

COMMENT: What is the difference between "results of a medical examination" and "diagnosis"?

RESPONSE: DDS cited DDS Policy 1035 for the definition of developmental disability. This policy uses both terms.

COMMENT: For epilepsy, the sentence is grammatically incorrect. Also, a neurologist is a licensed physician.

RESPONSE: DDS cited DDS Policy 1035 for the definition of developmental disability.

COMMENT: Does it really require all three of those professionals to make an Autism diagnosis in every instance? This does not seem to be the case universally.

RESPONSE: DDS cited DDS Policy 1035 for the definition of developmental disability. This is also the standard used to receive ABA therapy under EPSDT and the Autism Waiver.

COMMENT: A.2. – Part "b" seems redundant with part "a" with regard to IQ scores.

RESPONSE: This is correct, we will delete paragraph b.

COMMENT: 213.200 Non-Covered Services
DHS has proposed to include "**education**" as among those services that are not covered. Certain services, particularly habilitation, have both education and medical characteristics. This "overlap" does not mean that Medicaid will not cover them. A blanket exclusion of education services would violate Medicaid. *Massachusetts v. Sec'y of Health and Human Services*, 816 F.2d 796 (1st Cir. 1987). See also 42 U.S.C. 1396b(c). See also, *Chisholm v. Hood,* 110 F. Supp.2d 499, 507 (E.D. La. 2000) (a state cannot avoid its obligation to children with special needs by delegating it to the state's education system). While we understand that traditional education is not covered, this does not mean that habilitative services with educational benefits are excluded. Please remove "education" from the Non-Covered Services list.

RESPONSE: While you are correct that we cannot exclude all educational services for children, education for adults is a non-covered service. This is not a change for adults receiving DDTCS services.

COMMENT: Also, this section says, "An ADDT clinic must provide only those services that DPSQA licenses the ADDT clinic to provide." The Medicaid Manual may state which services it will or will not reimburse, but the ability of a provider to offer other services in a particular setting relates to licensure, not reimbursement, and should not be included here. Regarding licensure, there are reasons the state may want providers to offer services Medicaid does not cover in an effort to more fully address individuals' well-being.

RESPONSE: We are simply reiterating the fact that covered services must meet DPSQA licensure requirements.

COMMENT: 215.000 Individual Program Plan
Introduction -This says the plan must be designed to "improve" the beneficiary's condition. For some individuals, the service will be necessary to "maintain" their condition and prevent regression, but they will not necessarily "improve." Please add "maintain or" before improve. See 42 U.S.C

1396-1 (“rehabilitation” includes “services to help... families and individuals attain or retain capability for independence or self-care.”) (For background in Medicare context, see *Jimmo v. Sebelius* Settlement Agreement of 2013.)

RESPONSE: The word “maintain” will be added. The section also states that all services must be “medically necessary,” which is defined to include services that prevent a worsening of the individual’s condition. Therefore, the addition of the word “maintain,” reflects this requirement.

COMMENT: B. Here the schedule needs to be defined as a "tentative" schedule to allow the individual flexibility in choice of services.

RESPONSE: We will add the word “tentative” to clarify that the daily schedule does not have to be met exactly; however, treatment goals and objectives must be met or modified as needed during the annual treatment period.

COMMENT: 216.100 Occupational, Physical, and Speech Therapy
See earlier comment on “essential” vs. “optional.”

RESPONSE: Please see response to earlier comment regarding essential v. optional services.

COMMENT: 216.200 Nursing Services
We definitely support this as a much-needed service for certain clients. Programs may be able to take more medically complex individuals with this addition.
Please clarify that this an optional service – that a provider does not have to offer nursing to be licensed.

RESPONSE: We added the same introductory sentence used for Occupational, Physical and Speech Therapy, “Optional service available through ADDT include nursing services,” to clarify that they do not have to be provided.

COMMENT: The list includes “Administration of medication” as #7 among those nursing services that may be billed, but the next sentence says it is *not* reimbursable. Please clarify by wording like the children’s manual.

RESPONSE: This language will be removed to clarify that administration of medication can be a billable component of nursing services.

COMMENT: 217.100 Establishing Medical Necessity for Core Services
This section seems to say the prescription comes first, then the care plan. The DD waiver is the opposite order. (The waiver process-requires that a meeting be held and the physician signs the prescription (part of plan of care) within 30 days after meeting. The waiver PCSP must be submitted to DDS 45 days prior to the expiration of the current plan. The physician’s prescription is as much as 60 days prior to the implementation of the new plan.) If this requirement in Adult DDTCS could be changed to mirror the waiver criteria, the waiver plan and Adult Development plan could be integrated into one plan. It would also allow there to be, at some point in time in the future, one prescription that could result in the annual staffing dates being the same.

RESPONSE: We agree that ideally, clients will have one overarching plan of care that will be signed off on by a physician, this plan will include Waiver and all state plan services.

COMMENT: 220.000 PRIOR AUTHORIZATION
For children in EIDT, up to 4 units a day of nursing can be provided without prior authorization, yet under ADDT all nursing has to be prior authorized. This creates an unnecessary administrative burden and waste of state resources over a small amount of money. The services listed for nursing in both EIDT and ADDT are the same, so why is there different treatment? This could discourage adult clinics from taking more medically involved individuals. Please remove prior authorization up to 4 units.

RESPONSE: For EIDT it is a mandatory service. For ADDT it is an optional service that is completely new to the program. Therefore,.we are requiring a PA so that we can monitor utilization of this new service. We are happy to discuss removing the PA after we have at least one year of data.

COMMENT: 232.000 Retrospective Reviews
The current manuals have retrospective reviews in the context of therapy only. This broadens it to all non-prior-authorized services, including core services. These will now be conducted on top of on-site audits by Utilization Review. What is the cost of these reviews? In what frequency will they be conducted? These are low paying services for which retrospective reviews will create an administrative burden on providers and a cost to the state that may not be warranted by the results. Past retrospective reviews in therapy have not achieved significant benefits, and, in fact, have resulted in a net cost to the state. DDTCS has not had a rate increase since 2010, and that was less than $1. The minimum wage has increased more than that. Has a cost-benefit analysis been conducted? What is the cost of these reviews? In what frequency will they be conducted?

RESPONSE: All services provided to Medicaid beneficiaries and billed to the Medicaid program may be reviewed. *See* All Provider Manual, Section I. The frequency and process of reviews will be established in the contract with the new prior authorization/retrospective review vendor. An RFP will be put out later this year and will be available for public inspection. DDS has a duty to ensure federal Medicaid funding is being used in accordance with regulations, therefore, we have opted to do random retrospective reviews and eliminate the majority of prior authorization requirements.

COMMENT: 242.100 ADDT Core Services Procedure Codes

T1023	U6, UA	Diagnosis and Evaluation Services (not to be billed for therapy evaluations) (1 unit equals 1 hour; maximum of 1 unit per day.)

Is this code what is meant by "assessment" elsewhere in manual.
At front of manual (214.110) it states assessment can be done 1 unit, 1 x year and this section states it can be 1 hour per day. Rate that is on the rate sheet is same as the $108 it has always been. Please clarify.

RESPONSE: The code can be billed once per year, the same as it always has been. The language "once per year" will be added to the table to clarify this. Like any other service an extension of benefits can be requested.

COMMENT: DDPA supports Treatment Plan Development code 99367. Can you clarify if this can be done while in DDTCS or whether the person has to be logged out? Also, can provider request a second plan developer fee if the plan has to be revised during the year?

RESPONSE: A provider cannot bill for developing a treatment plan and providing other services at the same time, so a client would need to be "logged out" of day habilitation services for the time that the treatment plan was being developed. A provider can request an extension of benefits if the plan needs to be revised during the year.

COMMENT: Under the EIDT manual Treatment Plan Development is at $22.50 for 15 min unit with 4 units a year available ($90 year). See CPT 99367 in Section 232.100. This code is also in ADDT (adult day treatment) but adults cannot be broken into 4 units throughout the year--it has to be billed all at once. Section 242.100. Please make it match flexibility for individual's needs, as in children's.

RESPONSE: We put a more flexible schedule in place for children to meet their changing needs. Again, if an adult's plan needs to change the provider can request an extension of benefits.

2. TOM MASSEAU, EXECUTIVE DIRECTOR, DISABILITY RIGHTS ARKANSAS, INC.

COMMENT: DRA has concerns regarding the prior authorization requirements discussed in the manual. Individuals who require more than six units of a given therapy type (physical, occupational, or speech) over a one-week period and individuals who require nursing services must receive prior authorization. The only elaboration on this is found in Section 220.000, titled "Prior Authorization," which states only that: "Prior authorization not required for ADDT core service or for the first ninety minutes per week of each therapy discipline."
Section 216.200 discusses nursing services, stating they are available if prescribed by an individual's PCP and, "prior authorized in accordance with this manual." The only other reference to prior authorization for nursing services is in Section 220.000 states only that, "(a)ll nursing services must be prior authorized." As with the therapy requirement, this tells an individual receiving services nothing whatsoever about the prior authorization process and there is no further elaboration on prior authorization anywhere in the manual.
There is no information provided to explain the process to obtain authorization for extended therapy benefits or nursing services. There is no information provided laying out a timeline for the request process, and nothing is included to provide guidance on how often authorization for extended services would be required. As such, DRA recommends that DHS develop and promulgate a clear process for obtaining prior authorization for extended therapy and nursing services, including timelines and an easily accessible appeals process. We also recommend establishing a system for careful monitoring and tracking of extended therapy benefits requests in order to ensure that the prior authorization requirement does not lead to avoidable delays for individuals to access needed therapies.

RESPONSE: The process to request an extension of benefits is already in place with AFMC and is not being changed. The exact same language is being added to the RFP for the vendor who will take over in January 2019. This process is outlined in the Physical, Occupational, and Speech Therapy Manual.

COMMENT: There is a lack of clarity in those sections dealing with the evaluation process as well. Section 216.100(D)(l) of the ADDT guidelines states that Medicaid will reimburse up to two hours of evaluation time for each therapy discipline, and that additional evaluation units for individuals under 21 require a request for extended therapies. Not only is the request process left undefined, but no mention is made of any mechanism for obtaining extended therapies for individuals over 21 years of age. DRA recommends that these issues be clarified.

RESPONSE: Please see previous responses.

COMMENT: DRA has also identified some discrepancies between documents in the materials released for public comment. Section 216.100(0)(2) of the ADDT guidelines states that: "Medicaid will reimburse up to six (6) occupational, physical, and speech therapy units (1 unit= 15 minutes) daily, per discipline, without prior authorization." The State Plan has been amended to allow 6 units per discipline, per week without prior authorization. While DRA prefers the daily model in the ADDT guidelines, we would suggest that the policy be standardized across the different documents in order to prevent confusion.

RESPONSE: This discrepancy will be corrected to clarify that Medicaid will reimburse up to six (6) units per discipline, *per week*, without prior authorization.

PUBLIC COMMENTS ON PROPOSED CENTER-BASED COMMUNITY SERVICES LICENSURE RULES

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1. David Ivers, Developmental Disabilities Provider Association (DDPA)

   COMMENT: The new language seems designed primarily to bring CHMS providers under these licensure rules. However, the wording goes too far by saying it applies to "any day treatment program in Arkansas." We do not think you mean to include adult day care, adult day health care, behavioral health day treatment, and all other programs that could fall within that description, in and outside the Medicaid program. A simple modification of wording should fix that.

   RESPONSE: The Center-Based Community Services Licensure Rules apply only to ADDT and EIDT programs.

   COMMENT: However, overall, these rules reflect the quasi-governmental nature of non-profit DDTCS programs. Are the mostly for-profit CHMS clinics going to meet these requirements?

   RESPONSE: The merged EIDT and ADDT programs, regardless of non-profit, will meet the same licensure requirements.

   COMMENT: Licensing standards Section 202.B.3. addresses the requirement of a tuberculosis skin test. This needs to be removed from the manual. See attached memos. (MEMOS FROM DDS REGARDING DISCONTINUING TB SKIN TEST REQUIREMENT)

   RESPONSE: We are not requiring TB skin tests; we will follow the guidance in the memos we issued.

   COMMENT: Also, this manual, not the Medicaid Provider Manual, is the more appropriate location for staff qualifications and ratios. Some are included in Section 523 but not all.

   RESPONSE: We believe this will be clarified when the licensure standards are updated by the workgroup that will begin meeting at the end of May.

PUBLIC COMMENTS ON OCCUPATIONAL THERAPY, PHYSICAL THERAPY, AND SPEECH THERAPY RULE AMENDMENTS

1. JODI KUSTURIN, PT, DPT, DIRECTOR, RECOVERY ZONE PEDIATRIC THERAPY

COMMENT: I am writing for public comment of the proposed DMS-640. It is my recommendation that the "Private Clinic" row will capture the patients who receive therapy in a specialized clinic and that we do not need an additional row for specialties.

For example: If the child receives OT at a sensory integration clinic/equine-assisted therapy clinic but that clinic also provides outpatient care as a private clinic and that same patient also receives OT (depending on the week) through the private clinic, there would be some confusion on which row is appropriate for the recommended treatment time.

Recommend deleting this row on the DMS 640:

Specialized Clinic (i.e., equine assisted therapy)	minutes/ week	minutes/ week	minutes/ week	minutes/ week	N/A

RESPONSE: The addition of this line is not to limit the therapy a child or adult can receive, but to capture all therapies a child or adult is receiving in all settings.

2. GABE FREYALDENHOVEN, PT, PRESIDENT, REHAB NET OF ARKANSAS RIVER VALLEY THERAPY AND SPORTS MEDICINE

COMMENT: In reference to the recently proposed revisions for the DM-640, there is some confusion regarding its intended use.
The instruction line for the grid where the number of minutes of therapy is to be entered reads "Complete this block if this form is a prescription for 90 minutes or less per week". Is the intended use that this grid would not be used if the request is over 90 minutes? Instead the two lines at the bottom only would be used if greater than 90 minutes were being ordered? This seems like a point of confusion if DHS intends for the grid to be used for the physician to order the number of therapy minutes greater than 90 minutes in the grid as well. If this is not the intended use, to have the number of minutes greater than 90 to only be listed on the bottom 2 lines seems like not enough room, when considering multiple discipline could be ordered.
Additionally, Medical necessity historically has come from the therapist doing the evaluation, not the physician. Is it the intention for DHS/AFMC to begin new requirements from the physician?

RESPONSE: We agree with your comments. We will convene a workgroup to rework the DMS 640 based on public comments.

3. DANA WARREN MSPT, ABC CHILDREN'S ACADEMY

COMMENT: Our ABCCA team of health professionals oppose proposed changes to the attached DMS 640 for the following reasons:

1. The 640 script does not allow for blended treatment locations for children
   a. For a 90-minute week session, a child may see an equine assisted location for 60 minutes that week but the other 30-minute session that week may be at an Outpatient clinic all under the same service provider.
   b. The multiple rows infer two different scripts would need to be obtained and flexibility of treatment locations be limited.
2. The 640 script will not line up for EIDT programs that integrate their children in each classroom.
   a. if a child is in a EIDT program yet their Medicaid expires and therapy has to be converted to outpatient therapy yet the child never leaves the classroom. This MICROMANGED script infers a new script will have to be obtained with each transition.
   b. Another example is if a child is attending preschool in the Arkansas Better Chance program with therapies but would be better served in the EIDT program – an unnecessary additional DMS640 would have to be obtained 2 months after another one – frustrating and confusing physician staff.
3. Lastly, the proposed DMS 640 is predicted to be overall frustrating to the physician staff. It is unfamiliar and over complicated to fill out.
   Our recommendation would be to allow physicians two row options on the new DMS640 script and leave the other changes as proposed:
      Pediatric therapy row
      Adult therapy row

The rest of the 640 changes are beneficial; however, the over specified locations will CREATE MUCH MORE WORK FOR OUR PHYSICIANS AND THERAPY PROVIDERS. Common knowledge lends to the concept that with increased work load comes increased cost of service provisions and with proposed Medicaid cuts, providers are expecting decreased revenues. So making changes that increase costs and confusion seems worthy to take a second look.

RESPONSE: Based on the 90 minute loose caps that were put in place on July 1, 2017, multiple issues arose showing a child having several DMS 640 and receiving multiple therapy units without each therapy provider knowing of the other. The goal of the new DMS 640 is to have one prescription that outlines all of the child or adult's needs. It is not intended to blend or limit treatment, nor is it intended to require two prescriptions. DDS will be doing outreach to PCP's to train on the new DMS 640. However, we will convene a workgroup to rework the DMS 640 based on public comments.

4. RENEE BENNETT, PT, PHYSICAL THERAPY TEAM LEADER, ACCESS GROUP, INC.
SHELLY KELLER, MCD, CCC-SLP, CEO/OWNER, MIRACLE KIDS
STEPHANIE SMITH, COO, EASTER SEALS
CHERI STEVENSON, MS, CCC-SLP, ACCESS
DAVID IVERS, DEVELOPMENTAL DISABILITIES PROVIDER ASSOCIATION

COMMENT: Therapy 1-18, Section V 3-18 and SPA #2018-008

The amendment to the state plan section 11. Physical Therapy and Related Services to reflect the change made in the governing Medicaid manuals effective 7/1/2017 is not complete.

The language in the state plan should be amended to mirror the language in the state plan sections Attachment 3.1-A, page 4a, 9. Clinic Services:

The language bolded in red below is what should be added in order to ensure consistency with the language in all state plan sections related to Occupational, Physical and Speech therapy.

For recipients over age 21, effective for dates of services on or after July 1, 2017, individual and group therapy are limited to six (6) units per week per discipline. One unit equals 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). One unit equals 30 minutes. Extensions of the benefit limit will be provided if medically necessary.

RESPONSE: Agree that this was an oversight. This language will be added to mirror the other pages.

COMMENT: DMS-640

The proposed changes have resulted in a form that is cumbersome, extremely difficult to complete and results in duplication of other regulations already in place to manage utilization of services. The form also adds a service that falls under completely different regulations.

The following changes are recommended. These recommendations will not take away from the purpose and intent of the form. A proposed draft of the DMS-640 is also attached which incorporates the recommendations suggestions.

Suggested changes to the form itself:

- At the end of the first paragraph, add the following: "A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year."
- Move "Evaluate/Treat is Not A Valid Prescription" to the very top of form.
- Change the term "beneficiary" to "patient" throughout the form so terminology is consistent with the first line of the form. (i.e., "Patient name").
- Add "ICD-10" before "Diagnosis" and "Code" after "Diagnosis". Prescribing physicians do not always provide ICD-10 codes; instead they will put a narrative which does not always match a particular code.
- Remove "ABA" from the form as this service falls under different regulations.
- Reformat the form so that the referral and treatment sections are separate and distinct.
- Move the checkbox for "Therapy Not Medically Necessary" to the bottom of the grid. The decision to check this box should be made by the physician after reviewing all supporting documentation for the requested therapy treatment/services.
- Under "Setting", combine "EIDT" and "ADDT" to "Day Treatment".
- Eliminate the following language by the Day Hab box "can only be in EIDT or ADDT, not both". This statement is confusing and unnecessary as controls are in place to ensure this does not happen. (Prior Authorization for beneficiaries ages 6 to 21 in EIDT program; MMIS limits on maximum units of day hab built into billing system)
- Remove language "Complete this block if this is a prescription for 90 minutes or less per week". The prescription should be written for the amount recommended per the evaluation report. The control is already in place that anything over 90 minutes per week must first be approved by the physician as medically necessary based on his review of the evaluation report and other supporting documentation. Additionally, any therapy recommended over 90 minutes per week must be prior authorized by the QIO.

- Remove language next to "Other Information": "Medical necessity justification for more than 90 minutes per week:" The requesting provider must submit an evaluation report and any other supporting documentation that justifies the medical necessity of the service to the physician when requesting the prescription for treatment. By signing the prescription (DMS-640), the physician has determined that the services are medically necessary. The physician should not have to duplicate the work that the performing provider has already done.
- Format the form so that everything fits on one page.

Suggested changes to the Instructions:

- Change "Beneficiary" to "Patient" throughout form.
- Add "ICD-10" before "Diagnosis" and "Code" after "Diagnosis".
- Move "If therapy is not medically necessary at this time, check the box at the bottom" to be after the ICD-10 bullet. If therapy is not medically necessary, there is no reason for the form to be completed for the service determined not to be medically necessary.
- Add the language "(OT,PT,ST) or hours (Day Habilitation)" after minutes and at the end of the sentence add "based on the setting where the treatment will be provided".
- Remove "Settings and Duration" as this is duplicate to previous instruction.
- Remove language next to "Other Information": "Medical necessity justification for more than 90 minutes per week". The requesting provider must submit an evaluation report and any other supporting documentation that justifies the medical necessity of the service to the physician when requesting the prescription for treatment. By signing the prescription (DMS-640), the physician has determined that the services are medically necessary.
- Remove the last two bullet points. This is an inconsistent practice as this is not required of any other medical service. For example, when prescribing medication for a patient, a physician does not have to contact the patient's specialist to include all of those medications on the same prescription form. This creates a hardship for the physician and his/her staff, as well as for the patient/guardian and the treating provider. What will happen if the physician accidentally leaves one of the services off the form? Also, if a new prescription is required for all services every time there is a change, why wouldn't the expiration date change for all of the services each time a new prescription was generated? This is neither logical, nor necessary.

Occupational, Physical, Speech Therapy Services

Section 214.400 D.11: IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.

214.420Intelligence Quotient (IQ) Testing

Children receiving language intervention therapy must have cognitive testing once they reach ten (10) years of age. This also applies to home-schooled children. If the IQ score is higher than the qualifying language scores, the child qualifies for language therapy; if the IQ score is lower than the qualifying language test scores, the child would appear to be functioning at or above the expected level. In this case, the child may be denied for language therapy. If a provider determines that therapy is warranted, an in-depth functional profile must be documented. However, IQ scores are not required for children under ten (10) years of age.

Neither the Department of Education, nor the American Speech-Language Hearing Association recognize IQ scores as a determinant of whether a child will benefit from speech/communication services and supports. Research has demonstrated that cognitive prerequisite (IQ) are neither sufficient, nor even necessary for language skills to emerge and/or improve. Attached is the position statement of the American Speech-Language Association.

Please consider these proposed changes. I feel strongly that they are necessary to ensure that children can continue to receive medically necessary speech, occupational, and physical therapy services in Arkansas.

RESPONSE: We agree with your comments. We will convene a workgroup to rework the DMS 640 based on public comments.

5. MICHELLE EDWARDS, COMMUNITY SCHOOL OF CLEBURNE COUNTY, INC.

COMMENT: Proposed DMS-640
Complete this block if this form is a prescription for 90 minutes or less per week
This statement is included in the block that also Therapy rx but also includes EIDT Day Hab units – which will be hours/wk – not a max of 90 minutes per week. This distinction should be specified as this is a doctor prescription.

RESPONSE: We agree with your comments. We will convene a workgroup to rework the DMS 640 based on public comments.

6. MULTIPLE THERAPY PROVIDERS

COMMENT: § 214.400 D.11: IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.
214.420 Intelligence Quotient (IQ) Testing
Children receiving language intervention therapy must have cognitive testing once they reach ten (10) years of age. This also applies to home-schooled children. If the IQ score is higher than the qualifying language scores, the child qualifies for language therapy; if the IQ score is lower than the qualifying language test scores, the child would appear to be functioning at or above the expected level. In this case, the child may be denied for language therapy. If a provider determines that therapy is warranted, an in-depth functional profile must be documented. However, IQ scores are not required for children under ten (10) years of age.
Neither the Department of Education, nor the American Speech-Language Hearing Association recognize IQ scores as a determinant of whether a child will benefit from speech/communication services and supports. Research has demonstrated that cognitive prerequisite {IQ) are neither sufficient, nor even necessary for
language skills to emerge and/or improve. Attached is the position statement of the American Speech- Language Association.

Position Statement on Access to Communication Services and Supports: Concerns Regarding the Application of Restrictive "Eligibility" Policies

National Joint Committee for the Communication Needs of Persons With Severe Disabilities

About this Document

This position statement was developed by the National Joint Committee for the Communication Needs of Persons With Severe Disabilities. This position statement Is an official policy of the American Speech-Language-Hearing Association. National Joint Committee member organizations and their respective representatives who prepared this statement Include the American Association on Mental Retardation, Mary Ann Romskl; the American Occupational Therapy Association, Jane Rourk; the American Speech-Language-Hearing Association, Beth Mineo Mollica, Rose Sevcik, Diane Paul-Brown (ex officio), and Alex F. Johnson (monitoring vice president); the Council for Exceptional Children, Division for Communicative Disabilities and Deafness, Lee McLean (chair); RESNA, Kevin

Caves; TASH, Pat Miranda and Martha Snell; and the United States Society for Augmentative and Alternative Communication, David Yoder. This statement was approved by ASHA's Legislative Council (LC4 2002) at the Spring 2002 meeting.

Eligibility policies and practices often preclude children and adults with severe disabilities[1] from accessing needed communication services and

supports. Communication services and supports may include instruction of individuals and their communication partners, assistive technology, and environmental modifications, and may be delivered through a variety of service delivery models.[2] The expected outcome of such services and supports is to increase or to prevent decline in the individual's meaningful participation in daily activities. Categorical denial of communication services and supports without consideration of a person's unique communication needs may violate federal statute, and may also violate state law, regulation, and policy.

Position Statement.

It is the position of the National Joint Committee for the Communication Needs of Persons With Severe Disabilities that eligibility for communication services and supports should be based on individual communication needs. Communication services and supports should be evaluated, planned, and provided by an interdisciplinary team with expertise in communication and language form, content, and function, as well as in augmentative and alternative communication (MC). Decisions regarding team composition, types, amounts, and duration of services provided, intervention setting, and service delivery models should be based on the individual's communication needs and preferences. Eligibility determinations based on a priori[3] criteria violate recommended practice principles by precluding consideration of individual needs. These a priori criteria include, but are not limited to: (a) discrepancies between cognitive and communication functioning; (b) chronological age; (c) diagnosis; (d) absence of cognitive or other skills purported to be prerequisites; (e) failure to benefit from previous communication services and supports; (f) restrictive interpretations of educational, vocational, and/or medical necessity; (g) lack of appropriately trained personnel; and (h) lack of adequate funds or other resources,

References

Morris, **W.** (Ed.). (1981). *The American Heritage Dictionary of the English Language.* Boston: Houghton Mifflin Company.

National Joint Committee for the Communication Needs of Persons With Severe Disabilities. (1992, **March**). Guidelines for meeting the communication needs of persons with severe disabilities. *Asha,* 34(Supplement #7), 1-8.

Paul-Brown, D., & Caperton, C. (2001). Inclusive practices for preschool children with specific language impairments. In **M.**J, Guralnick (Ed.), *Early Childhood Inclusion: Focus on change* (pp. 433-463), Baltimore: Brookes.

Notes

[1] **Persons with severe disabilities include persons with severe to profound mental retardation, autism, and other disorders that result** in severe social-communication• and cognitive• communication impairments" (National Joint Committee for the Communication Needs of Persons With Severe Disabilities, 1992, p.2).

[2] Service delivery model includes both direct service and "indirect," consultative/collaborative service models, and any combination of these models identified as most appropriate to meet the individual's needs (See Paul-Brown & Caperton, 2001).

[3] a priori is defined as "made before or without examination and not supported by factual study" (Morris, 1981).

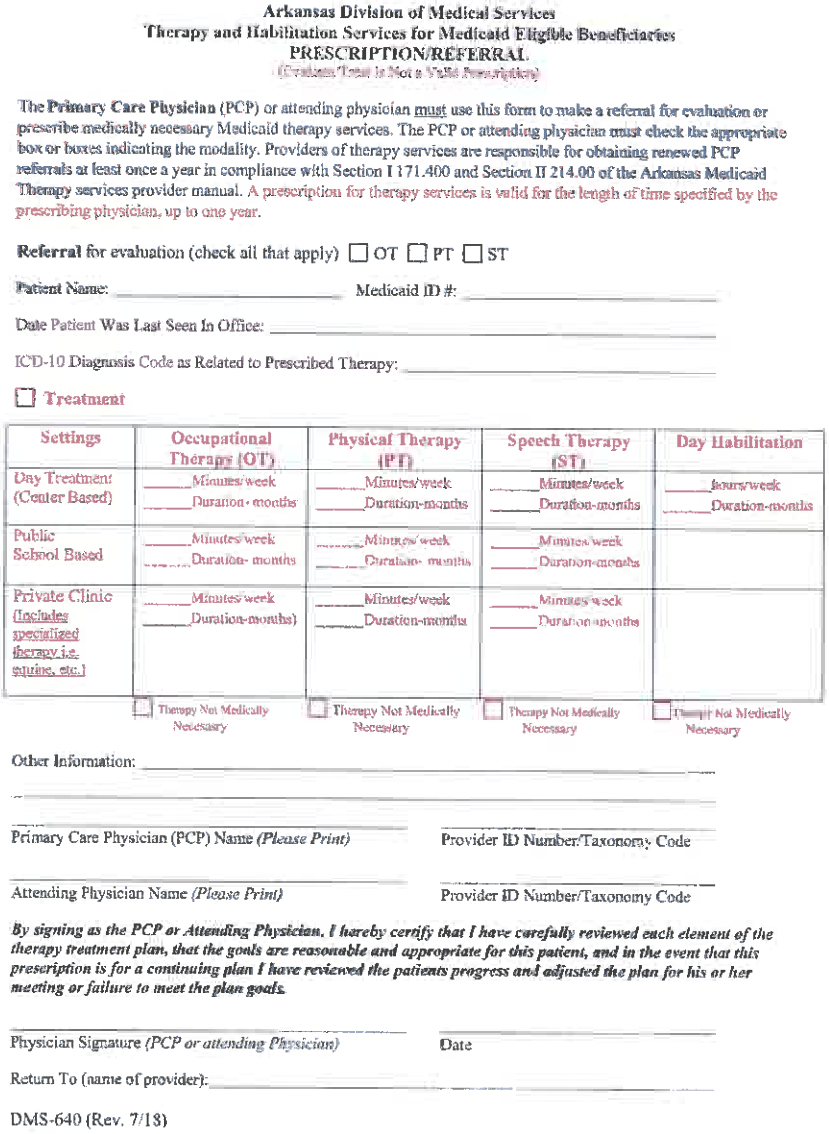
Index terms: admission/discharge criteria, people with disabilities

Reference this material as: National Joint Committee for the communication Needs of Persons With Severe disabilities. (2003), *Position statement on accessible communication services and supports: Concerns regarding the application of restorative "eligibility [...]* [Position Statement]. Available from www.asha.org/palicy or www.asha.org/njc.

RESPONSE: We did not change this requirement in July, 2017, and we are not changing it now. However, you raise good points which should be considered in a strategic manner by a group of experts. We will present this comment to our therapy work group.

6. CAROLINE CHANG, MS, OTR/L, OT TEAM LEADER, ACCESS GROUP, INC.
   OTHER THERAPY PROVIDERS

COMMENT:



Arkansas Division of Medical Services
Therapy and Habilitation Services for Medicaid Eligible Beneficiaries
PRESCRIPTION/REFERRAL
(Evaluation Alone is Not a Valid Prescription)

The **Primary Care Physician** (PCP) or attending physician must use this form to make a referral for evaluation or prescribe medically necessary Medicaid therapy services. The PCP or attending physician must check the appropriate box or boxes indicating the modality. Providers of therapy services are responsible for obtaining renewed PCP referrals at least once a year in compliance with Section I 171.400 and Section II 214.00 of the Arkansas Medicaid Therapy services provider manual. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year.

Referral for evaluation (check all that apply) ☐ OT ☐ PT ☐ ST

Patient Name: ____________________ Medicaid ID #: ____________________

Date Patient Was Last Seen In Office: ____________________

ICD-10 Diagnosis Code as Related to Prescribed Therapy: ____________________

☐ **Treatment**

Settings	Occupational Therapy (OT)	Physical Therapy (PT)	Speech Therapy (ST)	Day Habilitation
Day Treatment (Center Based)	______Minutes/week ______Duration - months	______Minutes/week ______Duration-months	______Minutes/week ______Duration-months	______hours/week ______Duration-months
Public School Based	______Minutes/week ______Duration- months	______Minutes/week ______Duration- months	______Minutes/week ______Duration-months	
Private Clinic (Includes specialized therapy i.e. equine, etc.)	______Minutes/week ______Duration-months)	______Minutes/week ______Duration-months	______Minutes/week ______Duration-months	
	☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary

Other Information: ____________________

____

Primary Care Physician (PCP) Name *(Please Print)* Provider ID Number/Taxonomy Code

Attending Physician Name *(Please Print)* Provider ID Number/Taxonomy Code

By signing as the PCP or Attending Physician, I hereby certify that I have carefully reviewed each element of the therapy treatment plan, that the goals are reasonable and appropriate for this patient, and in the event that this prescription is for a continuing plan I have reviewed the patients progress and adjusted the plan for his or her meeting or failure to meet the plan goals.

Physician Signature *(PCP or attending Physician)* Date

Return To (name of provider): ____________________

DMS-640 (Rev. 7/18)

Instructions for Completion

Form DMS-640 –Therapy and Habilitation Services for Medicaid Eligible Beneficiaries PRESCRIPTION/REFERRAL

- If the DMS-640 is used to make an initial referral for evaluation, check the box to indicate the appropriate therapy for the referral. After receiving the evaluation results and determining that therapy is medically necessary, you must use a separate DMS-640 form to prescribe the therapy. Check the treatment box for prescription and complete the form following the instructions below. If the referral and prescription are for previously prescribed services, you may check both boxes.

- Patient Name – Enter the patient's full name.

- Medicaid ID # – Enter the patient's Medicaid ID number.

- Return To – To be completed by requesting provider(s) to include provider/address/fax/secure email.

Physician or Physician's office staff must complete the following:

- Date Patient Was Last Seen In Office – Enter the date of the last time you saw this patient. (This could be either for a complete physical examination, a routine check-up or an office visit for other reasons requiring your personal attention.)

- ICD-10 Diagnosis Code as Related to Prescribed Therapy – Enter the ICD-10 diagnosis code that indicates or establishes medical necessity for prescribed therapy.

- If therapy is not medically necessary at this time, check the box at the bottom

- Prescription block – If the form is used for a prescription, enter the prescribed number of minutes (OT,PT,ST) or hours (Day Habilitation) per week and the prescribed duration (in months) of therapy based on the setting where the treatment will be provided.

- Other Information – Any other information pertinent to the patient's medical condition, plan of treatment, etc., may be entered.

- Primary Care Physician (PCP) Name and Provider ID Number and/or Taxonomy Code – Print the name of the prescribing PCP and his or her provider identification number and/or taxonomy code.

- Attending Physician Name and Provider ID Number and/or Taxonomy Code – If the Medicaid-eligible patient is exempt from PCP requirements, print the name of the prescribing attending physician and his or her provider identification number and/or taxonomy code.

- Physician Signature and Date – The prescribing physician must sign and date the prescription for therapy in his or her original signature.

- Arkansas Medicaid's criteria for electronic signatures as stated in Arkansas Code 25-31-103 must be met. For vendor's EHR systems that are not configurable to meet the signature criteria, the provider should print, date and sign the DMS-640 form. Providers will be in compliance if a scanned copy of the original document is kept in a format that can be retrieved for a specific beneficiary. Most electronic health record systems allow this type of functionality.

- When an electronic version of the DMS 640 becomes part of the physician/ or providers' electronic health record, the inclusion of extraneous patient and clinic information does not alter the form.

The original of the completed form DMS-640 must be maintained in the child's medical records by the prescribing physician. A copy of the completed form DMS-640 must be retained by the therapy provider(s).

What type of work space should be provided for students who received speech-language services in schools?

The quality of work settings and equipment varies widely in schools around the country. ASHA's 2002 Technical Report, Appropriate School Facilities for Students With Speech-Language-Hearing Disorders, addresses issues such as hearing screening, confidentiality, classroom acoustics, and advocacy for appropriate facilities for services to students with speech, language and hearing disorders.

Should Applied Behavioral Analysis (ABA) therapy be the only treatment for students who are on the autism spectrum?

The ASHA Issue Brief explains that all appropriate therapies should be provided to children with autism spectrum disorder (ASD) and that Applied Behavioral Analysis (ABA) should not be the sole means by which to treat children with ASD.

Eligibility and Dismissal Criteria

Does ASHA have recommended eligibility and dismissal criteria for educational settings?

ASHA does not recommend specific criteria for eligibility or dismissal of services for educational settings. Federal, state, and/or local guidelines determine criteria. For additional information, see Eligibility and Dismissal Criteria and Cognitive Referencing.

Can a child be eligible for speech-language services from a private practitioner and not eligible for services in schools?

SLPs in private practice provide a broad spectrum of communication services based on their education and experience. These services range from treating disorders of language, speech sound production, voice, and fluency to addressing accent reduction and literary skills, to name a few. SLPs in private practice are not held to the same eligibility guidelines and can treat disorders that may not be addressed in a school setting.

In school settings, speech-language pathology services must conform to federal regulations created to implement the Individuals with Disabilities Education Act (IDEA), a law designed to ensure that all students receive a free appropriate public education (FAPE).

Determination of eligibility for services in schools is a multi-step process that includes screening, evaluation, observations from teachers, information from parents, and review of the student's work samples. The school-based individualized education program (IEP) team considers all of this information to answer these questions:

1. Is there a disability?
2. If so, is there an adverse effect on educational performance resulting from the disability?
3. If so, are specially designed instruction and/or related services and supports needed to help the student make progress in the general education curriculum?

In some cases, parents may want services beyond what is determined appropriate in the school setting. Parents may obtain services from an SLP in private practice at their own discretion and cost. Read more about eligibility criteria for speech-language services in the schools.

Are children who have commensurate IQ and language scores eligible for speech-language services?

Comparing IQ and language scores as a factor for eligibility for speech-language intervention is frequently referred to as *cognitive referencing*. Cognitive referencing is based on the assumption that language functioning cannot surpass cognitive levels. According to researchers, the relationship between language and cognition is not that simple. Some language abilities are more advanced, others are closely correlated, and still others are less advanced than general cognitive level. Research results in recent years have demonstrated that cognitive prerequisites are neither sufficient nor even necessary for language to emerge. Therefore, **ASHA does not support the use of cognitive referencing.** For additional information, see ASHA's Cognitive Referencing resource. New provisions in IDEA 2004 permitting identification of specific learning disabilities based on a student's response to instruction offer an alternative approach that can be applied to identification of a language disorder.

Can a school district deny speech-language pathology services to a student with a "mild" articulation disorder if the district decides that the disability does not "adversely affect educational performance"?

State and/or local school education agencies may apply different interpretations to the phrase "adversely affects educational performance"; however, they cannot deny IDEA-mandated services to a child with a speech or language impairment just because that child does not have a discrepancy in age/grade performance in an academic subject-matter area. If acquisition of adequate and appropriate communication skills is a required part of your school's academic standards and curriculum and is considered to be a basic skill necessary for all children attending school, then a child with a speech or language impairment has a disorder that adversely affects educational performance. Sound production errors may affect the way a student hears, speaks, reads, or writes phonemes, and thus can affect academic and social performance. For more information, see ASHA's Eligibility and Dismissal resource, "Adversely Affects Educational Performance" section.

Medicaid, Private Practice, and Independent Contracting

Can public schools bill Medicaid for speech-language pathology services?

To date, most states have implemented or plan to implement Medicaid billing in the schools. There are provisions in federal and state law requiring state and local education agencies to seek sources other than those available under Part B or Part C of IDEA to pay for services for students with disabilities. Schools are increasingly tapping other sources to help finance special education programs. Covered Medicaid benefits include speech-language pathology services identified in the child's individualized education program (IEP) or individualized family service plan (IFSP). Federal law dictates that private insurance must be pursued first by local education agencies (LEAs) using Medicaid funds because Medicaid is the "payer of last resort." This means that a reasonable effort must be made to collect from all potential payers before Medicaid can be billed. Parents retain the right

RESPONSE: Please see previous responses.

7. AMY JAMISON-CASAS, MS, CCC-SLP

   COMMENT: Using outdated and archaic (not to mention cruel) cognitive referencing to disqualify children from treatment. This is NOT supported by current research and harms children and prevents them from progressing with functional communication and other language acquisition areas. If you could see a parent's face when being told their child who is finally thriving with a communication system's acquisition that the child cannot continue the one therapy that has brought hope to that family, simply because the child turned 10 years old and his IQ (often acquired by psychologists who are not skilled in individuals with severe communication impairments) was too low. Well, if you can picture that, surely you would insist this rule be overturned. In fact, I WAS that parent once. It hurts so deeply to think that the very funding source you're counting on to help your child gain as much independence as possible before you die...has a cut-off date for hope and progress. This simply cannot continue. What's more, policymakers in this area are opening themselves up for a class-action lawsuit at some point, given the evidence against cognitive referencing.

   RESPONSE: Please see previous responses.

   COMMENT: On the DMS-640, I believe a line for the Date of Birth should be included after the patient's name. Physicians always require we therapists include that anyway.

   RESPONSE: We agree with your comments. We will convene a workgroup to rework the DMS 640 based on public comments.

8. David Ivers, Developmental Disabilities Provider Association (DDPA)

   COMMENT: Suggested changes to the form itself:
   - Throughout the DMS-640 wherever it states "therapy" should be amended to state ***"therapy and habilitation,"*** as appropriate.
   - At the end of the first paragraph, add the following: ***"A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year."***
   - Move ***"Evaluate/Treat is Not A Valid Prescription"*** to the very top of form.
   - Change the term ***"beneficiary"*** to ***"patient"*** throughout the form so terminology is consistent with the first line of the form. ***(i.e., "Patient name").***
   - Add ***"ICD-10"*** before ***"Diagnosis"*** and **"Code"** after ***"Diagnosis".*** Prescribing physicians do not always provide ICD-10 codes; instead they will put a narrative which does not always match a particular code.
   - Remove ***"ABA"*** from the form as this service falls under different regulations.
   - Reformat the form so that the referral and treatment sections are separate and distinct.
   - Move the checkbox for ***"Therapy Not Medically Necessary"*** to the bottom of the grid. The decision to check this box should be made by the physician after reviewing all supporting documentation for the requested therapy treatment/services.
   - Under ***"Setting"***, combine ***"EIDT"*** and ***"ADDT"*** to ***"Day Treatment".*** Eliminate the following language by the Day Hab box ***"can only be in EIDT or ADDT, not both".*** This statement is confusing and unnecessary as controls are in place to ensure this does not happen. (Prior Authorization for

beneficiaries ages 6 to 21 in EIDT program; MMIS limits on maximum units of day hab built into billing system)

- Remove language ***"Complete this block if this is a prescription for 90 minutes or less per week".*** The prescription should be written for the amount recommended per the evaluation report. The control is already in place that anything over 90 minutes per week must first be approved by the physician as medically necessary based on his review of the evaluation report and other supporting documentation. Additionally, any therapy recommended over 90 minutes per week must be prior authorized by the QIO.
- Remove language next to ***"Other Information": "Medical necessity justification for more than 90 minutes per week:"*** The requesting provider must submit an evaluation report and any other supporting documentation that justifies the medical necessity of the service to the physician when requesting the prescription for treatment. By signing the prescription (DMS-640), the physician has determined that the services are medically necessary. The physician should not have to duplicate the work that the performing provider has already done.
- Format the form so that everything fits on one page.

COMMENT: Suggested changes to the Instructions:

- Change ***"Beneficiary"*** to ***"Patient"*** throughout form.
- Add ***"ICD-10"*** before ***"Diagnosis"*** and ***"Code"*** after ***"Diagnosis".***
- Move ***"If therapy is not medically necessary at this time, check the box at the bottom"*** to be after the ICD-10 bullet. If therapy is not medically necessary, there is no reason for the form to be completed for the service determined not to be medically necessary.
- Add the language ***"(OT,PT,ST) or hours (Day Habilitation)"*** after minutes and at the end of the sentence add ***"based on the setting where the treatment will be provided".***
- Remove **"Settings and Duration"** as this is duplicate to previous instruction.
- Remove language next to ***"Other Information": "Medical necessity justification for more than 90 minutes per week".*** The requesting provider must submit an evaluation report and any other supporting documentation that justifies the medical necessity of the service to the physician when requesting the prescription for treatment. By signing the prescription (DMS-640), the physician has determined that the services are medically necessary.
- Remove the last two bullet points. This is an inconsistent practice as this is not required of any other medical service. For example, when prescribing medication for a patient, a physician does not have to contact the patient's specialist to include all of those medications on the same prescription form. This creates a hardship for the physician and his/her staff, as well as for the patient/guardian and the treating provider. What will happen if the physician accidentally leaves one of the services off the form? Also, if a new prescription is required for all services every time there is a change, why wouldn't the expiration date change for all of the services each time a new prescription was generated? This is neither logical, nor necessary.

RESPONSE: These comments are duplicative, please see our previous responses indicating that changes will be made to the DMS-640.

9. TINA OSBURN, OT, BUILDING BRIDGES (AT PUBLIC HEARING)

COMMENT: But the real reason I'm here is because I deal with paperwork all the time. And this new script, how many people have seen it? Okay. And how many people think it is terrible? Thank you. Amen. So, I sent you an e-mail, and I don't know if you got it, Melissa, and I might should have sent it to someone else, because I don't know if you got it or not. And physicians are very intelligent, they can't fill out a script. Okay? And I argue with AFMC on a daily basis, and Dana hates me, because she won't tell me what she wants in a script and every day it changes. So, this is for the birds. (Indicating.) And I hope I don't know who designed it. I will be glad to consult and tell you what I do on a daily basis and how the physicians don't do it correctly, and I will work with somebody if we want to target and we want to look at utilization. I get that. But this will never be done, will never. And I spend my, days on the phone and so does Sheila, who does a great job with scripts. I mean, this is just going to be an added headache to everything else. Thank you.

RESPONSE: Please see previous responses.

10. AMANDA CLARK, BILLING MANAGER, AND KYM HANNAH, PHYSICAL THERAPIST, CHILDREN'S THERAPY SERVICES, INC.

COMMENT: Section 216.300 "Process for Requesting Extended Therapy Service" - redacted the Extension of Benefits process for evaluations exceeding 4 evaluations units per year.
o I'm sure this was an oversight when adding the new Therapy/EOB process for therapy over 90 minutes per week, but these two processes are different.
o For Extension of Benefits for evaluations, a denied Remittance Advice is required- and this has been crossed out, as has any mention of the process for creating Extension of Benefits for evaluations vs Pre-authorizations for therapy services over 90 days per week.

RESPONSE: This was an oversight and that process will be added back in.

COMMENT: The following changes to the proposed DMS-640 are recommended:

- At the end of-the first paragraph on the DMS-640, add the following: " prescription for therapy services is valid for I year unless the prescribing physician specifies a shorter period." This is the exact language in the current Occupational, Physical, Speech Therapy Services guide in section 204.000.
- Add "ICD-I0" before diagnosis and "Code" after diagnosis. AFMC requires an ICD-10 code on the prescription, but PCPs often write out the diagnosis, so the ICD-10 code has to be manually added to the prescription before submitting to AFMC.
- Remove ABA from this form as it falls under another provider type with strict credentialing regulations. ABA techniques provided by occupational, physical, or speech therapists in order to manage behavior during sessions so that they are able to perform occupational, physical or speech therapy is not ABA therapy. Billable ABA therapy is performed by a licensed BCBA or by a line therapist under the supervision of a licensed BCBA.
- Reformat the form so that the referral and treatment sections are separate and distinct.
- Add service type "DT - Developmental Therapy". This DMS-640 form replaces the Early Intervention prescription form, which had Developmental Therapy listed on it. Developmental Therapy is paid under the Medicaid program (for patients with active Medicaid) as well as through paid by the Early Intervention program. Developmental therapy can be provided by outpatient therapy providers in the patients' natural environment (it is not only provided in a Day Hab setting).
- Remove "Date Expires" - this could conflict with the duration entered and cause confusion for the dates for which the prescription covers. Could also cause another therapy provider's active prescription to end without their knowledge.

- Format the DMS-640 so that everything is on one page. It would be easy for the services portion of the DMS-640 form to be separated from the signatures and would also make it very easy for providers to fraudulently add signature pages from other valid prescriptions to create a signed prescription for another patient.
- Remove the last two bullet points. This is an inconsistent practice and could cause a lot of havoc as valid written prescription that have been used or could be used for Therapy EOB/Prior Authorization or retroactive reviews, could be rendered invalid and the therapy provider holding the active prescription would not know about it. Also, the practice of rewriting all of the service a patient receives multiple times a year would introduce unintentional inconsistencies. Accidentally missing writing in a service would cause that service to no longer be covered, which was not the PCP' s intention. These issues would cause delays in pre-authorization process as well as delays in patients being able to continue services.

RESPONSE: Please see comments above. The ultimate goal of the DMS-640 changes is to show a snap shot of a child receiving physical, occupational, and speech therapy services so that the physician and the individual providers know how much of these services a child is actually receiving. We have not seen multiple providers of developmental therapy billing for the same child. If this becomes an issue, we will revisit.

PUBLIC COMMENTS RECEIVED ON EARLY INTERVENTION DAY TREATMENT (EIDT) PROPOSED PROGRAM

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1. COMMENTS RECEIVED ON SECTION OF THE MEDICAID REGULATIONS

COMMENT: 201.00 -
A developmentally delayed child is a medical condition. It is a diagnosis that the child's PCP has to sign off on after a comprehensive evaluation.

RESPONSE: The use of the term "developmentally delayed" in this context is only to distinguish it from one of the six categorical diagnoses (intellectual disability, spina bifida, cerebral palsy, autism spectrum disorder, epilepsy/seizure disorder, downs syndrome), not to imply that it is not in itself a diagnosis given by a physician.

COMMENT: 201.100.C-
Clarify "self-referrals". If the physician has concerns, do they enter the referral into Optum or do they contact the EIDT program?

RESPONSE: The physician can refer straight to the EIDT program, who will then make a referral or opt-out request to Optum for a developmental screen.

COMMENT: 202.100.D.2 -
Does this mean the time that each individual skill was administered or services as a whole?

RESPONSE: This means the start and end time for each billable service provided to the beneficiary.

COMMENT: 211.00 -
When a child turns 6 years old, are they still eligible for services or are they eligible until they enter public schools the following fall?

RESPONSE: A child is eligible for day habilitation for ages 0-6 at 6 years of age through their 7th birthday, provided they have waived their Kindergarten year. When a child enrolls in public school, the child will not be eligible for day habilitation for ages 0-6, but will be eligible for day habilitation in the summer.

COMMENT: 212.00.C-
Can this original signature on the prescription from the doctor be faxed to the EIDT program?

RESPONSE: Yes. That is acceptable.

COMMENT: 212.00.D.1 -
Define Intellectual Disability and how is this diagnosed?

RESPONSE: Intellectual Disability is defined in DDS Policy 1035, which is attached as *Attachment B*.

COMMENT: 212.100 -

Is the Battelle Developmental Inventory the only norm based assessment accepted?

It is required to administer the annual evaluation less than 365 days from the previous year's evaluation. If you can only bill once each calendar year, how could you bill for both because they will both be within 365 of each other?

RESPONSE: The BDI is the only norm-referenced developmental assessment that will be accepted. It was chosen based upon the fact that new referrals will undergo a preliminary BDI screen. However, there are choices for the criterion-referenced assessment, they are listed. The criterion and norm-referenced assessments are considered one evaluation process and are billed simultaneously.

COMMENT: 212.100.B-

A child should not have to qualify for a therapy or nursing services to receive day habilitation services. Developmental delay is a stand-alone diagnosis and should qualify a child to receive day habilitation.

Clarify if children with delays only in social and adaptive areas qualify for EIDT services.

RESPONSE: Each individual child will be different. Children will have to qualify based on a norm-referenced and criterion-referenced developmental assessment; as well as qualify for at least one therapy service or nursing.

COMMENT: 212.100.C-

If a child is receiving ABA therapy off campus, does this count towards the 8 hours combined?

RESPONSE: No, this does not count. Only services provided by the EIDT will be considered in the "8 hours;" however, all services provided to a child must be medically necessary.

COMMENT: 212.100.E-

Clarify eligibility requirements on October, 1, 2017?

RESPONSE: DDS promulgated new DDTCS and CHMS manuals that were effective on Oct. 1, 2017. These manuals included the requirement for the Developmental Screen. A child who meets the eligibility requirements in these manuals (which are currently on the Arkansas Medicaid website, found here: https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx) will be grandfathered into the EIDT program until July 1, 2019, provided he or she continues to meet those requirements.

COMMENT: 213.000-

What is an approved "extension of benefits"? How is a child approved?

RESPONSE: Please see the Medicaid manual that outlines this process. If you have further questions, please contact DDS.

COMMENT: 214.200. C.1.b -

This is an increase from previous years that required 100% ratios to be met at 30 months and younger.

RESPONSE: We require 100% ratios be met at all times, other than naptimes. Please see draft manual.

COMMENT: 215.100-

According to nursing regulations, most of the nursing services listed can be delegated if trained by a professional. Do these have to be administered by a nurse to bill?

RESPONSE: Yes, these services need to be administered by a licensed nurse in order to be billed in accordance with the Nurse Practice Act.

COMMENT: 215.100.E-

Does this include inhalers?

RESPONSE: No, an inhaler is considered a prescription, not a breathing treatment. A breathing treatment is an updraft machine or something similar.

2. COMMENTS RECEIVED ON SECTIONS OF THE "DDS REGULATIONS"

COMMENT: 202.B.3. (a)-

TB skin test has not been required for several years and is no longer available at the health department. It also has to be administered by specific trained professionals.

RESPONSE: The TB skin test is not required pursuant to the memos that were sent by DDS Staff. The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 301.1.A.1.b.(c) -

Define infectious diseases.

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENTS: 301.3.1-

There has not been a 12-hour minimum training requirement for professional/administrative staff in previous years.

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 302-

There has not previously been a requirement for annual in-service for Managerial Staff.

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 405.A.15-

Define actions that are aggressive, disruptive, and/or present a danger to the individual or to others that would justify an incident report.

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 508.B.1

Medicaid will only pay for one physical a year. If it has already been completed the child will not have a current physical within 30 days of enrollment.

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 509-

When is psychological evaluation applicable for children ages 5-6 who choose to waiver Kindergarten and stay in an EDIT program?

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 510-

The Arkansas Department of Education requires that ALL evaluation be completed before enrollment.

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 513-

Was "Personal Futures Planning" taken out?

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 515.B-

"The actual beginning and ending time of the day the services were performed"-is this the time each individual skill was worked on or the services as a whole (Day Hab., Therapy)

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 518.B-

Is the "beginning and ending time of the day the services were performed" for each service only (Day Habilitation, Speech, Occupational, Physical Therapy) or broken down further?

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 518.C-

Is weekly progress notes all that are required?

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 521.1.C-

The team should not have to meet and sign to revise (add) objectives as long as the goal has not changed.

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 521.2-

What is the Family Rating Form?

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: 521.3-
This section does not match guidelines set by the ADE for transitioning to Kindergarten. All children enter Kindergarten in the fall at the same time so it does not make sense to start a transition plan according to age.

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

3. JILL FUSSELL, MD
PROFESSOR
DEVELOPMENTAL BEHAVIORAL PEDIATRICS FELLOWSHIP DIRECTOR
MEDICAL DIRECTOR OF THE JAMESL L. DENNIS DEVELOPMENTAL CENTER
SECTION OF DEVELOPMENTAL PEDIATRICS AND REHABILITATIVE MEDICINE
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
ARKANSAS CHILDREN'S HOSPITAL

COMMENT: In 201.300 section on page 2 of the new EIDT manual, under the definition of Academic Medical Center Program Specializing in Developmental Pediatrics, it is stated that the Center must meet several requirements, including:

F. Does not provide treatment services to children

My request for edit in that line is:

F. Does not provide day habilitation or therapy (i.e., speech-language, occupational, physical) services to children

Given that some medical follow up and some psychology therapy happens in academic medical programs in developmental pediatrics, the term "treatment services" could read too broadly. It is my understanding that Academic Medical Center Programs Specializing in Developmental Pediatrics cannot be specifically providing day habilitation or developmental therapy services.

RESPONSE: Your understanding is correct, and this change will be made to clarify the rule.

4. ERIN BRIGHT, UAMS, KIDSFIRST

COMMENT: The CPT codes for the nutrition assessments are: 97802, 97802 U1, 97802 U2, and 97803.
I'm also looping in Cheri Fink, Program Director for PACE/Foster Care. She noticed the following items regarding some of the codes used specifically for Foster Care:

EIDT CODE/Modifier	Comments
92523 UA	U1 modifier is missing
92551	U1 modifier is missing

92567	U1Modifier is missing
92587	U1modifier is missing

RESPONSE: Thank you for the additional information regarding codes for academic medical centers, these will be corrected.

5. ANONYMOUS COMMENT

COMMENT: The name for the combined DDTC/CHMS is misleading and confusing at best and inaccurate based on federal definitions of "early intervention." The Individuals with Disabilities Education Act (IDEA) defines "early intervention" as "a multidisciplinary, coordinated, natural environment-based system of service provision to eligible children birth to 3 years of age and their families provided under the U.S. Individuals with Disabilities Education Act."
Every state and US territory/jurisdiction has an early intervention program under IDEA, Part C. To call another, separate, different program "early intervention" creates unnecessary confusion for families trying to navigate a system that this terminology only makes more cumbersome to navigate, not easier. The two different programs (one under IDEA, Part C and required to comply with IDEA and the other a clinical/ medical model operating outside of IDEA and not required to meet federal requirements for early intervention 0-3 or early childhood special education 3-5) is extremely misleading to parents and also misleading to referral sources.
The DDTC/CHMS combo centers do not solely serve children 0-3, they also provide ECSE (Early Childhood Special Education) services to preschool aged children 3-5 yrs. of age, so calling them "Early Intervention" centers fails to acknowledge that these facilities also serve the preschool population.
These centers, while multidisciplinary and well-coordinated, fail to meet the most basic definition of "early intervention" as they do not educate children in a least restrictive, inclusive early learning environment in accordance with IDEA natural environment requirements 0-3 (defined in IDEA as settings and activities natural or typical for a same-aged child without a disability). These center-based services also fail to meet IDEA, Part B least restrictive environment requirements for preschool aged learners 3-5. "Day Treatment" is not a natural or typical activity for a typically developing child of any age.
In order for these centers to be an inclusive environment or an "early intervention" service, more than half (51% or greater) of the enrollment would have to be typically developing children, so these centers cannot and appear to have no intention of meeting IDEA requirements for natural environment/ inclusive learning environments, and calling them "early intervention day treatment" is not only misleading, it is highly offensive to individuals who advocate for the rights of individuals with disabilities.

RESPONSE: Thank you for your comment and concern over potential confusion. The name "early intervention day treatment" was derived from the statute, A.C.A. § 20-48-1101 et seq., which authorizes creation of the successor program to DDTCS and CHMS. The early intervention program under IDEA, Part C in Arkansas is known as "First Connections." We market the program by this name already, but will make extra efforts to First Connections for the Part C program under the IDEA to avoid confusion.

6. CANDACE JOHNSON

COMMENTS:

1) The BDI-2 does not provide age levels for children. The age levels are only provided for the sub areas of development so there is not a way to calculate it. How do we determine eligibility for the 0-35 month children without age levels? Are we allowed to continue using the DAY-C which does provide age levels?

RESPONSE: The BDI will be the only assessment accepted and it does have a scoring methodology in line with our requirements.

2) Regarding the rule for maintain staff ratios at 100% for 0-3 years. This has typically been when we have allowed for lunch breaks. This would affect over 50% of our staff if we are not able to go down in ratio at nap. Is it an option to not bill during the naptime and be able to go down in the ratio to allow for lunch breaks?

RESPONSE: Children aged birth to three with a developmental disability or delay need to maintain a 100% staff to beneficiary ratio to maintain health and safety.

3) Nursing care—Are we required to hire a nurse if we have a child with a feeding tube? Can multiple children be started on a feed and be billed for nursing care if this happens at the same time? Must a nurse be on staff full time or just during the "nursing" activities, such as tube feeds?

RESPONSE: Nursing is a core component of EIDT. Therefore, a nurse needs to be hired on staff or contracted with your program. Regarding the feeding tube, DDS does not understand how one nurse can be doing multiple treatments on multiple children at one time.

4) One therapy rule could limit service to a number of children, especially in the rural areas, that are in need of additional supports.

RESPONSE: Thank you for your comment.

7. DANA WARREN, PROGRAM COORDINATOR, ABC CHILDREN'S ACADEMY 7 RECOVERY ZONE PEDIATRIC THERAPY

COMMENT: Preserve History and Integration and promote the forward propulsion of Inclusion with two ideas:

1. Define and Allow Integrated DDS/CHMS centers to integrate typical and atypical children using ratios listed in 301.2 on page 22 of DCCECE MLR book.
2. Modify or clarify reg 301.13 on page 23 allowing CHMS Classrooms to triple group size to maintain ratios.
   In 1896 Plessy vs. Ferguson established "separate but equal" facilities. In 1954 this calamity in American history was overturned by the US Supreme Court. Some may still remember those times still today although they were near 64 years ago in history.

Lowering the ratios from 1:5 to 1:4 for infants and 1:5 for Toddlers and moreover 1:12 for preschoolers being lowered to 1:7 will be so financially difficult that grouping children by their ratio requirements is predicted to be the only solution for financial survival.

This means my humble integrated centers will have predictably unspoken labels such as: One site will be all children with CHMS funding because I have to have the funds to meet the low ratio requirements and then another site may be children with tuition based funding because the higher ratio provisions allow for more children in space. I know you all understand so I won't perseverate with continual explanations.

Is there any room to match the ratios in the DPSQA up and coming EIDT manual to the ratio requirements in the DCCECE MLR manual, specifically reg 301.2 page 22 – FOR THOSE CENTERS THAT ALREADY INTEGRATE CHILDREN'S SERVICES to preserve this valuable piece of socialization – this piece of American history?

I at least have to share my voice to prevent backwards momentum towards "separate but equal" facilities which Americans fought hard to move away from over 64 years ago. I love this saying, "Children without disabilities deserve to be around children with disabilities... I love that sentence... Some might think I typed that backwards, but the truth is typical kids who befriend children with atypical patterns are the ones that develop impeccable core values as well as children with atypical movements and speech learn so much from typical peers.

An alternative idea would be to allow "Utilization of the existing space" of 35 square foot per child and continuing with the 1:4 ratio but allow providers to have 3 teachers in a room of 12. This concept would keep the possibility of integration – yet honor the 1:4 (if the space allows for that many children). This would really help in the huge cut that is coming for 3-year-old classrooms... I could manage quite possibly if I would be allowed 3 teachers in a class of 21, etc. (1:7 ratio). This idea would call for a revision of the MLR 301.13 on page 23 that only allows 2 times the class size to be revised to " 3 times the group size allowable".

Long emails are hard to discern so I wanted to close with a brief summary:

Preserve History and Integration and promote the forward propulsion of Inclusion with two ideas:

1. Define and Allow Integrated DDS/CHMS centers to integrate typical and atypical children using ratios listed in 301.2 on page 22 of DCCECE MLR book.
2. Modify or clarify reg 301.13 on page 23 allowing CHMS Classrooms to triple group size to maintain ratios.

RESPONSE: We anticipate that DCCECE will receive additional funding to their annual budget for the 2019 Fiscal year. We will work with any DD provider to also become a federal daycare provider. We believe with the additional funding and additional slots, that providers will be able to financially maintain the different staffing and ratio requirements.

COMMENT: There is a highly talked about risk of our families losing dayhab funding for children in DDTCS centers with the addition of One therapy requirement. CHMS clinics and families are already familiar and use to the therapy requirements so CHMS clinics are not feeling the stress of this proposed adjustment as much. However, PT, OT and SLP testing has an eligibility score of -1.5 Sd below the mean which is typically referred to as a moderate delay. Section II of the *Medicaid Manual section II: 214.300.C.4*: Eligibility for therapy will be based upon a score of -1.5 standard deviations (SD) below the mean or greater in at least one subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.

With the new EIDT proposal the eligibility requirement of the BDI screening tool is – 2 SD below the mean which is typically referred to as a severe delay. The EIDT standard carves out children that are still impaired with a moderate delay (-1.5 SD) and routes EIDT services to the children with more profound delays (-2 sd below mean). Sounds very familiar to the DDTCS population who believes they will lose services for the children in dayhab only.

Some therapy providers will argue that -2 SD test scores on the BDI screening tool align with -1.5 sd below mean on more drilled down therapy testing but I can tell you as a Physical Therapist myself and the Owner of a CHMS clinic – this alignment is not always the case. There are several children who qualify for therapy based on -1.5 sd below the mean that WILL NOT qualify for EIDT program because the eligibility standard is -2 SD to get into the program.

To say that those two testing criteria align negate the reliability of norm reference testing: Meaning you cannot say that -2 sd below the mean is the same as -1.5 SD below the mean.

If EIDT would consider changing the language in the *EIDT manual on section 212.10*: For ages 3-6, a score of at least -2 standard deviations below the mean in at least two of the five domains: motor, social, cognitive, self-help/adaptive, or communication on the BDI and 25% or greater delay on the criterion referenced test;

TO the following:

(recommendation for change) *EIDT 212.10* - For ages 3-6, a score of at least -1.5 standard deviations below the mean in at least two of the five domains: motor, social, cognitive, self-help/adaptive, or communication on the BDI and 25% or greater delay on the criterion referenced test;

Then our team is predicting a decrease sense of fear and loss of services for these families in both CHMS and DDTCS programs and a decrease risk of lack of other ABCSS spots to absorb these children as the testing will TRULY align and those children.

After listening to the rural area providers speak at the public hearing, I feel that if the proposed EIDT standard does NOT change - there very likely may be children who are receiving Outpatient therapy in a typical preschool or ABC program at a moderate delay on SLP, OT or PT testing by a doctorate level evaluator who MISSED the opportunity to get into an EIDT program because the Optum screener carved those children out of EIDT eligibility because they did not meet the -2SD entry score from the Battelle Screening tool.

RESPONSE: Each individual child will be different. Children will have to qualify based on a norm-referenced and criterion-referenced developmental assessment; as well as qualify for at least one therapy service or nursing.

8. JESSI SUASTEGUI, DIRECTOR, ABC CHILDREN'S ACADEMY AND DEVELOPMENTAL CENTER, INC.
TAYLOR BUNGER, PROVIDER
SARAH ROBINSON, HR DIRECTOR, ABC CHILDREN'S ACADEMY

COMMENT: As a member of a long standing early childhood organization: I would ask you to consider allowing changing OPTUM qualifying score to -1.5sd instead of -2sd.
In talking to other providers, there are appeals in place for children who qualify for therapy and do not get passed the OPTUM screener.

If lawmakers would consider changing the language in the *EIDT manual on section 212.10*: For ages 3-6, a score of at least -1.5 standard deviations below the mean in at least two of the five domains: motor, social, cognitive, self-help/adaptive, or communication on the BDI and 25% or greater delay on the criterion referenced test; TO align with what the doctorate level PT, PT and SLP tests already measure as a criteria level – then the risk reduces significantly of these moderately delayed children losing services.
At the current EIDT proposal – there will be children who get therapy EVEN two therapies and do not qualify for an EIDT program.

RESPONSE: Each individual child will be different. Children will have to qualify based on a norm-referenced and criterion-referenced developmental assessment; as well as qualify for at least one therapy service or nursing.

9. SHONDA GADBERRY, ECD SPECIALIST

COMMENT: As an ECDS coordinator, I have administered several Battelie screening tools as well as the comprehensive BDI test at its most current version. I work hand in hand with therapists as well.
If lawmakers would consider changing the language in the *EIDT manual on section 212.10*: For ages 3-6, a score of at least -1.5 standard deviations below the mean in at least two of the five domains: motor, social, cognitive, self-help/adaptive, or communication on the BDI and 25% or greater delay on the criterion referenced test; TO align with what the doctorate level PT, PT and SLP tests already measure as a criteria level – then the risk reduces significantly of these moderately delayed children losing services.
I am an experienced tester and work in a CHMS program. At the current proposal – there will be children who get therapy EVEN two therapies and do not qualify for an EIDT program. I am looking at test protocols right now of children who would not get pass the Optum screener of -2sd below the mean yet would get specialized OT and PT services.

RESPONSE: Each individual child will be different. Children will have to qualify based on a norm-referenced and criterion-referenced developmental assessment; as well as qualify for at least one therapy service or nursing.

10. SHELLY KELLER, MCD, CCC-SLP, CEO/OWNER, MIRACLE KIDS

COMMENTS:

1. Will you elaborate on what "overseen by a physician means"? Does that mean an MD/pediatrician needs to come to the clinics to examine the children, as in a CHMS facility? Or does the child's PCP fulfill that role?

RESPONSE: A child's PCP fulfills that role.

2. Autism and intellectual disabilities are both qualifications for the program, however, you have eliminated evaluation codes for psychologists. Will you consider adding psych testing codes?

   RESPONSE: The addition of these codes has been discussed at length with the work group. Autism and intellectual disability are diagnoses made by a physician.

3. The EIDT manual states "Evaluation services are covered once per calendar year, if the service is deemed medically necessary by a physician." Is "calendar" year correct, or should it be "fiscal" year?

   RESPONSE: You are correct, the MMIS will bill on a fiscal year. This will be corrected. However, as with any service, you may request an extension of benefits.

4. According to EIDT, SLPs, OTs and PTs qualify as Early Childhood Developmental Specialists (ECDSs). My concern with this is that children may not be properly cared for in the classrooms, but a facility with a PT on site will meet the qualifications. Will you consider classroom supervision requirements for SLPs, OTs and PTs who have patients on their therapy caseloads?

   RESPONSE: One ECDS is required for every forty children to oversee the development of their care plan and the program. All EIDT sites will have a PT on staff or by contract, as it is a core service. And, all EIDT sites will be required to meet the supervision and staffing requirements is every classroom.

5. The EIDT eligibility criteria states that the standardized and criterion referenced developmental assessment tools must be the most current edition. This is concerning because we aren't always informed when the most current version comes out. And also, replacing these tools gets very expensive. Will you consider saying providers are encouraged to use the most current edition but may continue to use prior editions if the protocols for the prior editions are still in print/available for sell?

   RESPONSE: Thank you for your comment, but we disagree. The most current version must be used.

6. Developmental assessments take much longer than one hour to perform correctly, especially since two tools must be used. Will you consider increasing the maximum number of evaluation units from 4/year to 8/year?

   RESPONSE: As always, there is an extension of benefits process if you need extra units.

11. CHRISTINA FONTAINE

COMMENTS: I am writing in regard to the "Save My Services" campaign. I read the channel 11 news article about ending services for so many children with Developmental Delays. Melissa Stone's responses to this situation shows a blatant disregard for the children of Arkansas. These life changing services could have helped change the course of an upcoming generation.
Working as a case manager for over 13 years has given me a front row seat to see the dramatic positive changes in the lives of children. The two programs, CHMS and DDTCS could not be more different in the populations they serve, and the services they provide. I understand, on paper, the two may look very similar, but by combining the two under the new regulations, neither will be able to give the individualized services to two very different populations.
CHMS has doctors and nurses on staff. They are there to help those children who are considered medically fragile. The medical needs and developmental needs sometimes go hand in hand, but other times they do not overlap. Making a requirement of the Developmental

Evaluation is not pertinent to their purpose. Placing the requirement of DDTCS to deliver nursing services is another burden that an already financially suffering program can't endure. Our Child Development Aides receive a wage that keeps them under the poverty level. If DDTCS must hire nurses, what hope do our Child Development Aides have of ever earning a decent wage.
DDTCS serves children with Developmental Delays, regardless of medical need. The DDTCS program helps children to improve their developmental skills, and gives a firm foundation for future learning. In order to qualify for DDTCS the child must have a standard deviation of -2.00 in two or more developmental areas. Although therapy does address gross motor, fine motor, and speech. Therapy does not address one of the most important developmental areas, Cognition. The Developmental Evaluation and the Therapy evaluations sometimes line up, but not always. The Developmental Evaluations and Therapy evaluations test for very different skills. We have had children qualify in all three therapies, but not qualify for our program because they did not have a qualifying score on the Developmental Evaluation.
Working with Medicaid, we take eligibility very seriously. Medicaid's previous standards were already very strict, and did identify children in need. To ignore the value of the Developmental Evaluation, which includes a norm referenced test, and a standardized test, in favor of Therapy evaluations that do not address Cognitive or Social/Emotional functioning will leave a generation very behind when beginning school.
DDTCS gives children the best possible outcome. Regular daycares that will "kick" these children out for behaviors will have nowhere else to go. DDTCS receives referrals from ABC and Head Start programs frequently because their staff cannot "handle" the child. Most ABC programs will not take children who are not potty trained. DDTCS takes children who are not potty trained. The child will not qualify for Occupational Therapy if he/she is not potty trained, but that is one of the factors considered by the Developmental Evaluation.
The decisions made by the state of Arkansas seem very short sited. DDTCS provides an invaluable service to the children and families of Arkansas. We have had families move from other states because of this value. Those 3,300 children will not end up in a state sponsored program. They will be at home without any services because the state sponsored programs are not equipped to care for these very special children.

RESPONSE: Thank you for your comments. We respectfully disagree. We are not devaluing the importance of developmental assessments. Daycares that accept federal dollars and that are regulated by DDS are not allowed to expel children for behavior or to deny children admittance who are not potty trained. We are assembling a panel of experts made up of DD providers, daycare providers, and parent advocates to track children who may transition from EIDT into a federally funded daycare to ensure that no child falls through the cracks.

12. MULTIPLE PROVIDERS, PARENTS, AND ANONYMOUS COMMENTERS

COMMENT: I am writing in opposition to these Medicaid state plan amendments, new provider manuals, and manual updates that will merge the DDTCS and CHMS programs into one Early Intervention Day Treatment program.
I am not opposed to the concept of merging the two programs. However, I am opposed to the Department's proposed changes that will:

- Deny early intervention services to 3,300 Arkansas children who do not also require physical, occupational, or speech therapy;

- Unnecessarily drive up the utilization of therapy services as families seek out therapy services in order to get the developmental day treatment services they really need;
- Within a few years, create an influx of 10,000 additional children into state-funded settings such as ABC and public pre-k programs, which do not have the funding, staff, or infrastructure to handle these additional children; and
- Leave no option for many families whose child has been rejected by or will not be accepted by these other programs.

There is no clinical justification to impose this requirement that will discriminate against children who have a cognitive or social/emotional impairment but do not require therapy. These are two distinct services, and DHS should not make one dependent upon the other in order for children to receive any treatment at all.

I am asking that you reject these proposed rules and the devastating consequences that would result from their adoption.

RESPONSE: Please see response immediately above. We disagree that the new criteria will create an influx of 10,000 additional children. As also stated above, we anticipate that DCCECE will be awarded additional funding that will go towards prioritizing these particular children. We believe children who have a cognitive and social/emotional delay will benefit from an integrated daycare setting.

13. ALTA LOCKELY

COMMENT: I recently had the opportunity to visit Pattillo Center School in DeWitt, Arkansas. Pattillo Center School provides a vast amount of support to children with disabilities. The loss of this facility would be detrimental to the children and our community.

RESPONSE: Thank you for your comment.

14. R.M., PARENT

COMMENT: I would like to share my son's and my story with you. I am a mother of two young boys (both 3 years old), a wife to a hardworking man, and I am a full-time employee. In 2015, my nephew came to live with us, he wasn't in a good living situation and was placed into foster care. During his first few months of life he had already experienced more terrible things than anyone should have to, including having severe head trauma. When he first came to live with us, he was receiving no services, but we knew he was delayed. I talked with all the right people (PCP, teachers, directors, DHS workers) to try and get him the help he needed.

Currently he is receiving day habilitation services, Speech therapy, and Occupational therapy at Milestones Services INC. He was receiving Physical therapy as well but tested out in November 2017. He is so smart and making progress. I am so proud of him for the challenges he has overcome.

In November 2017, he was seen at Arkansas Children's Hospital for an MRI of his brain to assess the damage done. When the scan came back it really put into view the damages that was done to this sweet boy. His PCP is putting in a referral for him to be evaluated at Dennis Developmental, as well. Knowing this referral is coming up I began speaking with his therapist about him and just how he was doing during his sessions. One therapist made the point to tell me how great he was doing in his one on one speech time, BUT, she said he is a completely

different child during the classroom setting. He has trouble handling the noise of a preschool room, the sharing and playing with peers, he becomes very impulsive, he tries to run off from his teachers, and he is just on sensory over-load. As a parent that is very involved in his life at school and home I knew these things already, but it helped to hear it from a professional.
You see right now the one therapy rule does not affect my kid because he is receiving two therapies and day habilitation services, but the way he is in therapy and receiving that one on one services he may test outcome his next annual evaluation. For this mom, if you vote for this rule and he tests out, there will be nowhere for him to go. I know that you guys are all saying Headstart and ABC programs will house these children, but I do not see how. They already operate using a waiting list and they are going to be calling me every day because my son is on sensory overload and very impulsive due to his disability. His disability in a regular daycare/preschool setting will not allow his to excel in his educational needs. I am really worried about this and how it will change our son's life.
I know our story is rather long, but I really wanted to share it with you. I am not the only parent that is thinking ahead and worried about my children's future. So when it is your turn to vote remember this story about my son. A smart young man who may just need a little extra help more than a regular daycare/preschool could give him and vote no to the one therapy rule.

RESPONSE: While we understand your concerns, we believe we are addressing them. We are striving to ensure that all children receive services in the most appropriate and least restrictive setting.

15. MICHELLE BOWLIN, RAINBOW OF CHALLENGES

COMMENT: I am writing in opposition to these Medicaid state plan amendments, new provider manuals, and manual updates that will merge the DDTCS and CHMS programs into one Early Intervention Day Treatment program.
My name is Michelle Bowlin and I am a certified early childhood special education teacher for Rainbow of Challenges in Hope Ar. I am not opposed to the ruling regarding the screener nor am I opposed to the threshold for therapies; however, I do agree with many of the comments made last night opposing the "one therapy" rule. Without being repetitive of what was said in regards to the rural areas, the lack of resources available to those children without the need for therapy, I would like to add that although some one said that most of their children qualify in the areas of communication and cognition, which would reflect the need for speech therapy, many of our children often qualify or are eligible for day habilitation because of social and self-help skills. For the population under the age of three, often times children will not qualify for speech therapy if they make more than 5 sounds in the evaluation session or point to one body part, etc. However, many of our children qualify due to the need of peer interaction and socialization. Often times, many of our parents are previous recipients of our services when they were young. Many of our children who are developmentally delayed, are also environmentally deprived. They need a structured setting that provides a positive atmosphere, routines, sometimes even meals, as well as prepare them for Kindergarten/ public school. If we are unable to provide this setting and established the basic needs and meet developmental milestones, what will the public school be faced with when that child becomes Kindergarten ready? By being able to provide developmental skills and early intervention now, we will be able to deter many of the possible behaviors that could arise later in their young lives. Our children deserve a chance to achieve and succeed in public school, but without day habilitation

services many of our children will fall in the cracks....and life is hard enough without missing the opportunity for early intervention.

Many of our children who do not receive therapy will not have the opportunity to receive services elsewhere. ABC and Head Start programs will fill up, capacities will be reached, and children will be lost. If our parents cannot afford to send diapers or a coat to school now, in a program that is funded by Medicaid, they will not be able to afford weekly daycare rates. Many of our parents are single, trying to survive on one income, or less, struggling with day to day issues, and with multiple children in the home. We have to be able to provide day habilitation services to those children who simple need this program in order to succeed in school and life. These are not just children of low income families, these are children who truly meet eligibility requirements for day habilitation services based on evaluation results, observations, and diagnosis.

I feel more studies need to be done regarding the "one therapy" rule and the long term effect it will have on children and programs. We seem to have pilot projects and case studies for everything else, why can't we do that with this, instead of implementing it so quickly, especially with all the concerns noted across the state.

I am asking that you reject these proposed rules and the devastating consequences that would result from their adoption.

RESPONSE: Thank you for your comments. Please see responses above. DDS would also like to add that Arkansas has one of the top preschool daycare programs in the nation. The goal is to ensure children receive services in the most appropriate and least restrictive setting.

16. JANIE SEXTON, DDPA REPRESENTATIVE

COMMENTS:

1. In principal, DDPA is in agreement to the idea of merging the two types of children's programs (DDTCS and CHMS) in order to make the programs similar in staffing, ratios, and available services. We also share the goal to make the programs more efficient and sustainable.

2. We are strongly opposed to the 1 therapy requirement for eligibility which is an arbitrary measure that is not clinically sound. Many children with Developmental Disabilities receive a therapy, but needing a therapy should not be part of the requirement to qualify for intensive habilitation services. We believe that children should qualify for each service independently and not overlay an additional service requirement in order to receive the one service in which they need.

3. The children that this rule will impact often qualify in cognitive and personal social, or cognitive, adaptive, and communication, but may not meet the threshold for therapy services. These children are sometimes children that have experienced trauma and their brain just does not process information the same way as other children. Other causes could be: Poor birth outcomes such as low birth weight or prematurity, inadequate stimulation in the home, malnutrition, chronic ill health, psychological and familial situations, or other environmental factors.

The frontal lobe of the brain controls emotions, reasoning, planning, movement, and parts of speech. It is also concerned with purposeful acts such as creativity, judgement, and problem-solving. These are areas that would be assessed as part of the cognitive portion in

developmental testing. This is why children may qualify in cognitive, adaptive, personal social, and communication, but still not qualify for a therapy. These skills are addressed as part of habilitation.
Process that is being proposed for eligibility:
4. 1) Child goes to their PCP for an EPSDT, delays and intervention needs are identified. Both physical and mental health are assessed.
2) Physician then refers the child to OPTUM for an independent screening.
(Our state has made a significant investment in this screening process)

3) If a child fails the screening, then they can be referred to a provider for a comprehensive developmental evaluation which includes therapy if that need is identified.

4) And every year after the initial evaluation, the child has to requalify for services through that comprehensive developmental assessment which includes therapy if needed.

That is enough to make sure the right children are in the right service setting with the right services in place.

The proposal includes 1-4 plus qualifying for a therapy.

5. My suggestion is to study the entire service system. We could transform the entire system and implement standardized programming and track outcomes. That may be a lofty goal, but I believe that would be a way to really address inclusion if the state is serious about improving inclusion in early childhood.
The service system includes: Physician, DDTCS, CHMS, Head Start, Early Head Start, ABC, Public-school Pre-K, Part B Special Education Services, First Connections, HIPPY, Home visitors, and private daycare. (There may be others) Let's include all the players. Maybe the entire system could be more efficient for the children of the state of Arkansas.
There was a study conducted by the legislature in 2013 that identified the needs for our state in the field of early childhood.
"When low income children have special needs, the ability of current early childhood education programs to meet increased levels of need is strained."
Now, DHS wants to add 3,300 children with special needs to that system.
We don't believe the current early childhood system has the capacity to meet the needs of these children.
Arkansas Advocates for Children and Families report that only 45% of children on Medicaid receive screenings. Shouldn't we look at our entire referral system instead of carving out one piece and implementing an arbitrary measure?
What if this one piece implodes the entire early childhood system? I think we have a delicate balance currently in place (and especially in the rural areas) and this one policy could have numerous unintended consequences for a fragile population of children as well as the early childhood system.

RESPONSE: Thank you for your comments. Please see previous responses about ensuring children receive services in the most appropriate and least restrictive setting. We plan to strictly monitor the transition of children from EIDT into federally funded daycare setting through the panel described above.

17. AMBRA MCPETERS, PARENT

COMMENTS: I feel as if you do not care about what you are doing to the children, or how it's going to affect the families. It seems now that somebody has their career staked in just trying to reduce the waiting list for services, and doesn't care how they hurt kids in the process. The One Therapy Rule is dangerous to our children's futures. It's not going to matter 20 years from now that you moved them through quickly if the kids don't actually get the help they need. It makes me wonder about the credentials of the ones working on this project, it seems they do not understand children and development at all. If parents, schools, and doctors are all saying no, then how can you justify your actions? And not to give parents update on what is going on is just wrong. I bulleted out several problems areas with the plan, the potential damage, and alternatives and you do not even want to acknowledge them. That tells me you don't care.
I took my daughter for her well child check-up today and the doc was dumbfounded that she no longer qualifies for speech therapy. This lead into the One Therapy Rule discussion and now she is on board to fight it, as well as being furious that as the ones that refer children, they have not been notified of the pending changes.
Im glad to see channel 11 has picked this up. Hopefully we can stop this from happening. Please do the smart thing and work on opening more options for kids, instead of taking away options. It's better to pay for services now and give them a future, than to try to make yourself took good by moving them through quickly and then having to pay all these kids a check when they get older because they can't function well enough to work.
I really cannot see how people who are supposed to be working for the good of our children, can only think of plans that will hurt them. I would like to see the person who proposed this idea fired. They have no business being a voice for my children, or any other kids in our community. The state reps already told me they would fund building more schools and hiring more therapist over taking services away from kids. This makes no sense to push something so dangerous when there are viable options.

Received following reply:
Thank you for the link showing the updates. I will look through them. Having only the original plan the prospects were looking scary. Hopefully through these amendments things will look better. I appreciate it.

RESPONSE: Thank you for your comments and the follow-up phone calls. The discussions regarding merging of the two programs started after a 2013 statute change. DHS has had several conversations with Arkansas Department of Education, Special Education services regarding funding for special education services, if needed.

18. ELIZABETH R. ESKEW

COMMENTS: I am writing to inform you about the reasons the Department of Human Services (DHS) proposal to restrict eligibility for children's services is a terrible plan for children, as well as the state.
The plan to merge the Division of Developmental Disabilities Services and Child Health Management Services is not my concern. My concerns are the proposed changes that will affect 3,300 children instantly. This means that they will no longer be eligible for

developmental preschool services in the new merged program. As you are aware, not all children diagnosed with developmental disabilities require therapy services.
An additional 10,000 more children who have been diagnosed with developmental disabilities integrated into mainstream schools, such as ABC and Pre-K programs will be affected by this proposal. These programs do not have the trained staff, money, or infrastructure to handle these children.
This proposal does not leave options for many families whose child(ren) has/have been rejected by or will not accept these children. Please reject theses proposed rules and the devastating consequences that would result from their implementation.

RESPONSE: Thank you for your comments, please see previous responses.

19. DAVID SANDERS

COMMENT: I am so scared for some of the families I see on a daily basis! These kids need Day Hab services for their children but they don't necessarily need Therapy! I would be so sad to see these families lose their help! I am voting NO to the 1 Therapy Rule!

RESPONSE: Thank you for your comments, please see previous responses.

20. BRADLEY ALTON CHAMBLESS

COMMENTS: I am currently a resident of DeWitt, Arkansas County, Arkansas. I grew up in Dumas, Arkansas, and have lived my entire adult life in the Delta Region of Eastern Arkansas. With that said, I am intimately familiar with the families and citizens of this part of the State as a result of my law practice and banking career. My letter today is drafted with compassion for every citizen of this Great State. irrespective of whether they reside in urban. suburban. or the more rural communities.
My purpose is to respectfully express my opposition to the Medicaid amendments set forth hereinabove, as an attempt to consolidate departments and cut spending. While I am a staunch proponent of controlled spending and balanced budgets. I also place significant weight on the benefit being achieved. With that being said, I have tried to follow this issue to determine not only the benefits of the proposed legislation but how it ultimately impacts the communities and Citizens of Eastern Arkansas. While I do not see the departmental consolidation as harmful provided it creates and promotes consistency. the qualifications change will create a significant harm for many children in the State. While the theory of the qualification change may appear on the surface to be beneficial/neutral. in reality it will have a disparate impact in practice.
Many of the current facilities who offer services to our youngest Citizens are simply not located within metropolitan areas of the State. To that end, it is imperative that a comprehensive impact analysis be performed to insure fairness before any legislation is considered that may impact our Children. Specifically, there are Children in rural areas or our State whose parents cannot get them to the services they so desperately need. Currently, many facilities provide transportation to insure each child receives the services they need and are protected. How will this transportation issue be addressed, but more importantly how will it ultimately affect the families with Children needing services! Will the additional burden of transportation or the additional distance these families must travel to seek services for their Children create an obstacle they simply cannot overcome'?
I am confident that a large number or Children who attend facilities in rural Eastern Arkansas come

from low to moderate income families. My concern is how the new qualification changes will impact the Children from those families. In supporting the facilities that I outlined above. I have always humbled myself with the knowledge that the Children needing special services are in a situation that they did not even create. While the Jody Partridge facility in Dumas focuses on servicing the special needs of older Citizens, I am not aware that the new legislation impacts that age group as directly as it does small Children.
As a citizen of the Great State of Arkansas. I have been a proponent of education and child welfare. It has given me great reward to have been a small part of supporting the literacy council's publicschools, special needs schools, and non-profits such as the Imagination Library and [??] Inc. If we are going to provide the Citizen of this State the chance to break the literacy, poverty, income, or health barriers necessary to become stronger and more productive Citizens, then I respectfully implore you to reconsider this legislation until a comprehensive impact study has been completed. The most basic tenet in Arkansas Chancery Law is to always focus on what is in the best interest of the children. By adhering to that principal, we are charged to insure that our youngest Citizens have the resources and opportunities to be greater than our generation. Thank you for our time and consideration to this matter.

RESPONSE: DDS understands your concerns regarding transportation; however, federal law only allows Medicaid dollars to be spent on transportation for Medicaid clinic-based services. Several federally funded daycares do have agreements with local school districts to provide transportation to daycares. We acknowledge that this is not a statewide service. However, we are happy to discuss cases with you on an individual basis.

21. JANICE DANIELS

COMMENTS: I am writing in opposition to these above-mentioned Medicaid state plan amendments, new provider manuals, and manual updates. There is no clinical justification to support the proposed changes that will discriminate against children who have a cognitive or social/emotional impairment, but do not require therapy.
Please vote against the proposed rules.

RESPONSE: Thank you for your comment, please see previous responses regarding ensuring children receive services in the most appropriate and least restrictive setting.

22. KENNY GRIMES

COMMENTS: I'm writing to you to ask you to vote no on this issue.
The kids who may not be "severe" enough to qualify for an individual therapy still have needs that can be addressed through the classroom program. The mission is to guide them to success in K-12. These are some of the kids who have the best outcomes.
These kids are the forgotten ones. They don't qualify for skilled therapy but they are not typically developing. This population needs intervention as well.

RESPONSE: Thank you for your comment, please see previous responses regarding ensuring children receive services in the most appropriate and least restrictive setting.

23. HEATHER MORGAN, MS, OTR/L

COMMENT: My name is Heather Morgan. I am a licensed and registered occupational therapist in the state of Arkansas where I currently work with children at a developmental day treatment center in rural southeast Arkansas. We enroll ninety-eight children, of which only forty-seven receive therapy services. I am writing concerning the Medicaid state plan amendment, new provider manuals and manual updates that will merge the DDTCS and CHMS programs into one Early Intervention Day Treatment program. Our facility alone would be forced to transition fifty-one children into other facilities that do not exist in Arkansas County. Tell me how that is going to work for these children?
Let me be clear, I am not opposed to the concept of merging DDTCS and CHMS programs; however, I am violently opposed to the department's proposed changes that will deny thousands of Arkansas children early intervention services as well as unnecessarily drive up the utilization of therapy services as families seek out service providers in order to get the treatment they need for their child. Permitting the "one therapy" rule to come to fruition only creates a bigger problem. In addition to thousands of children being left without services you run the risk of forcing hundreds of employees to file for unemployment further contributing to the growing statistics of those without jobs in the state of Arkansas. There is simply no clinical justification to impose this requirement that will discriminate against children who have a cognitive or social-emotional impairment, but do not require physical therapy, speech language therapy or occupational therapy. DHS should not make these services dependent upon the other in order for children to receive any treatment at all. Within a few years the EIDT merger would create an influx of 10,000 additional children into state-funded settings such as ABC and public pre-k programs, which do not have the funding, staff, or infrastructure to handle these additional children. There are no options in rural Arkansas. Implications of the "one therapy rule" will leave no option for many families whose child has been rejected by or will not be accepted by these other programs. Several of these programs are not equipped to hand children with social-emotional or cognitive impairments.
I am asking you to reject these proposed rules and the devastating consequences that would results from their adoption. Agreeing to the "one therapy rule" will devastate the children of Arkansas. The "one therapy rule" will be costly both financially and developmentally. It's a loose, loose situation. If the merger passes you put thousands of children without developmental services and hundreds of adults without jobs. Do not contribute to the regression of our children. Do not contribute to yet another unemployment statistic. Vote against these proposed changes.

RESPONSE: Please see previous responses.

24. MICHELLE EDWARDS, COMMUNITY SCHOOL OF CLEBURNE COUNTY, INC.
ANGEL WAGGONER, SERVICE COORDINATOR, CSOCC

COMMENT: 212.000 – D - For all beneficiaries who are enrolling in habilitative services for children (0-6), the prescription must be based on the results of an age appropriate developmental screen performed by DHS' Third Party Assessor that indicates the beneficiary has been referred for further evaluation, as well as the results of the full evaluation.
The Developmental Screener that is currently being used by DHS' Third Party Assessor does not screen infants under 6 months old. This excludes all infants under 6 months of age from possible Early Intervention services they may need – unless they have an eligible diagnosis that would make them exempt from the Third Party Assessment. The proposal states that beneficiaries who are enrolling in habilitative services for children 0-6 must have the results of an AGE APPROPRIATE developmental screen. The current screener being used is NOT age appropriate for children 0-6 months. Furthermore, the proposal states that EIDT services are available for children birth-6 years

– however, infants under six months who do not have a diagnosis could not access these services due to the Third Party Assessment that is not available to them being an eligibility requirement. That is not to say infants under six months should be exempt from the Third Party Assessment – however, there should be an Assessment tool that is used to screen children under six months to determine the need for EIDT services. (i.e. the Brigance Screen or the Denver Developmental Screening Test, Developmental Profile 3, or the Ages and Stages Questionnaire) Our center has had infants with severe medical needs that, while not having the diagnoses that would exempt them from the screener, do have significant overall developmental delays. These children would not be able to access EIDT services due to the screener currently being used.
In addition – while we have been told by DHS that there will be an appeal process for the Developmental Screener – there are no processes outlined regarding this. If a child passes a screener and their PCP still has concerns regarding the child's development – what can be done to appeal the decision made by the Third Party Assessor? If a child's PCP feels there is a medical need for the child to, at minimum, receive a FULL Developmental Evaluation even though the child has passed the screener – there should be some way for the PCP to appeal the decision of the Third Party Assessor.

RESPONSE: The Battelle Developmental Inventory (Screener) is used for children from birth to the 8th birthday, so no other screen would be needed to assess children birth to six months for services. Habilitative Services in the summer does not require a Battelle Screen.

COMMENT: 212.100 Eligibility Criteria
To receive EIDT day habilitation services, the beneficiary must have a documented developmental disability or delay, as shown on the results of an annual comprehensive developmental evaluation. The comprehensive annual developmental evaluation must include a norm referenced (standardized) evaluation and a criterion referenced evaluation. The norm referenced evaluation must be the most current addition of the Battelle Developmental Inventory (BDI).
The ONLY evaluation that can be used to determine eligibility is the BDI? While the BDI is probably the most widely used Developmental Evaluation – it is not the only norm referenced evaluation that is reliable. Therapists are not required to use only ONE norm referenced evaluation to determine eligibility for therapy. I am unclear why this would be a requirement for EIDT services. The use of other norm referenced evaluations is a valuable tool for clinicians to gain a truly comprehensive overview of a child's development. EIDT programs should not be limited to only the BDI in establishing eligibility. Other norm referenced evaluations include the Brigance Inventory of Early Development III, Developmental Assessment of Young Children-2, Kent Inventory of Developmental Skills, Bayley Scales of Infant Development-3, Mullen Scales of Early Learning (MSEL).

RESPONSE: Please see response above regarding use of Battelle Developmental Inventory.

COMMENT: 204.000 Election to Provide Special Education Services in Accordance with Part B of the Individuals with Disabilities Education Act (IDEA)
Local Education Agencies ("LEA") have the responsibility to ensure that children ages three (3) until entry into Kindergarten who have or are suspected of having a disability under Part B of IDEA ("Part B") receive a Free Appropriate Public Education. The Arkansas Department of Education provides each EIDT with the option of participating in Part B as an LEA. Participation as an LEA requires an EIDT to provide special education and related services in accordance with Part B ("Special Education Services") to all children with disabilities it is serving aged three (3) until entry into Kindergarten. A

participating EIDT is also eligible to receive a portion of the federal grant funds made available to LEAs under Part B in any given fiscal year.

Each EIDT must therefore make an affirmative election to either provide or not provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into Kindergarten.

If the goal of this integration of programs is to utilize the best of both programs to provide the best services for our children – providing the option for centers to "Opt Out" of providing Special Education Services is NOT in the best interest of these children. As Special Education Providers we are held to a very high standard regarding qualifications and service provisions. Our teachers are required to be Certified in in Early Childhood Special Education – giving them the foundation needed to navigate the individualized services and interventions needed for the special needs of these children. In addition, the transition services that are required for these children transitioning from these programs into the public schools is crucial to the success of these children when they become school age. When centers are Special Education Providers they are required to work very closely with the public schools children will be transitioning to. This ensures that the Special Education Services the child needs will be in place the first day of Kindergarten – so, there are no lapses in services. This is also extremely beneficial to public schools to plan for the needs of these children. If we want the best possible care for these children – all centers should be providing Special Education Services. Based on the eligibility criteria – all of the children who qualify for EIDT would also be identified as being eligible for Special Education services. EIDT centers have a responsibility - an obligation - to provide those services for the children in our programs. Maintaining a Special Education status provides an additional level of expertise, integrity, and enhanced reputation for all EIDT programs.

RESPONSE: The parent has the right to opt-out of the IDEA and choose to stay at that center. This right has always been available, however, we are inserting required action on behalf of the EIDT so that the family is fully informed of their rights and options prior to making a decision.

COMMENT: 212.100 Eligibility Criteria

B. In addition to having a documented developmental disability or delay, the beneficiary must have a documented need for at least one of the following, as shown on a full evaluation for that service:

1. Physical therapy,
2. Occupational therapy,
3. Speech therapy, or
4. Nursing services

Physical, Occupational and Speech Therapy evaluations must meet qualifying scores as written in the Medicaid Occupational, Physical and Speech Therapy Provider manual.

For children who have a documented delay in the areas of social emotional and adaptive only, a referral must be made to an appropriate head start, home visiting, or Early Interventions or Part B program. This referral must be documented and placed in the child's evaluation record.

In addition to having a documented delay in the area of social emotional and adaptive skills – children may also show delays in COGNITIVE skills on the BDI. As stated in 214.200, Habilitative Services are instruction in areas of cognition, communication, social/emotional, motor, and adaptive skills. These services are provided to treat a child's developmental delays (which, is a medical diagnosis - ICD-10-CM Diagnosis Code R62.50). A child who has documented delays in the areas of social emotional, adaptive, or cognitive "only" STILL are developmentally delayed and require specialized treatment for these delays. Habilitative Services ensure that the child has an individualized care plan with objectives addressing the child's delays that are worked on daily in a classroom setting. These children will not receive these individualized interventions to address these needs in a head start or ABC program.

Therapy services are specialized services provided at a much higher rate than habilitative services. The eligibility for habilitative services should not be tied to eligibility of therapy services. The need for therapy services is not a true indicator of a need for habilitative services. A Developmental Evaluation and diagnosis of a Developmental Delay ***IS*** an indicator for the need for habilitative services. As noted before, there are children who are developmentally delayed in the areas of social emotional, adaptive, and cognitive skills who do not show a need for more specialized therapy services. These children will be excluded from services they show a **MEDICAL NEED** for because they do not qualify for a therapy service.

In addition, rural areas of Arkansas do not have alternative educational programs for these children to be referred to. In the area I live in, we have 20 Head Start slots (that are currently filled) and no ABC or Early Head Start programs. DHS keeps maintaining that there are enough programs when providers are adamant that, in rural areas, there just are not. The educational programs DHS is expecting to provide services to these children are not adequate enough to accommodate the number of children this will impact. While these children will be discharged from our programs because they no longer qualify as eligible for EIDT – they will still be identified as eligible for Special Education services with IEPs in place. Local educational cooperatives will become responsible for providing a free and appropriate education for these children. In a community where there are only 20 Head Start slots – I'm curious where all these children will be receiving their Special Education services. In addition, these alternate programs do not provide transportation services – which are critical for many parents utilizing habilitative programs.

Early Intervention and Early Childhood services are critical for the success of children with developmental delays. Head start, home visiting, or ABC programs are not always ***"appropriate"*** placements for these children. Habilitative programs are providing these services and are able to provide special accommodations for these children who ***"only"*** show delays in social emotional, adaptive, or cognitive skills. It would be devastating for these children and their families to exclude them from services simply because they do not show a need for specialized therapy services.

RESPONSE: Please see previous responses regarding ensuring children receive services in the most appropriate and least restrictive setting. Also, all children who currently meet the eligibility requirements will be grandfathered in to the EIDT program until June 31, 2019. We will be convening a panel to oversee transition of children from EIDT into federally funded daycare programs.

25. JANICE LAHR
    TROY AND HEATHER SHEARER

COMMENT: I am writing in opposition to these Medicaid state plan amendments, new provider manuals, and manual updates that will merge the DDTCS and CHMS programs into one Early Intervention Day Treatment program. I am opposed to the Department's proposed changes that will deny early intervention services to children that do not require therapy services, leaving no options for families who child will be rejected by these programs, and unnecessarily drive up the utilization of therapy services as families seek out therapy services in order to get the developmental day treatment services they really need.

I am asking you to reject the proposed rules and think about the consequences that will follow should you not.

RESPONSE: Please see response above.

26. WARRAN AND DEBBIE DIEMER

COMMENT: I am writing this letter to oppose the one therapy rule. Children should not have to qualify for therapy to receive day habilitation. These are two different services, and OHS should not make one dependent upon the other for children to receive any treatment at all. There is no reason to impose this requirement and discriminate against children with cognitive, social, and self-help impairments.
I am asking you to say NO to the one therapy rule for the sake of children who have significant delays but do not qualify for therapy.

RESPONSE: Please see previous responses.

27. PARENT

COMMENT: I am a parent of 3 children who have all attended Milestones Service, Inc., which is a developmental preschool. I am concerned about the DHS proposal to restrict eligibility to one therapy. I know this will mean approximately 3,330 children will no longer be eligible for the services they currently receive.
There will be nowhere for these children to go because there are not enough Head Start or ABC spots. Also, for children under 3 there are not many options. Most cities do not have Early Head Starts and there is not enough voucher funding for the children to attend daycare. Children are going to fall through the cracks until they enter public school and then they are going to be struggling to catch up. This could be avoided if they could receive the developmental instruction they need in areas such as cognitive, social, and self-help in developmental preschools. Children can be delayed and need help catching up without qualifying in physical therapy, occupational therapy, or speech therapy.
There Is no clinical justification to impose this requirement that will discriminate against children who have a cognitive or social/emotional impairment but do not require therapy. These are two different services, and DHS should not make one dependent upon the other in order for children to receive any treatment at all.
I am asking you reject these proposed rules and the devastating consequences that would result from their adoption.

RESPONSE: Please see responses above. We anticipate that DCCECE will receive additional funding for federally funded daycares in fiscal year 2019.

28. LORNA JEAN STONE

COMMENT: By the age of three, I already didn't like myself. let me repeat that as you may not have fully grasped what that entails. At the time when most children are just learning how to be potty trained, I had already had enough exposure to the world to know that I was different and different was not acceptable. So, because of my speech impediment, I began a time that I barely spoke in public. You never knew where the critiques would come from. No one was to be trusted. Not people at the stores, not the people at church, not even the people at family reunions.

This mistrust and refusal to speak may not have hindered my social skills as a young child, but it certainly interfered with my social skills as I grew older. Had I received speech therapy at an early age, I do not believe that I would have had these issues. However, I was born in the fall of 1968 and the IDEA was not passed until 1975.

I didn't have a voice to speak up for myself. My parents did the best they could, but nothing was addressed until I was in the first grade. By then, the bullies had taught me to believe that I was less than. Less than perfect. Less than smart. Less thanhuman.

No child ever needs to feel this way.

No one had a voice for me when I needed it.

And so, I now write this letter in opposition to the department's proposed changes that will:

1. Deny early intervention services to 3,300 Arkansas children who do not also require physical, occupational, or speech therapy.
2. Unnecessarily drive up the utilization of therapy service as families seek out therapy services to get the developmental day treatment services they need.
3. Create an influx of 10,00 additional children into state-funded settings such as ABC and public pre-k programs which do not have the funding, staff, or infrastructure to handle these additional children.
4. There will be on option left for many families whose child has rejected by or will not be accepted by these other programs.

There is no reason to force these changes. It will only discriminate against children who have a cognitive or social delay but do not require other therapies.

I am asking you to reject these proposed rules and the distressing consequences that would result.

RESPONSE: Thank you for your courage in sharing your story with us, we greatly appreciate knowing the personal experiences of people that we service. We are striving to ensure that all children receive appropriate services in the most appropriate and least restrictive setting. Please also see other responses above.

29. TERRAN HENDERSON, PARENT

COMMENT: I am writing to inform you of my opposition of the new therapy requirements in regards to the new merger between the DDTCS and CHMS programs. I do not oppose the merger, just one therapy rule.

My son has hypotonic cerebral palsy. He attends Patillo Center School in DeWitt, AR. He is one of the lucky ones that already receives therapy. Our school does extensive testing for enrollment, so while all of the children have delays, only 35 receive therapy. This new requirement would force our center to close, as they are not self-sustainable with the funds of 35 children. I have many concerns. First and foremost, where will my son and the other 34 children receive therapy once Patillo closes? The nearest we have is in Little Rock that is over 1.5 hours away. Secondly, where will the other children that have social and behavioral delays go? We only have the ABC program that is for ages 3 and up in Arkansas county. They are full already and do not provide transportation. My son is only 2. Patillo offers services from birth. When our children have nowhere to go, many parents will be forced to stay home with their children, which will put more stress on programs like SNAP and affect the unemployment numbers in our state. All of Patillo's employees will lose their jobs. The already stressed special needs programs in our public school systems will be put under more pressure to catch these children up and the costs will sky rocket. The short term benefits of this change will be detrimental in the long term.

This will not only affect our city and county, this will be an issue for many centers across the state, especially in rural areas. This one therapy rule doesn't just affect the 3300 kids. In reality, there are many more like my son who will have nowhere to get the therapy they are qualified to get. At 5 months old, my son could not roll or lift his arms. Without early intervention therapy, I don't know where he would be today. The state currently is not offering anything to help him develop closer to his peers.

Please consider the real cost. Please, think about my son and others like him. This will hurt the most **vulnerable** in our state.

RESPONSE: DDS is specifically looking at the Patillo Center in DeWitt and to see other daycare options in that area. As noted above, we anticipate DCCECE will receive additional funding for federally funded daycares. Based on a preliminary review of the data, we agree a certain portion of that funding should be directed to that area of the state for capacity building.

30. DIANA BECK, EXECUTIVE DIRECTOR, CONWAY COUNTY CENTER FOR EXCEPTIONAL CHILDREN, INC.

COMMENT: The Arkansas definition of developmental disability includes individuals who experience delays in development. I cannot understand how our State will overlook children who have intellectual, social, and adaptive delays and not provide them specialized services unless they require a therapy. As a Director for 29 years, I have seen the benefit to our children. Please do not let Arkansas go backwards regarding early intervention.

RESPONSE: Thank you for your comments. We believe realignment of the program will allow children to receive care in the most appropriate manner in the least restrictive setting.

31. RICH HUDDLESTON, EXECUTIVE DIRECTOR, ARKANSAS ADVOCATES FOR CHILDREN AND FAMILIES

COMMENT: Arkansas Advocates for Children and Families (AACF) supports ongoing work to transform the health care and early childhood education systems for children in Arkansas. The smart investments we make today will result in better overall health and wellness of children in this state and improve life in Arkansas for future generations.

The enclosed letter, which was signed by several child health and education organizations, highlights several important principles that prioritize the needs of children. These principles should drive any system changes that are implemented to ensure that all children, regardless of their needs, have equitable access to quality early education.

While the state has indicated that a one-year transition period will be used to appropriately identify the services that children who aren't eligible for EIDT services, we recommend that the state address the following issues prior to moving forward with the proposed system changes:

1. County-level data on the number of children who are currently served by a CHMS or DDTCS provider who will become ineligible for pre-K under new EIDT eligibility rules;

2. Assessment of capacity and gaps in early childhood system including; a. Update on progress with recommendations from 2014 early childhood study (ISP-2013-050) on access, funding needs, and staffing

b. County-by-county data on ABC slots for children

3. Comparison of the data in recommendations 1 and 2b, to provide a snapshot of the state's capacity to meet the current demand for services;

4. Update on progress implementing recent policy changes to DDS services for children (independent assessment, therapy limits, etc.);

5. Transition plan for children ineligible for EIDT to include; and a. Strategies to mitigate any services losses

b. Resources to support early childhood providers

c. Outreach and communication activities to families

d. Timeline of activities during one-year transition period

6. Regular legislative updates on progress and system readiness (based on the plan in previous recommendation) during one-year transition period.

We strongly recommend that these minimum requirements are implemented to ensure our most vulnerable young children and their families do not experience additional barriers to service because of a failure to adequately plan. Many times, the policy intended to help families have unintended consequences that often do them harm. The potential impact of swiftly rolling out this policy is much too great a risk to move forward without a thoughtful transition plan and a guarantee that resources and supports are adequate to serve families.

RESPONSE: Thank you for your comments. We always appreciate feedback from Arkansas Advocates for Children and Families. Please see responses above, specifically regarding additional funding and the advocacy panel, which we will invite you to be a member of. We have provided outreach and communication to families, which we have discussed in previous responses. And, we are happy to sit down and discuss the available resources we currently provide to support early childhood providers.

32. LETTER ENDORSED MAY 8, 2018, BY THE FOLLOWING ORGANIZATIONS:

Arkansas' Act Early Ambassador
Arkansas Association for Infant Mental Health (AAIMH)
Arkansas Autism Resource & Outreach Center (AAROC)
Arkansas Disability Coalition (ADC)
Arkansas Early Childhood Association (AECA)
Arkansas Mental Health in Education Association (ARMEA)
Arkansas Support Network, Inc. (ASN)
Arkansas Waiver Association (AWA)
Disability Rights Arkansas (DRA)
Learn the Signs Act Early (LTSAE) State Team
Partners for Inclusive Communities
The Center for Exceptional Families (TCFEF)
University of Arkansas special education program

COMMENT: In response to the State's proposed regulations for Early Intervention Day Treatment (EIDT) for Children (successor program of CHMS and DDTCS for children), we, the undersigned organizations, submit the following comments:

We believe that all children, including those with developmental needs deserve:

- ongoing monitoring of their development, including screenings and assessments as warranted;
- swift access to early intervention services that utilize evidence-based practices;
- services provided in high quality, inclusive settings;

- a well-planned curriculum that promotes growth and development across all areas (social, emotional, physical, language and cognitive);
- teaching strategies that are developmentally, culturally and linguistically appropriate;
- appropriately credentialed teachers, therapists, and paraprofessionals who work as a team, alongside the parents/caregivers, to respond to the needs of the child;
- therapy services that are integrated into natural environments, building the skills of all instructional staff and parents to implement and reinforce developmental skills; and
- services that build positive relationships among all children and adults and are free of abuse, restraint, isolation and humiliation.

Inclusive education for all children is the national standard in providing high quality services. Inclusive education starting in early childhood leads to quality outcomes and self-sufficiency in adulthood.

RESPONSE: DDS has reviewed your letter dated May 8, 2018, and we are in agreement with the points you asserted. We believe the changes we are proposing specifically drive children to receive services in an inclusive setting when appropriate.

33. SETH COULTER, PT, PRESIDENT, ARKANSAS PHYSICAL THERPAY ASSOCIATION

COMMENT: In accordance with the Administrative Procedures Act process, I am submitting comments on proposed Medicaid policy revisions. The streamlining of Medicaid funded services with the planned transition of Child Health Management Services (CHMS) and Developmental Day Treatment Clinic Services (DDTCS) facilities into the new program of Early Intervention Day Treatment (EIDT) has produced frustration and genuine concern with some members of the Arkansas Physical Therapy Association (ArPTA).

As the President ArPTA, I have heard from members who support the transition as well as members opposing it and have personally studied the issue. It is obvious that this decision is controversial. Combining two similar programs into one with shared eligibility criteria is a monumental task which will come with frustrations and uncertainty. There is concern for children that may not qualify to receive services needed to prepare them for success in the future. There is concern that the new eligibility requirements will potentially jeopardize some existing facilities which may not be able to meet the new requirements putting a significant burden on the system. There is encouragement that some children will now qualify that may not have been eligible previously. Over 3,000 children are projected to be transitioned out of DDTCS facilities into a system that is not equipped to absorb them.

Understanding the financial urgency to save money in the Medicaid program in order to continue providing services for our children in need, dictates that changes have to be made which are difficult. The new EIDT model will surely create some unintended consequences and hardships affecting our most vulnerable citizens. If this transition proceeds without change, it is critical that during the year of transition, DHS works closely with stakeholders (providers, parents, and guardians) to determine how we can best meet the needs of the children who do not qualify for EIDT.

The ArPTA will always support the proper and efficient care of our pediatric patients. The ArPTA wants to be a part of the solution for children needing physical therapy services and their being able to access those services appropriately and efficiently to enable them to reach their full potential. The ArPTA will always strive to work with DHS and other healthcare associations and professionals in finding appropriate avenues to meet the demand for providing needed services to children in Arkansas in a fiscally responsible manner that sustains the viability of the program.

RESPONSE: Thank you for your comment. DDS has had several discussions with the Arkansas Department of Education regarding funding if additional special education services are required due to any child transitioning from an EIDT program. To ensure appropriate transition into other programs, DDS is giving all children who currently qualify for DDTCS and CHMS services until June 31, 2019, to either meet the new criteria or transfer into a new program. A panel will be formed to monitor transition from EIDT into a federally funded programs. Please see previous responses detailing the membership of that panel.

34. GLADYS NETTLES

COMMENT: Morning to you, this email is to ask you to prayerfully consider your decisions on the lives and early existence of these children that will left behind on so many benefits that will help them get a better start in life. As a mother with a child that is grandfathered in I thank God every day for the help I received. Let's do unto others as we would want done to us or our loved ones. Please pull the 1 therapy rule.

RESPONSE: Thank you for your comments, please see responses above.

35. GREGORY C. NETTLES, PASTOR

COMMENT: I am writing to you in opposition to restrict eligibility for children's services name change. The Developmental Day Treatment Clinic Services(DDTCS) and Child Health Management Services(CHMS) should remain as they are. This will affect and effect many clients, one of which is my son, Derrick, who is a client of Ouachita Enrichment Services, a/k/a, Ouachita Industries, Camden, Arkansas.
Elimination of the DDTCS program would result in the loss of services to approximately 146 children and 50-60 adults, plus the loss of 170 full-time, part time, and sheltered workshop positions. This would create a similar loss for other cities in the Golden Triangle Area (El Dorado, Magnolia, Fordyce).
I would hope and pray your careful consideration for those who cannot tend to themselves, but has to have help, as well as the caregivers. Again, thank you for your prayerful consideration of maintaining the status quo for the good of the hold.

RESPONSE: DDS respectfully disagrees with the numbers you cited in your comment. Please see responses above.

36. TONI WILSON, EXECUTIVE DIRECTOR, STEPPING STONE SCHOOL

COMMENT: The proposed State Plan Amendment **is in conflict with Title XIX of the Social Security Act as amended in OBRA '89. There is no requirement for a child with developmental delays to require a therapy in order to be eligible for the day habilitation services.** OBRA '89 (federal law) brings broad-based evidence that Day Habilitation is indeed **considered a "medical" or "medically necessary" service under the Federal/State Medicaid partnership.** Social Security Act. Section 1901 of the Social Security Act reads, "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish...2)rehabilitation (habilitation) and other services to help such families and individuals **attain or retain capability for independence or self-care,** there is hereby authorized to be

appropriated for each fiscal year a sum sufficient to carry out the In reality **the proposed rule would narrow the scope of services that providers have been providing under Medicaid,** and imposes requirements that will have a significant financial and administrative impact on community-based services as described in Act 1792 of 2001.
In reality **the proposed rule would narrow the scope of services that providers have been providing under Medicaid,** and imposes requirements that will have a significant financial and administrative impact on community-based services as described in Act 1792 of 2001.
Any revised rule should make clear that the state will continue to cover preventive services including habilitation services and other services for people with intellectual and other developmental disabilities that meet the requirements of 42 C.F.R. s 440.130(c) (Social Security Act). **Nowhere in federal law is it required that a child has to have a therapy in order to receive habilitation services.**
Any revised rule should make clear that the state will continue to cover preventive services including habilitation services and other services for people with intellectual and other developmental disabilities that meet the requirements of 42 C.F.R. s 440.130(c).
Comments regarding the Transportation Provider Manual, DDS Standards, and the New EIDT Manuals are attached.

RESPONSE: The Omnibus Budget Reconciliation Act of 1989 (OBRA '89), which you cite, is a prohibition on the Secretary of the U.S. Department of Health and Human Services (DHHS) to defund an *old* program until such time as the Secretary finalized regulations addressing the issue of habilitation services. That legislation in no way presents a limitation on the Secretary's ability to approve alteration or fund a *new* program. A great deal has changed in the Medicaid program in the past 29 years which has provided states with new options that did not exist in 1989. DHS will not sunset DDTCS or CHMS without having CMS approval of the new programs.

37. TONI MCCOMB, BS

COMMENT: My name is Toni McComb, working in the social work field, advocating on the behalf of the children in Arkansas with an emphasis the counties of Clay, Randolph, and Lawrence. I would like to express my concern about the new rule that will be taking place on the 1st of July known as the "one therapy rule." Children who are attending the Doni Martin Center for Developmental Services would be required to need at least one therapy in order to keep attending this center even though they may qualify cognitively or otherwise. However, this would put many children in other day ares that aren't equipped to handle children who have special needs. Other day cares may not be able to handle the sudden influx of children and even still, many of these children will be left out due to financial issues, transportation, or other matters.
By implementing this rule, it would limit the entitlement for services in EIDT to only those children needing at least one therapy. The estimated number of children that would be denied these needed services are approximately 3300 in Arkansas. In the Doni Martin Center alone if this change were currently in effect there would be one child who would have to be discharged and three other foster children. That is 25% of the preschool population just in this particular center. Preschool children are at the peak age where they are learning, growing, and developing. If they are denied the services they need through the center, then it is a big risk for them to possibly regress. They may also become more delayed and not be able to attend regular schools when they are older.
The children that attend this center need the extra one on one attention and learning time. These children are our future and we should want to invest in them instead of only letting them exist. If

this rule were to go into effect that is exactly what would be happening. Every success that these children have makes them a contributing member to society. We are striving to help them meet their goals, not let them down.

RESPONSE: Thank you for your comment. DDS has had several discussions with the Arkansas Department of Education regarding funding if additional special education services are required due to any child transitioning from an EIDT program. To ensure appropriate transition into other programs, DDS is giving all children who currently qualify for DDTCS and CHMS services until June 31, 2019, to either meet the new criteria or transfer into a new program. A panel will be formed to monitor transition from EIDT into a federally funded programs. Please see previous responses detailing the membership of that panel.

38. DAVID IVERS, DEVELOPMENTAL DISABILITIES PROVIDER ASSOCIATION

COMMENT: The proposed Early Intervention Day Treatment (EIDT) and Adult Development Day Treatment (ADDT) rules imperil funding for every DDTCS program in the state of Arkansas. This is primarily due to the great likelihood that Arkansas would lose its "grandfather" status under OBRA 1989 by replacing that program with EIDT and ADDT. See Legal Comments. Further, the rules fly in the face of the wishes of the General Assembly when it instituted payments to DDTCS under Medicaid. The General Assembly intended DHS to encourage support and reimbursement for DDTCS services under Medicaid, not to discourage or reduce them. *See, e.g.,* Ark. Code Ann. 20-48-103; 20-48-702; 20-48-704(b). For example Arkansas "encouraged the nonprofit {DDTCS} community programs to build with nonstate funds." Ark. Code Ann. 20-48-103(1). The General Assembly has instructed DHS to "not reduce reasonable cost funding of nonprofit community programs." Ark. Code Ann. 20-48-103. The existence of DDTCS programs has allowed many individuals with disabilities to live in the community at much less cost to the state than institutional placement1 or to be prepared for mainstream school placement with much less burden on the public school system. The proposed rules are counter to legislative intent and sound fiscal policy.

It is extremely troubling that DHS does not appear to have developed a plan to deal with those displaced by the proposed rules. When asked where they would go, the state's response consists of vague references to traditional education programs or "the waiver." While the state has a home and community-based waiver program, it is not appropriate for all individuals; many would not qualify, particularly children, and it has a years-long waiting list.

As for educational placement, school districts and education cooperatives are already reporting they do not have the capacity, in terms of staff and facilities, to serve these children DHS has provided no evidence of a transition plan or any input by education leaders into such a change, which will greatly impact the state's education system if implemented.

1 "The General Assembly finds that the State of Arkansas contracts with nonprofit community programs serving individuals with developmental disabilities as quasi-governmental instrumentalities of the state in order to provide a service that the state would otherwise provide for this population through state-operated programs and facilities." Ark. Code Ann. 20-48-701.

RESPONSE: Please see previous responses above. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89), which you cite, is a prohibition on the Secretary of the U.S. Department of Health and Human Services (DHHS) to defund an *old* program until such time as the Secretary finalized regulations addressing the issue of habilitation services. That legislation in no way presents a limitation on the Secretary's ability to approve alteration or fund a *new* program. A great deal has changed in the Medicaid program in the past 29 years which has provided states with new options that did not exist in 1989. DHS will not sunset DDTCS or CHMS without having CMS approval of the new programs.

COMMENT: Apart from the OBRA '89 issue DDPA is profoundly opposed to the "one therapy" requirement. The proposed requirement is burdened with many practical problems:

--For instance, if eligibility is based on qualifying for a therapy, **what happens to children who go in and out of therapy** based on re-evaluations? This is a frequent occurrence. What if the child is re-evaluated in the middle of the year and no longer qualifies? Programs cannot shift children back and forth like this. By hinging the proposed rule on therapy, the Department is generating unnecessary "churning."

--**Most "typical" day care or educational settings do not operate year-round** as do DDTCS programs. It is disruptive for any young child, especially with developmental disabilities and delays, to move them in and out. Where will they go in the **summer**? Most parents are working. Again, this creates many practical and logistical problems for these families.

--The proposed "one therapy" requirement **does not address transportation** services that are critical to provide access, especially in rural communities. Without transportation services many children diagnosed with developmental delays will not benefit from the service options in the state's Medicaid State Plan and will go from one chronological age to the next without the needed habilitation/early intervention needed to improve or ameliorate their delays. This is a huge cost to that child's future and quality of life and an increased cost to the state for long term care costs.

--DHS has said it will **prioritize placement** for the children impacted by the requirement. There are not enough slots for current children. Does this mean DHS will remove other children from existing slots? **Under what authority** will DHS "prioritize" any class of children over others?

-- Moreover, the **Individual with Disabilities in Education Act (IDEA)** does not permit DHS to transfer these children en masse into ABC programs or other traditional education settings. The IDEA requires development of an individualized family service plan (IFSP) or individualized education

plan (IED), with parental involvement and consent. This will require development of plans that address the special needs of these children with disabilities and delays so that they can learn and develop in that setting. This means specially trained staff, more staff with lower ratios, the capacity to accommodate this many more children – and the resources to make all this happen without federal matching funds.
However, DDPA continues to support the alignment of rules for DDTCS and CHMS. We believe that with the independent screens, mandatory annual re-evaluations, and soft caps for therapy, that the state will achieve the Governor's requested savings in DD services without the "one therapy" requirement. This was an "add-on" that was unnecessary and destroyed a long-sought agreement by DDTCS and CHMS on aligning their programs.

RESPONSE: Please see previous responses.

COMMENT: DDPA remains committed to the principle of aligning the rules governing DDTCS and CHMS services. However, we cannot support an actual merger since that would jeopardize Arkansas' grandfather status for DDTCS services under OBRA 1989. Thus, while our comments below reference "EIDT," we believe the two programs must maintain separate licensures, which could collectively be referred to as EIDT. Further, DDPA cannot support any proposal based on a "one therapy" rule, which is clinically unsound and discriminates against children based on their condition.

RESPONSES: Thank you for your comment, we respectfully disagree. Please see previous responses.

COMMENT: 201.000 Early Intervention Day Treatment (EIDT)
This proposed rule, which creates a new program (EIDT) and ends licensure under DDTCS, puts at risk the state's "grandfather" status under OBRA 1989. See Legal Comments.
The word "medical" in the second paragraph is too limiting. These services can be remedial and developmental in nature as well as medical. Recommend add "remedial," which will also match the fifth paragraph of this section and 216.000.B. See also 42 U.S.C. 1396-1 (Medicaid covers both "medical assistance" and "rehabilitation and other services.")
In the fourth paragraph, please remove the phrase "overseen by a physician" language since that is not a requirement for the facility itself.
In the fourth paragraph the reference to serving children with "developmental disabilities, developmental delays, *and* a medication condition" is unclear. Read literally that could mean you have to have all three. You can have a developmental disability or delay without a separate "medical condition." Using "or" instead of "and" would be more precise, since a child with a disability or delay still must pass a developmental evaluation to qualify, but the sentence needs to be made clear.
The fifth paragraph could be read to mean that an EDIT provider has to offer every type of service listed in the first sentence While we understand this language was pulled from EPSDT, no single provider is required to provide any and all services recommended by a physician. That would be a massive expansion of scope of these clinics. Please revise this paragraph.
The first, sixth, seventh and eight paragraphs all jeopardize the DDTCS grandfather status under OBRA 1989. See Legal Comments.

RESPONSE: Please see responses above, particularly regarding OBRA '89.

COMMENT: 201.000 Licensing Requirements
The new licensure language risks the "grandfather" status under OBRA 1989. See Legal Comments.

RESPONSE: Please see previous responses.

COMMENT: 201.200 Providers in Arkansas and Bordering States
Recommend adding "including the underserved status requirements" in statute and rules to make clear that providers in bordering states cannot enroll unless the area is underserved.

RESPONSE: Underserved status is mandated by a state statute. Any successor program will be under the same requirements.

COMMENT: 201.300 Academic Medical Center Program Specializing in Developmental Pediatrics
"C" – "Specializes in developmental pediatrics" is new language. Please explain.
"F" is new and says: "Does not provide treatment services to children." But then it lists 25 codes that only UAMS may bill and says these codes are "in addition to" the other EIDT codes in 232.100 that all providers can bill. What does this mean?
DDPA's position has long been that UAMS academic medical center role ("Kids First") is best utilized as a source of expertise to which other providers refer for specialized diagnostic and medical treatment that UAMS provides – not as a competitor with private providers.

RESPONSE: Please see response to Jill Fussell's comment above. The Kids First EIDT will have to comply with the same EIDT requirements as all other EIDT providers. Because they provide day habilitation services, they will not be able to bill the AMC codes. However, certain other programs within UAMS (for example, PACE for foster children), if they meet the requirements, will be able to obtain a specialized AMC license.

COMMENT: 203.000 Referral to First Connections program, pursuant to Part C of IDEA
Some providers are confused by this language and believe that it means they no longer refer children ages 0-3 to Optum for screenings, but only refer them to DDS First Connections and DDS takes it from there. It might be advisable to explain this is not the case. While providers will refer to First Connections, many families will still have to rely on providers to handle the rest of the process for qualifying for services. Unfortunately, the First Connections program has never worked as a single point of entry and would not be able to handle the volume of referrals were families and providers to rely on it in this manner. A comprehensive review of First Connections and its role in the early intervention system is needed.

RESPONSE: It is not our intention for First Connections to be the single point of entry. DDS has facilitated a minimum of five trainings with DDTCS and CHMS providers to discuss the referral process for the Battelle Screens with Optum and the workflow.

COMMENT: 204.000 Election to Provide Special Education Services in Accordance with Part B of IDEA
Providers continue to have questions about the "opt-in"/ "opt-out" process.

RESPONSE: We continue to address all providers concerns and questions. We will be happy to address any specific questions about the opt-in/opt-out process that providers may have.

COMMENT: 205.000 EIDT Providing Occupation, Physical, or Speech Therapy
Please revise the title to reflect that this section governs contracting, employment and billing requirements for therapists. These are not the substantive standards for therapy.

Please remove the first paragraph, which is duplicative of 212.100.
Also, therapies are not an "essential component" of an individual treatment plan for all children.

RESPONSE: There are specific manuals within the Medicaid State Plan for OT, PT, and Speech. We reference those manuals in the new EIDT manuals. Therapy services are an essential component of a child's ITP unless the child is receiving nursing.

COMMENT: 212.000 Establishing Eligibility
D. Developmental screens. DDPA proposed and supports developmental screening as an alternative to DHS' proposal for full-blown assessments from outside parties with no first-hand knowledge of the child. However, legally, screenings cannot supplant that of the interdisciplinary team and the PCP. See Ark. Code Ann. 20-48-703. Screenings should be a reference tool, but cannot override physician judgment. We suggest "informed by" rather than "based on" the results of the screen.

RESPONSE: We disagree that screening should be a reference tool. Prior to implementing the screening requirement, DDS met with a group of providers to discuss the standard deviation cut off to be used and the process for using the mandatory screener. This group included DDPA providers.

COMMENT: 212.100 Eligibility Criteria
A. Instead of "social", please correct to "social/emotional," to match existing language.
This paragraph requires a "full evaluation" for the listed services including "Nursing services," which raises the following questions:
(a) What would a full evaluation for nursing services look like? Is there a set assessment or tool we will need to use?
(b) If nursing is a qualifier for a child does that mean a nurse must be available at all times at the preschool, or just available to do needed services for that child at designated times based on the child's needs? Contract or employed? If a provider has 2 preschools in a town could the nurse work at both preschools if nursing needs of the children allowed that?
B. The requirement that a child have a condition that requires therapy or nursing services violates federal and state laws. See Legal Comments.
EIDT services should be based on a DEVELOPMENTAL EVALUATION. A developmental evaluation is the lynchpin for any program serving children with developmental disabilities or delays. This is true not only for DDTCS, but also for regular daycare, Better Beginnings, ABC Preschool, Head Start/Early Head Start, Early Intervention Part C (First Connections), and Early Intervention Part B (Educational Cooperatives). To require that a child qualify for therapy without qualifying through a developmental evaluation is logically and clinically unsound and violates the fundamental rule that in order to qualify for a Medicaid service you must meet medical necessity for that service, not a different service.
E. Paragraph "E" delays the effect for one year on children who are already enrolled, but immediately disqualifies any new children whose condition does not require therapy and who seek admission before then. See Legal Comments. Thus, this violates federal and state laws as soon as it becomes effective not just on July 1, 2019.

RESPONSE: We agree that social should be changed to social/emotional. In regards to a full evaluation for nursing services, the PCP should outline the extent of the service array. Please see comments above regarding other items.

COMMENT: 213.000 Core Services

In first paragraph, why is the "outpatient basis" reference included? That seems unnecessary in this context.
The current DDTCS manual lists habilitation as the "Core" service, while speech, physical and occupational therapies are all categorized as "Optional Services." (DDTCS Manual at 214.200.) In the proposed EIDT Manual, DHS has reclassified the therapies as "Core" services to support the proposed "one therapy" requirement. (Proposed EIDT Manual at 213.000.) This does not resolve the problem. See Legal Comments. It is also inconsistent with the proposed adult manual and with standards used across the country to evaluate necessity for habilitation.

RESPONSE: Upon review, we believe this is another OBRA '89 argument. Please see previous responses above.

COMMENT: 213.200 Non-Covered Services
DHS has proposed to include "**education**" as among those services that are not covered. Certain services, particularly habilitation, have both education and medical characteristics. This "overlap" does not mean that Medicaid will not cover them. A blanket exclusion of education services would violate Medicaid. *Massachusetts v. Sec'y of Health and Human Services*, 816 F.2d 796 (1st Cir. 1987). See also 42 U.S.C. 1396b(c). See also, *Chisholm v. Hood,* 110 F. Supp.2d 499, 507 (E.D. La. 2000) (a state cannot avoid its obligation to children with special needs by delegating it to the state's education system.*)* While we understand that traditional education is not covered, this does not mean that habilitative services with educational benefit are excluded. Please remove "education" from the Non-Covered Services list.

RESPONSE: We recognize that there has been a longstanding debate at the federal level regarding this issue; however, the purpose of this rule is to specify those medically necessary services that will be reimbursed by the Arkansas Medicaid program.

COMMENT: 214.100 Evaluation
Screenings do not determine medical necessity. See Ark. Code Ann. 20-48-703. Screenings should be a reference tool, but cannot override physician judgment. See Comments under 212.000. Please revise language.

RESPONSES: We disagree that screening should be a reference tool. Prior to implementing the screening requirement, DDS met with a group of providers to discuss the standard deviation cut off to be used and the process for using the mandatory screener. This group included DDPA providers.

COMMENT: Are you giving separate names to summer services called "habilitative services in the summer" rather than just "habilitative services" for a reason?

RESPONSE: Yes, after seeing a need for summer services that are not currently available for DDTCS clients, we have outlined how to qualify for habilitative services in the summer.

COMMENT: 214.200 Habilitative Services for Ages 0-6
B. Staff qualifications and C. Class ratios. These standards are more appropriately addressed in Certification Standards, not in the Medicaid Provider Manual.

RESPONSE: Thank you for your comment.

COMMENT: 214.200 Habilitative Services for Ages 0-6
B. Staff qualifications and C. Class ratios. These standards are more appropriately addressed in Certification Standards, not in the Medicaid Provider Manual.

RESPONSE: Thank you for your comment.

COMMENT: 214.300 Occupational, Speech, and Physical Therapy
This paragraph should apply to both 0-6 and 6-20.

RESPONSE: There is a completely separate eligibility section for children 6-20 who will attend a summer program.

COMMENT: 214.500 Habilitative Services in the Summer for Ages 6-20
This section says the purpose is "to *continue* habilitation instruction to prevent regression during the summer months while school is not in session," which presumes that school-age children have been receiving habilitation during the school year. We recommend deleting the words "to continue habilitation instruction."
Public schools are required to do testing on kids in special education over Christmas and spring break to determine if the child regresses during those breaks and qualifies for summer school services. Is this supplanting the obligation and requirements of the public schools for these kids? If the school tests them and says they do not show a regression in skills over the school breaks and don't need summer school, can they still qualify for EIDT?

RESPONSE: This program will not supplant any obligation from the Department of Education.

COMMENT: 215.000 Description of Optional Medical Services
This section refers to "services" plural but lists only one "service" – nursing. This is because you have moved therapies into "Core." See objections above and Legal Comments.

RESPONSE: We will remove the reference to optional services.

COMMENT: 215.100 Nursing Services
We support your effort to address nursing needs, but believe it should not be part of *eligibility*. It does not make sense to say that a child qualifies for day habilitation based on a need for a service that may occur only a fraction of time(s) during the day. Making this an eligibility determiner could be subject to abuse. However, Medicaid should reimburse for nursing for children who need nursing services while in the program since that is an expense the provider has to cover (and a benefit Medicaid receives) for those children if they are to be able to remain in the program.

RESPONSE: By including nursing services in the list of services for eligibility, we are providing this necessary care to children who could not otherwise attend an integrated daycare due to their nursing needs. The goal of the EIDT program is to ensure children are provided services in the most appropriate and least restrictive settings.

COMMENT: 222.000 Retrospective Reviews
From this new section, we understand DHS is proposing to conduct retrospective reviews on top of the EPSDT screens, developmental screens, the PCP prescription, the developmental evaluation, and on-site audits by Utilization Review. These are low paying services for which retrospective reviews

will create an administrative burden on providers and a cost to the state that may not be warranted by the results. Past retrospective reviews in therapy have not achieved significant benefits, and, in fact, have resulted in a net cost to the state. DDTCS has not had a rate increase since 2010, and that was less than $1. The minimum wage has increased more than that. Has a cost-benefit analysis been conducted? What is the cost of these reviews? In what frequency will they be conducted?

RESPONSE: All services provided to Medicaid beneficiaries and billed to the Medicaid program may be reviewed. *See* All Provider Manual, Section I. The frequency and process of reviews will be established in the contract with the new prior authorization/retrospective review vendor. An RFP will be put out later this year and will be available for public inspection. DDS has a duty to ensure federal Medicaid funding is being used in accordance with regulations, therefore, we have opted to do random retrospective reviews and eliminate the majority of prior authorization requirements.

COMMENT: LEGAL COMMENTS: The Early Intervention Day Treatment (EIDT) and Adult Day Development Treatment (ADDT) rules proposed by DHS imperil federal funding for every Developmental Day Treatment Clinic Service (DDTCS) program – children and adults – across the state of Arkansas. Because the rules would replace the DDTCS program with two new programs, Arkansas would likely lose its "grandfather" status under the Omnibus Budget Reconciliation Act of 1989 **(OBRA '89).** This would leave 9,708 children and 5,056 adults in 100 different programs throughout the state without access to needed services and remove over $162 million from the local economies.

In addition, the proposed EIDT rule violates multiple federal and state laws by grafting onto the eligibility standards a requirement that a child must qualify for speech, physical, or occupational therapy in order to get day treatment. This **"one therapy" rule** violates the federal EPSDT statute, the federal "comparability" requirement, the Americans with Disabilities Act, the Rehabilitation Act, and state statutes governing eligibility for these services. The rule is not supported by clinical evidence and runs counter to decades of habilitation guidelines in Arkansas and across the nation. To pass such a rule would be akin to Arkansas allowing access to mental health treatment only for individuals who have both a mental illness and a substance abuse disorder.

While it is true that many children with developmental disabilities or delays also require speech, physical, or occupational therapy, it is also true that many do not. Indeed, Medicaid claims data shows that some 3,300 children of the 19,0001 will be excluded in the first year alone, with that number continuing to grow. In just a few years, more than 10,000 children will be forced into the ABC, Early Head Start, Head Start,

1 Approximately 19,000 children are in DDTCS and CHMS, about half in each program. The proposed "one therapy" rule would disqualify approximately 3,300 children based on the claims data, all from DDTCS. DHS has argued that it is being "fair" by also including a developmental evaluation requirement on CHMS, something the therapy-based program has not previously been required to use. DHS has not provided any data to show how many children if any would be impacted in CHMS. Various CHMS providers have been publicly supporting the "one therapy" rule.

and other programs that are underfunded, burdened by wait lists, and not prepared in terms of ratios or staff training to care for this population.

The proposed rule also results in anomalous situations. For example, a child who has a permanent and serious cognitive disability such as Down syndrome or autism might not qualify for therapy and thus be excluded from day treatment. Yet other children with only transient physical delays will qualify because of their need for therapy. Indeed, some of the those with only physical delays would come closer to readiness for a regular day care setting than those with only cognitive delays. This makes the point DDPA has emphasized to DHS repeatedly: Requiring developmental evaluations to qualify for a developmental day treatment program makes sense. So does requiring a therapy evaluation for a therapy program. But requiring a child to qualify for therapy in order to receive developmental day treatment makes no sense.

FEDERAL LAW

A. OBRA 1989

Both of the proposed DD rules – children's EIDT and adult ADDT – would jeopardize Arkansas' OBRA 1989 "grandfather" status.

Arkansas was in the forefront of states that planned and implemented a system of day habilitation programs within the Medicaid program in the 1980s as an alternative to building more state-operated institutions. Other states began implementing such programs as well. A debate soon arose as to whether these programs should be funded through State Plans, as 19 states were doing, including Arkansas, or whether they should be discretionary programs under 1915(c) home and community-based waivers.

By 1989 Congress foreclosed new habilitation day programs in State Plans, allowing them only under waivers. But through efforts of providers, advocates and others, especially Arkansas' Congressional delegation, Congress "grandfathered" the states like Arkansas with existing habilitation programs under their State Plans. This is extremely important because waivers require a higher "institutional level of care" in order to qualify, and waiver programs in many states, including Arkansas, have developed long waiting lists.

The grandfather clause was contained in the Omnibus Budget Reconciliation Act of 1989 (OBRA '89):

(g) DAY HABILITATION AND RELATED SERVICES-

(1) PROHIBITION OF DISALLOWANCE; PENDING ISSUANCE OF REGULATIONS- Except as specifically permitted under paragraph (3), the
Secretary of Health and Human Services may not—
(A) withhold, suspend, disallow, or deny Federal financial
participation under section 1903(a) of the Social Security
Act for day habilitation and related services under paragraph
(9) or (13) of section 1905(a) of such Act on behalf of
persons with mental retardation (developmental disabilities)
or with related conditions pursuant to a provision of its
State plan **as approved on or before June 30, 1989,** or
withdraw Federal approval of any such State Plan Provision.

Section 6411(g) of Pub.L. 101-239 (42 U.S.C.A. § 1396b West annotations)2. The loss of grandfather status is not an imaginary threat. A state can lose its status unintentionally. In 2006, CMS determined that Ohio had lost its grandfather status when it terminated the habilitation program that existed prior to 1989 and tried to implement a different one in 2006.

2 The reference to "except as specifically permitted" refers to (g)(2) which gives the Secretary authority to promulgate regulations "specifying the types of day habilitation and related services a State may cover..." On August 20, 2007, CMS published a proposed rule that appeared designed to

move all habilitation services out of State Plans into waivers, but the proposed rule met with opposition and was withdrawn.

Similar to the situation in Ohio, under DHS' proposed rules the DDTCS program would cease to exist. New licensure would be issued under EIDT for children and ADDT for adults. *Such a move could end Medicaid reimbursement for services not only to the 3,300 children impacted by the "one therapy" rule but also would place in risk services provided under every single DDTCS program in this state.* DHS officials are aware of the grandfather status, and DDPA brought concerns about this matter to DHS' attention in an email dated March 28, 2018, prior to the promulgation of the rules. We received no response.

B. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

1. Under EPSDT, states cannot pick and choose which allowable services under the Medicaid Act children may obtain.

The proposed EIDT rule violates the federal early and periodic screening, diagnostic, and treatment services (EPSDT) statute. This statute provides low-income children with comprehensive health care. The law mandates four specific categories of services: screening, vision, dental, and hearing services. 42 U.S.C. 1396d(r)(1)-(4). In addition, there is a catch-all provision:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section *to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services*, whether or not such services are covered under the State plan.

42 U.S.C. 1396d(r)(5). "Accordingly, every Circuit which has examined the scope of the EPSDT program has recognized that states must cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a)." *S.D. ex rel. Dickson v. Hood,* 391 F.3d 581, 590 (5th Cir. 2004) (and circuit cases cited therein, including Eighth Circuit.) There are 29 categories of allowable services under 1396d(a) of the Medicaid Act, including "clinic services" and other rehabilitative services that encompass habilitative day treatment.

The screening service a physician provides under EPSDT is what leads to identification of a child in need of services. In each case of a child in day habilitation, the physician has examined the child, referred the child to a provider for a developmental evaluation, and then issued a prescription for day habilitation. The EPSDT statute does not allow states to deny any allowable service if the physician recommends such treatment.

2. The proposed "one therapy" rule violates the *Pediatric Specialty Care* line of cases decided against DHS under the EPSDT law.

In 2001, DHS attempted to eliminate Child Health Management Service (CHMS) services. CHMS providers and parents sued DHS and obtained a permanent injunction from the district court, which was upheld by the Eighth Circuit. *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Services,* 293 F.3d 472 (8th Cir. 2002). The Eighth Circuit reviewed the evidence on the effectiveness of day treatment and reviewed the statutory language of EPSDT to conclude that "a Medicaid-eligible individual has a federal right to early intervention day treatment when a physician recommends such treatment." *Id.* at 480. See also a subsequent appeal, where the Eighth Circuit reiterated: ***"children are entitled to day treatment under the Medicaid Act."*** 364 F.3d 925, 928 (8th Cir. 2004) (emphasis added).

After the initial rulings, DHS then created an arbitrary "two therapies" guideline much like the "one therapy" rule proposed now.3 They also reduced the day treatment from 6 hours to 3.5 hours, which, of course, meant it was not really "day treatment" anymore. In doing so, the state argued that it had the right to set "medical necessity" standards. The district court took issue with the state going after "*large categories* of impaired children." 2005 WL 5660038, at *5 (emphasis added). The court emphasized that "the state may make eligibility decisions only on the basis of individual need." 2005 WL 5660038, at *5.

3 "Defendants have created guidelines where a child with a malady that creates a single impairment-requiring only one type of therapy such as speech therapy, physical therapy, etc.-is not prior authorized for CHMS services, despite the severity of the impairment." *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Services*., No. 4:01 CV 00830 WRW, 2005 WL 5660038, at *8 (E.D. Ark. Feb. 7, 2005),

4 42 U.S.C. 1396a(a)(10)(B) reads in full:

"A state plan for medical assistance must –

(10) Provide

(B) that the medical assistance made available to any individual described in subparagraph (A) [categorically needy category]--

(i) shall not be less in **amount, duration, or scope** than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A) [medically needy category].

"Any coverage denial cannot be based legitimately on the diagnosis of the recipient or on budget concerns." *Id.* at *6. This rule holds true whether the state is trying to exclude children based on a "two-therapy" rule for CHMS or a "one therapy" rule for DDTCS. A state cannot make "sweeping exclusions." 2005 WL 5660038, at *5.

While the *Pediatric Specialty* cases involved CHMS clinics, DDTCS services are also provided under EPSDT and also constitute "early intervention day treatment." See Ark. Code Ann. 20-48-1102(5). *See also*, Proposed EIDT Manual at 201.100. DHS cannot avoid the precedents these cases establish by now aligning itself with CHMS clinics and trying to deny services to needy children served by DDTCS.

C. The Medicaid Act's "Comparability" Requirement

The "one therapy rule" also violates the Medicaid Act's "Comparability" requirement. It is a fundamental principle of Medicaid law that a state cannot make a service available to some categorically needy individuals that is not made available to other categorically needy individuals. 42 § U.S.C. 1396a(a)(10)(B).

5 This law is known as the "comparability" requirement. The statute prohibits states from offering some individuals a service that is less in "amount, duration, or scope" than is offered to other individuals. In simple terms: "All persons within a given category must be treated equally." *White v. Beal,* 555 F.2d 1146, 1149 (3d Cir. 1977).

5 Individuals in traditional aged, blind and disabled Medicaid, and pregnant women and children whose income eligibility is based on the federal poverty level are "categorically needy." Those who are not eligible because their income is too high but who have high medical bills are "medically needy." The proposed rule applies to both, though most if not all the children in question are categorically needy.

6 More specifically, for children ages three to five, they must have a deficit that is at two more standard deviations from the mean in two or more of those areas. For children from birth to three years, they must have a 25% or greater delay in two or more areas.

Under DHS' proposed rule, Arkansas will pay for day habilitation only if a child's disability results in a need for speech, physical or occupational therapy. Those children whose need is primarily cognitive or social/emotional and thus not requiring therapy will be denied EIDT services. In cases dating back four decades the courts across this country have rejected attempts by states to restrict services by deciding one group is more deserving than another.

1. The proposed "one therapy" rule violates comparability by discriminating on the basis of "diagnosis, type of illness, or condition."

CMS has interpreted the statute through regulation at 42 C.F.R. 440.230, which states:

The Medicaid agency may not arbitrarily deny or reduce the amount, duration or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the *diagnosis, type of illness, or condition.* (emphasis added)

Eligibility for a particular service must be based on an *individual's* need, not a diagnosis, type of illness or condition. The comparability provision "prohibits discrimination among individuals with the same medical needs *stemming from different medical conditions.*" *Davis v. Shah*, 821 F.3d 231, 258 (2nd Cir. 2016) (emphasis added). Yet, that is exactly what the "one therapy" rule does.

Physicians and experts in the field of childhood development have for many years determined medical necessity by relying on tests that measure how a child scores in five domains: (1) cognition, (2) social/emotional, (3) communication, (4) motor development, and (5) adaptive (self-help) skills. Since its establishment in the 1980s, eligibility for DDTCS day habilitation has been based on developmental evaluations that measure functional deficits in those five domains.6 The deficits are measured through use of one norm referenced (standardized) and one criterion referenced assessment instruments to ensure that the child scores comparably on both. These same requirements are reflected in DDS Policy 1035 ("Agency Definition of Disability/Eligibility for Services").

The proposed EIDT manual retains those same requirements for eligibility as used in DDTCS but grafts an additional one on to them: the requirement that a child also qualifies for at least one of three therapies. The three types of therapies are treatment modalities and correspond to deficits in the following domains: communication (speech therapy); motor development (physical therapy); and adaptive (occupational therapy). The two domains that do not typically require therapy are cognition and social/emotional.

In the *Pediatric Specialty Care* cases, DHS tried to exclude children from CHMS clinics in a similar manner. The court viewed this as a violation of the comparability requirement, stating: "Therefore, the across-the- board denial of CHMS day treatment services to children with a single impairment raises a reasonable inference that children are being denied EPSDT services because of their disorder without consideration of individual medical need." 2005 WL 5660038, at *8. See also *White v. Beal*, 555 F.2d 1146, ___ (3d Cir. 1977) "We find nothing in the statute that permits discrimination based on etiology [causation] rather than the need for the service."

Likewise, the state cannot split hairs by making eligibility dependent on how the disability manifests itself, i.e. a need for therapy. *See Cota v. Maxwell*, 688 F. Supp.2d 980 (N.D. Ca. 2010) (eligibility requirements for organized adult day care impacted mentally or cognitively impaired adults more than those with physical disabilities); *See also, Rolland v. Cellucci*, 52 F. Supp.2d 231 (D. Mass. 1999) (exclusion of individuals with cognitive disabilities from Personal Care Attendant services). DHS' proposed rule explicitly excludes children without a physical disability: "For children who have a documented delay in the areas of social emotional and adaptive only, a referral must be made to an appropriate head start, home visiting, or Early Interventions or Part B program." 212.100 Eligibility Criteria (second "B"). In other words, these children will not be allowed to access day habilitation. This is *prima facie* discrimination and a violation of the comparability provision.

2. When a state agency tries to dictate which children have the "highest" or "greatest" need for a service, it violates the comparability requirement.

DHS does not seem to dispute that the services in question are medically necessary for those children who do not require therapy. It would be hard to sustain such an argument since DHS has been approving such services as medically necessary for decades. Instead, DHS' position is that these children have the "highest need." *See* DHS Flyer (attached). This "highest need" or "greatest need" argument has been tried many times in the past and consistently rejected by the courts for sound policy reasons since to rule otherwise would allow states to decide who is most "deserving." See, e.g., *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Services*, WL 5660038, at *5 (E.D. Ark. Feb. 7, 2005); *Davis v. Shah, supra*; *Cruz v. Zucker*, 116 F. Supp.3d 334, 346 (S.D.N.Y. 2015); *Cota v. Maxwell, supra*; *Hern v. Bye*, 57 F.3d 906 (10th Cir. 1995); *Bontrager v. Indiana Fam. & Soc. Services Admin*, 829 F. Supp.2d 688 (N.D.Ind. 2011); *V.L. v. Wagner*, 669 F. Suupp.2d 1106 (N.D. 2009).

The Eighth Circuit ruled years ago that the fact that the state considers certain individuals as the "most needy" is not a proper consideration. *Hodgson v. Board of County Com'rs, Hennepin County*, 614, F.2d 601, 608 (8th Cir. 1980). Such an approach would allow states to determine through broad generalizations who is deserving of services and who is not, and thus fails to take into account individual circumstances. In short, the fact that DHS considers those children who need speech, physical or occupational as having the "highest need" for day habilitation is not a proper consideration.

In the *Pediatric Specialty Care* cases, DHS argued then, just as it does now, that the children "don't have a serious medical problem" and could be served by "Head Start and Arkansas Better Chances [ABC]." Relying on the comparability requirement, the court rejected the argument unequivocally. 2005 WL 5660038, at *6. The judge looked to the federal statute for guidance: "[T]there is nothing in the Medicaid Act which limits EPSDT services to only children with a need for two or more intervention therapies. Therefore, the across-the-board denial of CHMS day treatment services to children with a single impairment raises a reasonable inference that children are being denied EPSDT services because of their disorder without consideration of individual medical need." 2005 WL 5660038, at *8. It is equally true that there is nothing in the Medicaid Act which limits EPSDT services to only children who need one or more therapy.

DHS position then as now was that only those children afflicted with "the most serious conditions" were entitled to day treatment. *Id.* at *8. However, limiting services prescribed under EPSDT to a "serious medical problem" would fly in the face of the statutory language and Congressional intent. The purpose behind EPSDT is to provide preventive care and to "[a]ssure that health problems found are diagnosed and treated early, *before they become more complex and their treatment more costly*." CMS State Medicaid Manual § 5010.B (emphasis added). "EPSDT was ... added to expand coverage for children beyond adult limits and to ensure availability of *treatments for conditions affecting growth and development*."7 That is the heart of a DDTCS program.

7*EPSDT: An Overview*, Commonwealth Fund, at page 1 (emphasis added), http://www.commonwealthfund.org/publications/data-briefs/2005/sep/epsdt--an-overview.

3. Rewriting the program's "purpose" to fit an exclusion does not resolve the comparability problem.

The DDTCS manual lists habilitation as the "Core" service. Speech, physical and occupational therapies are all categorized as "Optional Services." DDTCS Manual at 214.200. In the proposed EIDT Manual, DHS has reclassified the therapies as "Core" services to support the "one therapy" requirement. Proposed EIDT Manual at 213.000.

Such a sleight of hand like this does not fool the courts. In *Davis v. Shah*, New York was trying something similar by amending its state plan provision for footwear. The court noted that the state had simply amended the governing regulations to define the purpose of the treatment as coextensive with the coverage it had decided on – just as DHS is attempting to do here in Arkansas. "[A]llowing a state to deny medical benefits to some categorically needy individuals that it provides to others with the exact same medical needs simply *by defining such services –however arbitrarily – as aimed at treating only some medical conditions* would risk swallowing the comparability provision whole. *Davis v. Shah*, 821 F.3d at 257 (emphasis added).

DHS cannot get around the comparability requirement by simply redefining day treatment to require therapy in the proposed EIDT Manual. DHS has not previously used therapy to measure an individual's need for care. The current DDTCS Manual does not use therapy as an eligibility standard, nor does DHS' own DDS Policy 1035 ("Agency Definition of Disability/Eligibility for Services"). Therapy is a treatment modality – not a determination of developmental disability or diagnosis. Therapy is a separate program within Medicaid that serves children and adults, many of whom do not need day habilitation.

D. Americans with Disabilities Act and Rehabilitation Act

The proposed EIDT rule violates the Americans with Disabilities Act and the Rehabilitation Act. ADA Title II provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Similarly, Rehab Act § 504 provides that "[n]o otherwise qualified individual with a disability ... shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 29 U.S.C. § 794(a).

The standards under ADA and Rehab are generally equivalent and treated the same by the courts. *Davis v. Shah,* 821 F.3d 231, 259 (2d Cir. 2016). Because the proposed EIDT rule denies services to those children who have only a cognitive and social/emotional disability, it violates these laws. As the court stated in *Davis v. Shah*, "Any disabled persons who do not happen to suffer from these enumerated ailments are thus denied access to medically necessary assistance directly on the grounds of their disabling condition." Similarly, under the proposed EIDT rule, any children with disabilities who do not happen to need at least "one therapy" are denied access to day habilitation directly on the grounds of their disabling condition.

The fact that the "one therapy" rule is applied to all children does not mean it is not discriminatory. It still has a disparate impact on a whole class of children who do not need therapy. *Cota v. Maxwell*, 688 F. Supp.2d at 996. Any time a criterion "screens out or tends to screen out an individual with a disability or a class of individuals with a disability," it violates the law. *Id.*

ARKANSAS LAW

A. Act 1792 of 2001

The proposed "one therapy" rule violates Arkansas law on eligibility standards.

The EIDT "one-therapy rule constitutes a violation of Arkansas statutes. More specifically, Act 1792 of 2001, states:

(a) *Eligibility for services* and appropriate placement in the least restrictive environment for individuals with developmental disabilities under any of the service models included in the state's Medicaid plan with the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services or for services covered from state general revenue dollars *shall be made by the interdisciplinary team* composed in keeping with federal and state laws pertaining to individuals with special needs. This section does not negate nor preclude the rights of individuals with developmental disabilities under existing federal and state laws.

Ark. Code Ann. 20-48-703(a) (emphasis added). The interdisciplinary team is comprised of the parent/guardian, special educator, and representatives from each discipline necessary to provide for day habilitation, therapies or other treatment needs according to the results from the assessment data.

In the next paragraph, the statute states: "[T]he Department of Human Services will accept an *individualized family service plan or an individualized program* plan developed in conformity with all applicable state and federal laws as prior authorization for Medicaid-covered therapies provided to persons with developmental disabilities." 20-48-703(b) (emphasis added).

The statutes also establish the treating physician – not DHS – as the *gatekeeper* for these services. Ark. Code Ann. 20-48-703(c) (no prior approval can be required for developmental day treatment services "where the individual's primary care physician, independent of the providers, serves as the gatekeeper and prescribes day treatment services.")

The statutes make clear that the physician as gatekeeper, and the interdisciplinary team, not DHS officials, are to determine which children are in need of the services. The whole concept of individualized family service plans is that they must be individualized – no two children are exactly alike.

The proposed "one-therapy" rule is an across-the-board requirement that runs counter to that whole concept. The legislature has not authorized DHS to circumvent the treating physician or the interdisciplinary care team. Moreover, if the need for therapy were a true determinant of who needs day habilitation in each case, then interdisciplinary team and physicians would be using that for their determinations. DHS is acting in contradiction to 20-48-703 in the promulgation of the "one therapy" rule.

B. Arkansas Administrative Procedure Act

The proposed "one therapy" rule violates the Arkansas Administrative Procedure Act in at least three ways.

Under the Arkansas Administrative Procedure Act, a rule will be invalidated if it does not meet certain standards:

(h) The court may affirm the decision of the agency or remand the case for further proceedings. It may reverse or modify the decision if the substantial rights of the petitioner have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:
(1) In violation of constitutional or statutory provisions;
(2) In excess of the agency's statutory authority;
(3) Made upon unlawful procedure;
(4) Affected by other error or law;
(5) Not supported by substantial evidence of record; or
(6) Arbitrary, capricious, or characterized by abuse of discretion.
Ark. Code Ann. § 25-15-212.

The proposed "one therapy" rule violates at least three of these grounds: (1) in violation of state and federal statutes discussed above; (2) in excess of DHS' authority as limited by the General Assembly through Ark. Code Ann. 20-48-703 discussed above; and (6) arbitrary and capricious in that the "one therapy" rule is simply a crude way of reducing services not tied to any rationale that would support it.

While DHS has claimed that the children excluded under the proposed rule could be served in regular preschool settings, it is not a need for therapy that is the chief indicator of whether a child will be able to function in a regular preschool setting. Therapists can and do treat children in regular preschool settings. The determination of where a child can best be served is the *developmental* evaluation.

The disconnect between day habilitation and therapy is further evident when one reviews the rules for adults. Even though DHS proposes to start requiring children to qualify for therapy in order to get habilitation, adults will not be able to receive therapy unless they qualify for day habilitation. See ADDT Manual 216.100. Thus, the rule is completely the opposite for adults. The proposed "one therapy" rule is so arbitrary it defies logic – and the law.

RESPONSE: We strongly disagree with your interpretation of state and federal law.

39. TOM MASSEAU, EXECUTIVE DIRECTOR, DISABILITY RIGHTS ARKANSAS, INC.

COMMENT: Generally speaking, DRA is not opposed to the idea of combining early intervention day treatment services into one program. However, as will be more clearly explained below, there are many issues that the proposed EIDT manual raises that are concerning and that need to be addressed prior to DHS finalizing this plan.
First, DRA recognizes the benefits to all children that receive access to quality education and services. DRA also believes that children with disabilities greatly benefit when provided services and education in inclusive settings and actively encourages and supports the idea that children with disabilities should receive an education and quality services with their nondisabled peers as much as possible. That said, DRA is concerned that access to these services may not be a reality in many locations of our State without careful consideration of available resources.
Many communities throughout the State struggle with easy access to services for people with disabilities, both children and adults. The EIDT manual is silent on how DHS will address service provision in underserved areas when shortages of non-developmental programs are identified. Subsidized child care programs, such as those that utilize vouchers, are historically underfunded, resulting in waiting lists for child care assistance. Underserved areas with shortages of non-developmental programs are also areas that often lack adequate access to occupational, physical, speech, and other therapies, thus reducing the likelihood children will receive the early interventions designed to help them 'catch up' to their typically developing peers. Due to the importance of early intervention services, DRA recommends that both the Division of Developmental Disabilities Services and the Division of Childcare and Early Childhood Education work with the Arkansas Department of Education to develop and provide a clear plan for ensuring that children will have ready access to early intervention services in whatever setting they choose prior to instituting the one therapy rule.
In addition, DRA has learned that there is concern that the proposed programmatic changes may detrimentally impact the State's ability to fund these programs under the State Plan. DRA recommends that DHS address this concern and provide assurances that any proposed changes will not impact available funding for services.

RESPONSE: We appreciate the support regarding merging the early intervention day programs in the state. We will continue to work with ADE regarding funding issues for child care.

COMMENT: Early intervention day treatment is defined as "services provided by a pediatric day treatment program run by early childhood specialists, overseen by a physician, and serving children with developmental disabilities, developmental delays, or a medical condition that puts them at risk for developmental delay." Ark. Code Ann. § 20-48-1102(5)(A) (emphasis added). The legislation was designed to capture eligibility for children that have been diagnosed with any one of the above-mentioned categories, each independent of the other. However, the EIDT manual uses "and" in place of "or," which makes a requirement that children have all three-a developmental disability, a developmental delay, and a medical condition-in order to need early intervention day treatment. DRA recommends the language in the EIDT manual be revised to align with authorizing legislation. "Early intervention day treatment includes without limitation diagnostic, screening, evaluative, preventive, therapeutic, palliative, and rehabilitative and habilitative services, including speech, occupational, and physical therapies and any medical or remedial services recommended by a physician for the maximum reduction of physical or mental disability and restoration of the child to the best possible functional level." Ark. Code Ann. § 20-48-1102(5)(B) (emphasis added).

In addition to Arkansas law, the federal early and periodic screening, diagnostic, and treatment services (EPSDT) statute prohibits placing limitations on allowable services and provides for broad coverage of medically necessary services for children under age 21.
In the EIDT Manual, DHS proposes placing limits on receipt of the following services: year-round day habilitative services and summer habilitative services limited to five (5) units per day; nursing services limited to four (4) units per day; speech therapy limited to six (6) units per week; physical therapy services limited to six (6) units per week; occupational therapy services limited to six (6) units. Placing limits on services is not allowed under both state and federal law and is not supported by the basic premise of early intervention (EI) programs - to reduce a child's medical or physical disability and restore the child to the best possible functional level. EI promotes overall child development; it provides a support system not only for the child, but also the family; and it supports a child's skills and abilities to achieve their highest level of independence. DRA recommends that DHS remove the limitation on services to align with state and federal requirements.

RESPONSE: We are not eliminating the First Connections Early Interventions grant.

COMMENT: Successful transition from pre-school to kindergarten is vital to establishing a solid foundation for the provision of educational services to children with developmental disabilities, developmental delays, or medical conditions. The involvement of local education agencies (LEA) in this transition process prior to entry into kindergarten provides for the development of individual educational programs with appropriate services and accommodations needed. Programs that choose to 'opt out' increase the transition burden on small rural school districts. While it is true that a participating EIDT is eligible to receive a portion of the federal grant funds made available to LEAs under Part B, funding for IDEA Part B is not fully funded at the federal level resulting in inadequate funding, specifically for children ages 3-5, to offset the costs of providing special education services to children with disabilities. Independent Treatment Plans (ITP) should contain goals and objectives that are measurable and reference progress toward achieving stated goals and objectives. Additionally, a description/definition is needed for the term 'remedial' services. The EIDT manual also does not include the requirements outlining special education referrals to the appropriate LEAs. DRA recommends that the EIDT Manual be revised to address all of these concerns.
In addition, the EIDT Manual refers to the DPSQA EIDT Licensure Manual for clarification on Special Education Services. However, the DPSQA EIDT Licensure Manual is not available for public view or commenting. Therefore, DRA is concerned that DHS has not provided all information necessary to ensure a meaningful opportunity for public comment on this important area. DRA recommends DHS immediately provide access to this information for public commenting prior to finalizing the EIDT Manual.

RESPONSE: The Center-Based Standards for Community providers have been in place and applicable to DDTCS. We revised these existing standards to apply to the new EIDT and ADDT programs. However, the workgroup that assisted with the development of the EIDT and ADDT programs will reconvene to discuss any needed amendments to these standards beginning in May, 2018.

COMMENT: DHS has not provided clinical justification for the requirement that a child have a documented need for at least physical, occupational, speech therapy, or nursing services. It is viewed merely as a programmatic compromise between the two therapy requirement for existing CHMS programs and a zero therapy requirement for existing DDTCS programs. The requirement of one therapy places a limit on services available that is contrary to the authorizing language of Ark. Code Ann.§ 20-48-1102(5)(B) that states "early intervention day treatment includes without limitation ..."

The imposition of the one therapy rule has the potential to negatively impact children with certain disabilities, including those with fetal alcohol syndrome disorder (FASD), opioid dependence, or premature birth, who are at a higher risk of developmental delay yet too young to be adequately evaluated against the baseline eligibility criteria to receive services from an EIDT. These are high intensity-need children that, if determined ineligible to receive services in the existing programs, will move into childcare programs in their communities that may be ill-equipped to address their needs. The move from a year-round developmentally enriched program into a more traditional nine-month childcare program reduces the overall amount of time a child experiencing developmental delays has to receive needed services. Parents may be placed in a position to seek out private developmental and therapeutic services in the summer. Or, worse case, the one therapy requirement may deny some children with disabilities needed access to very important early intervention services. DRA is concerned that there will be inadequate resources available to serve the children identified as no longer eligible to receive developmental services in both childcare venues and available therapeutic support services. DRA recommends that DHS carefully evaluate the options available to those children who might be found ineligible before instituting the one therapy requirement in order to ensure that children with disabilities have access to early intervention services.

RESPONSE: In addition to our previous responses, we did assemble a workgroup of physicians who specialize in pediatric development to finalize the eligibility criteria.

COMMENT: Under the current CHMS program, the staff to child ratio for children age six (6) and up is one staff to every ten (10) beneficiaries. DRA recommends inclusion of the designated staff/child ratio in the newly created EIDT. Additionally, DRA requests clarification regarding the statement "additional staff must be provided for children with significant medical or behavior needs that require individual attention." How will this be determined? What type of additional staff? Children with developmental disabilities and delays are often expelled from programs at a disproportionately higher rate than typical children due to inadequate access to services and supports. DRA recommends that the EIDT Manual include information on what EIDT programs will do to support and serve children with disabilities who have behavior support needs.

RESPONSE: Child to staff ratios are outlined in the EIDT manual. If they have other medical or behavioral needs, it should be addressed by the child's nursing or behavior management plan.

COMMENT: References throughout the EIDT Manual provide for summer habilitative services for children ages 6-21. However, Section 214.500 seems to limit this to only those individuals up to the age of 20. DRA recommends that DHS revise this section for consistency and to ensure that individuals will have access to summer habilitative services through the age of 21.

RESPONSE: The services are to be provided to children through the age of 21, this will be clarified as needed.

COMMENT: As briefly discussed above, the proposed EIDT policy no longer includes licensure and certification criteria as outlined in the existing CHMS program. The proposed EIDT policy references additional manuals and source information -DPSQA EIDT Licensure Manual and Manual Governing

Independent Assessments and Developmental Screens -for example, for which the Division of Provider Services and Quality Assurance (DPSQA) is responsible that are not available for public review in conjunction with these changes at this time. DRA recommends the EIDT policy include a link to these manuals to assure access to these standards for a simultaneous review in order for meaningful public commenting.

RESPONSE: See previous comments about the updated Center-Based Licensing Standards.

COMMENT: Manuals for existing programs include procedures for requesting extensions of benefits. This information is lacking for the EIDT program. The policy does not provide an explanation of who is responsible for submitting requests for benefits extensions nor how it is to be done. Arbitrary limits established for core services sets the stage for an unending cycle of benefits extension requests involving regular habilitative services, summer habilitative services, nursing services, etc. thus placing an undue burden on parents, physicians, and service providers.

RESPONSE: This language will be added back in where appropriate. Please see previous comments.

40. ELAINE EUBANK, PRESIDENT/CEO, EASTER SEALS

COMMENT: The proposed rules threaten federal funding for every DDTCS program - for children and adults - across the state of Arkansas. This is because both rules would replace the DDTCS program with two new programs, thereby likely losing Arkansas' "grandfather" status under federal law. If Arkansas loses its grandfather status, over 14,000 children and adults will be without these critical services and the waiting list for waiver services will increase dramatically and immediately.
In addition, the proposed EIDT rule requires that a child must qualify for speech, physical, or occupational therapy in order to get day treatment. This "one therapy" rule discriminates against children with autism, down syndrome and other cognitive and social/emotional impairments that are not "physical." There is no clinical basis for requiring a therapy in order to receive day treatment services.
Within a few years, this will create an influx of I 0,000 additional children into state-funded settings such as ABC and public pre-k programs; federally-funded Head Start and Early Head Start; and regular day care, none of which have the funding, staff, or infrastructure to serve these additional children with significant developmental disabilities or delays. It will leave no option for many families whose child has been rejected by or will not be accepted by these other programs.
The consequences of these proposed rules will be devastating. I am asking that you pull down these proposed rules and re-engage with all stakeholders to thoroughly evaluate the current system of services for children and adults with developmental disabilities as well as the early childhood service system and develop a plan with resources to insure a continuum of quality services and supports.

RESPONSE: This rule has been under development since 2013. DDS has engaged with the provider community extensively on this program. We continued to work with DDPA providers until March 2018, when the proposed rule was released. The rules have a built in transition period for all children, so that no services will be disrupted.

41. MARGARET PACE

COMMENT: PULL THE 1 THERAPY RULE! Do not take much needed resources from families in Arkansas.

RESPONSE: This rule has been under development since 2013. DDS has engaged with the provider community extensively on this program. We continued to work with DDPA providers until March 2018, when the proposed rule was released. The rules have a built in transition period for all children, so that no services will be disrupted.

42. SUSANNE JACKSON, CFO, ELIZABETH RICHARDSON CENTER (AT PUBLIC HEARING)

COMMENT: My name is Susanne Jackson, and I am the Chief Financial Officer at the Elizabeth Richardson Center. I'm tackling this from a totally different perspective. I'm tackling this from a financial perspective, and I'm very concerned about some of the rulings and things that are about to happen. For instance, right now in our centers, there is about a dozen children that are only in habilitation and they are not in therapy. Habilitation doesn't mean that we are just housing them and babysit them. That is an extension of the care and the therapy that we provide with our therapists already. So, 12 of these kids would drop off right now.

The other point I want to make is, our parents are not very educated on the bureaucracy in Little Rock or DHS. We have to walk them through everything. We have people that work with them to apply for all the different therapies. We have to spend an enormous amount of administrative time to get these kids enrolled. It takes right now 46 days to get a kid in center. You add three more layers of checking and testing on it, when I open the center up after the vacation time in July and August, my centers are not going to be full. I'm going to have to run the centers on full staffing with less children and I'm going to run at a loss. If we do that, we are going to run ourselves out of business. That's a concern I have.

The other thing is, as a grandmother of a child that is dyslexic and was just diagnosed, she is in the school system in Prairie Grove, we were told by the Prairie Grove school system that they can't provide therapy for her. They can't even do that for the kids in the school system. So what are they going to do with our kids? And we cannot set them up to be successful because we are not going to have them in the center, so they start in the new school system and there is nothing there to support them. That's all things that goes through my mind.

Then, also, when it comes from the old system and the new Medicaid portal they rolled out, and my biller that spends hours and hours every week on the phone to try to get kids approved to receive therapy, to try to get claims that were denied active again, kids that dropped off the Medicaid rolls for no apparent reason trying to find answers why, staying on the phone for hours, talking to five different people, getting five different answers, then have to go through e-mailing and our support in the House here in Little Rock to get to the people who put some pressure on the people in charge to get us some answers. Up to Facebook that all our providers organized a Facebook page where we share our information and our knowledge, because it's so darn hard to get our claims paid. And now you are going to put a third-party in the middle of it that is supposed to save money. Me, from an administrative and financial perspective, I tackle that totally different. And I came to Elizabeth Richardson a year ago. We are trying to adjust to the new world. So, for us it is, we have to readjust our business, streamline and everything. I haven't seen that here happening in OHS. Clean your house first, streamline your stuff, make your APAR and all the functions sustainable, and then we talk about reform.

RESPONSE: Thank you for your comment, please see previous responses.

43. STEPHANIE SMITH, COO, EASTER SEALS (AT PUBLIC HEARING)

COMMENT: I'm Stephanie Smith, I'm the COO for Easter Seals Arkansas, I'm also a DDPA and CHMS and DDTCS provider. And I get real nervous, so I'm going to read.

In principle, we support the merger of the two programs and the design of the EIDT program with the exception of the one therapy requirement for children with developmental disabilities or delays to qualify for habilitation services. We strongly believe that with the new requirements for the independent screen and the annual developmental evaluation, that more children will transition from the EIDT program to other program settings without the addition of the one therapy requirement for eligibility.

We would again request that the new program model without the one therapy requirement be implemented, and then collaboratively, the providers and DHS evaluate the outcomes of the new model and make appropriate changes based on measurable outcomes. At the same time, the state and early childhood stakeholders can also evaluate the capacity of the other early childhood programs with respect to available slots, funding, staffing credentials, training, workforce, and access. In collaboration with all stakeholders, a long-term plan and timeline for a statewide array of quality and comprehensive early childhood programs that can meet the needs of all children, especially those that transition from one program to another could be developed and implemented. Therapy (OT, PT, and speech) and habilitative (developmental pre-school) services and the need for either or both are independent of each other; a child qualifying for habilitative services is not indicative that the child needs therapy or vice versa. The one therapy requirement to receive habilitative services has no clinical basis. It is also inconsistent with how the state has defined eligibility for similar services.

Just to give all an overview, if we just remove the one therapy requirement, the steps that a child would have to go through just to still get services. First, the child's PCP will complete the EPSDT and, if they follow the APA recommended schedule, from the time that they are born to four years of age, they will have had a total of 11 EPSDT screens. These screens include a developmental assessment. And, I'm going to try to be brief here. That assessment is done by a history, observation of a child, or by one of the developmental tests. This portion of the EPSDT includes assessment of eye-hand coordination, gross motor function, fine motor skills, speech development, daily living personal skills, behavioral development, and proofs of mind with body integration. It's designed to give the PCP the information he needs to determine if a child needs to be evaluated and receive additional services to address concerns in the development of the child.

Now, based on his interpretation of the results of the screen, he will refer the child to an EIDT program because he has identified the child to have a developmental disability, delay, or be at risk for delay. We will now schedule the independent screen with Optum to determine if the child qualifies to be evaluated for services not for services, but qualifies to be evaluated. The independent screening requirement by Optum is currently being implemented in phases with full implementation on July 1st.

If the child fails the independent screen, the PCP will receive the report and then write a prescription referring the child for a full developmental evaluation. If the child qualifies for hab services based on the developmental evaluation, he will then write a script for the habilitation services. He can also choose not to write a script. And it is important to note that the child must qualify annually for these services.

Again, there is not a clinical basis for the one therapy requirement, and it marginalizes the results of the EPSDT assessments by the PCP, the independent screen and the full developmental evaluation. What other services in Medicaid have three levels of qualification for a single service that is then contingent upon requiring a child to be eligible for a completely independent service?

It should also be noted that if the one therapy requirement is implemented: After the child has failed independent screen, the child will have to be referred by the PCP for one to three therapy evaluations at the same time they are getting their evaluation for hab. As a result of the one therapy requirement, if it's implemented, we anticipate growth in therapy utilization both in evaluations and in treatment for this age group. At this time, it's not quantifiable, but we do anticipate it will be significant.

Lastly, there is no plan. In 2013, Representative David Kizzia sponsored a study, "The Effective Use of State Resources and Coordination of Programs to Improve Educational Outcomes for Children Birth to Age Five". The same areas of concern still exist today that were identified in the study: Access, funding, staffing with respect to workforce availability, credentials, training, and ratios. Our state's highest level ranking for quality childcare providers is a level three, which is still not equivalent to the highest level programs in other states. Per the study, I quote, "With its comparatively high level of poverty among children under five, Arkansas' resources to meet the needs of low income children is difficult. Additional concerns include substantial service delivery challenges in many of the more isolated rural areas. When low income children have special needs, the ability of current early childhood education programs to meet increased levels of need is strained. Underserved low income children may have physical or developmental disabilities, live in unstable homes, or in homes where English is not spoken. They have needs for more resources than even other low income peers, yet they often have less access to programs and providers that can meet their needs." This is not to say that efforts are not being made to address these areas, but not to the point that the existing ABC, Head Start, Early Head Start, Public Schools, and regular day cares have the capacity or resources to effectively serve children with developmental disabilities or delays and they will not have that capacity in a year.

The one therapy requirement not only hurts children with developmental disabilities and delays, it hurts all children served by our state's early childhood programs. Again, we request that the one therapy requirement for eligibility be removed from the proposed EIDT manual. Thank you.

RESPONSE: This rule has been under development since 2013. DDS has engaged with the provider community extensively on this program. We continued to work with DDPA providers until March 2018, when the proposed rule was released. The rules have a built in transition period for all children, so that no services will be disrupted.

44. JANIE SEXTON, DDPA AND BUILDING BRIDGES DEVELOPMENTAL AND COMMUNITY SERVICES (AT PUBLIC HEARING)

COMMENT: I'm going to be brief. My name is Jamie Sexton, I'm representing DDPA, and also a new name for us, Building Bridges Developmental and Community Services. Okay. Stephanie pretty much took all my comments. So, I'm just going to reiterate a couple of them. I was on the work group working with CHMS and DHS, working on these rules. So I agree with what Stephanie said. We are pretty much in agreement on the principle of these programs. Merging the two programs, having similar staffing ratios and available services, that all makes sense to me. We also share the goal of making the program sustainable over time, and also efficient.

Now, I want to tell you just briefly, my background is as an occupational therapist. This one therapy rule, as a clinician, baffles me. I cannot -- not I. I say, "Well, maybe it's me, I am kind of old, I will go back and research." Nothing in the literature supports having one service makes you eligible for other services. And I know that's not exactly what it says. But, basically it says, "if you"— the rule says, "if you are going to qualify for habilitation, you must also qualify for a therapy in order to receive habilitation." That makes no sense to me in a clinical manner, 31 years' experience, that makes no sense.

And I agree with CHMS, that's exactly what we see, kids are failing in cognitive, communication, and personal-social. Those are the kids I worry about. Because the kids that I see that have those delays, they are right on the edge of meeting the criteria. Medicaid has done a really good job of making speech criteria really, really hard to qualify for. So, they might be on the edge but they don't meet all those qualifications.

Those kids are the kids in our centers that have been exposed to trauma. Many and I won't say all of these children. Many of these children, many of these children live in rural areas, they have been exposed to trauma that we cannot even imagine.

Other causes for -- to explain why a child would need habilitation and not therapy: Poor birth outcomes, children that are born with low birth weight, prematurity, inadequate stimulation in the home, malnutrition, chronic ill health, psychological or familial situations or other environmental factors. Those are conditions that can -- many of those children do need therapy. But there are some children that fall in this range that do not need the therapy. And I don't believe that we should be providing therapy if they don't need the therapy.

I want to reiterate what she said about the process to get services starting on July 1st. Imagine you are a parent, you go to your physician, you get the EPSDT screening and they say, "You need more services. I see some concerns." So, then, you are going to go through Optum -- which by the way our state is investing a lot of money in, so I have high hopes that they are going to do an excellent job in these screenings. They have the screening, and then they go to a provider and they have a full developmental assessment, and they are told, "Your child has a delay. But not only that, now you are also going to be available for therapy, and if you don't need a therapy, we are going to send you somewhere else." Now, I don't know about the children you all work with, but the children that I work with, that's going to be traumatic for them and the families. It's going to be a very difficult process. DDPA feels like that these processes are enough to make sure we have the right kids in the right services.

And I've got one final suggestion. I have been working in this field a very long time, not only in this state, but in the State of Georgia. And one thing that I feel strongly about is that we—Stephanie mentioned it about a study. We need to study this, we need to revamp our whole early childhood system. We are just picking out a piece and making a change. And, I'm telling you what I feel, is it going to implode the entire system. I feel like it's going to implode. I have talked to teachers that are concerned about this, I have talked to LEAs, I have talked to other early childhood, people in ABC, they are very concerned about what this is going to do to the entire service system. They suggested to me, "Let's all get at the table, let's all hash this out and make sure we get the kids where they need to be served. 11 Thank you.

RESPONSE: Please see previous comments.

45. CINDY ACREE, CEO, ELIZABETH RICHARDSON CENTER (AT PUBLIC HEARING)

COMMENT: There are only a few states left that offer this day treatment program. And the definition of these services are day treatment. It is not just therapies. There are other supports that these children need· that our public schools can't provide. I want assurances that we are not starting in bits and pieces to increase the requirements for eligibility so that we can tear away at the program and totally eliminate it. I think that many of our providers are doing everything they can to provide cost effective services. I mean we are operating businesses. We want to see as many kids as we can see. But if we delay getting kids off our interest list and into services, we are not serving the very population that we are designed to serve.

We also are working to work together, collaborate to help cut costs. If there are a few bad apples out there, then let's address compliance with the rules, but let's not punish our kids by making it more difficult for them to get the services they need.

RESPONSE: Thank you for your comment, please see previous responses.

46. SABRINA WOODSON (AT PUBLIC HEARING)

COMMENT: I also will read. The controversy of the one therapy rule is very simple to me, it's called a conscience. 3,300 children initially losing services is wrong, 10,000 children within a few years is catastrophic for our children in the State of Arkansas. Not every child needs to be tested for all therapies. There will be more costs with therapy evaluations and therapy at which the children we are serving right now for habilitation works, sometimes with therapy and sometimes without. It's called individualization.
I oppose the one therapy rule. I do believe there are cognitive, communication, and social delays, and they are real. Qualifying for therapy does not make them less real. $24 million we have used for third-party testing, and that's a lot of money. I, as an early childhood Special Ed teacher with a Master's degree, feel like I have been told that I do not and cannot test when I have the degree and I have the experience. It's like I have not been doing the job that I have been -- that I have learned to do.
We already have to obtain a prescription for these children to receive habilitation services. When did a doctor's prescription not become enough justification? Working with these children that I have worked with for almost 20 years, I have seen these children come in and have environmental delays -- or environmental factors that affect them. But by the time they get ready to go to kindergarten, they are caught up. And it's not that they have to have OT and PT and speech. What we do are good services, they are much needed services. And as a taxpayer, I believe in my services and I believe in the services that we provide for these children. So, to me, I oppose the one therapy rule and I believe it is wrong.

RESPONSE: Thank you for your comment, please see previous responses.

47. TINA OSBURN, OT, BUILDING BRIDGES (AT PUBLIC HEARING)

COMMENT: Again, I'm an occupational therapist, therapy coordinator, I supervise 16 therapists. We have a great program. And again, I will make this short and sweet. One reason I came up here is for a whole different topic, is the prescription. But I will say that I do not support one therapy. I believe these services are here and for a reason they are here, and therapy has always been optional. These kids, a majority that we see, they will not go to an ABC program, they will not go to a pre-K, they do not have transportation, the parents will not care. And I hate to say that, but they won't. They won't -- we will refer them wherever, we do it right now, and they don't take them. We can't even get them in our door for intake half the time because they don't have transportation.
These services are here for a reason. And therapy is very important. I'm an occupational therapist. I would see every kid that walked in the building, but I don't, they don't need me all the time. Sometimes they just need that classroom and that classroom only.

RESPONSE: Thank you for your comment, please see previous responses.

48. KATHRYN LOYD WILSON, MITCHELL BLACKSTOCK LAW FIRM ON BEHALF OF SOUTH ARKANSAS DEVELOPMENTAL CENTER FOR CHILDREN AND FAMILIES (AT PUBLIC HEARING)

COMMENT: I have also been requested to submit some comments on behalf of the South Arkansas Developmental Center for Children and Families. Their concerns revolve around whether this plan is in conflict with the Social Security Act as amended by OBRA in '89. And they have written comments that I'm going to give to you.

(WRITTEN COMMENTS SUBMITTED BY RITA M. TAUNTON)
The proposed State Plan Amendment (SPA) that DHS went public to explain to a statewide audience on Feb 2, 2018, is in conflict with Title XIX of the Social Security Act as amended in OBRA '89. There is no requirement for a child with developmental delays to require a therapy in order to be eligible for the day habilitation services; this is arbitrary and discriminatory for the group of children with diagnosed developmental delays. (Impacts approx. 3300 children in first round & multiples in subsequent years.)
OBRA '89 (federal law) brings broad-based evidence that Day Habilitation is indeed considered a "medical" or "medically necessary" service under the Federal/State Medicaid partnership:
(G) DAV HABILITATION AND RELATED SERVICES-
(1) PROHIBITION OF DISALLOWANCE; PENDING ISSUANCE OF REGULATIONS- Except as specifically permitted under paragraph (3), the Secretary of Health and Human Services may not-
(A) withhold, suspend, disallow, or deny Federal financial Participation under section 1903(a) of the Social Security Act for day habilitation and related services under paragraph (9) or (13) of section 1905(a) of such Act on behalf of Persons with mental retardation (developmental disabilities)
Or with related conditions pursuant to a provision of its State plan as approved on or before June 30, 1989, or Withdraw Federal approval of any such State Plan Provision.
* Social Security Act. Section 1901 of the Social Security Act reads, "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish ... 2) rehabilitation (habilitation) and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title."
* Any revised rule should make clear that the state will continue to cover preventive services including habilitation services and other services for people with intellectual and other developmental disabilities that meet the requirements of 42 C.F.R. s 440.130(c) (Social Security Act). Nowhere in federal law is it required that a child has to have a therapy in order to receive habilitation services.
• In reality the proposed rule would narrow the scope of services that providers have been providing under Medicaid, and imposes requirements that will have a significant financial and administrative impact on community-based services as described in Act 1792 of 2001.
* Any revised rule should make clear that the state will continue to cover preventive services including habilitation services and other services for people with intellectual and other developmental disabilities that meet the requirements of 42 C.F.R. s 440.130(c)
• We believe that the proposed changes would restrict access to services and cause significant harm to children with intellectual and other developmental disabilities in two major ways: l}. it eliminates the longstanding option for community-based services for providing day habilitation to children with developmental delays who do not have a need for speech therapy (ST), occupational therapy (OT) or physical therapy (PT) and 2) it imposes a discriminatory and arbitrary exclusion from receiving many habilitative and related services.
• There is no research in the IDD field that supports that a child must have a need for a therapy in

order to benefit from habilitation. Habilitation provides the specialized intervention for improving or eliminating developmental delays that impair the foundation for future learning and development of skills as well as providing training for attaining social skills needed to attend and function in a classroom setting so that optimal learning can occur. It prepares them to move on to the public school setting with fewer deficits.

* The impact of the proposed rule on children who are Medicaid beneficiaries will not fully comply with Medicaid's Early and Periodic, Screening, Diagnostic and Treatments (EPSDT) requirements. The EPSDT mandate requires that all Medicaid beneficiaries under age 21 must receive all necessary services listed in section 1905(a) of the Social Security Act to correct or ameliorate physical or mental illnesses and conditions (includes intellectual and other developmental delays and disabilities) regardless of whether those services are covered under a state's Medicaid plan. The DHS proposed SPA excludes a whole group of children who are Medicaid beneficiaries who are in need of habilitation but not ST, OT or PT. Any children excluded through this SPA for Medicaid will require services which the state will pay for with GR or other funding.

* The proposed rule does not address Transportation Services that are critical to provide ACCESS to DHS recommended services for the children excluded by the "one-therapy rule" in rural communities in this largely rural state. Without Transportation services many children diagnosed with developmental delays will not benefit from the service options in the State's Medicaid State Plan and will go from one chronological age to the next without the needed habilitation/early intervention needed to improve or ameliorate their delays. This presents a barrier that could prevent Medicaid beneficiaries from receiving "medically necessary" services covered by the SSA. This is a huge cost to that child's future and quality of life and a increased cost to the state for long term care costs.

RESPONSE: Please see previous responses regarding OBRA '89.

49. JENNIFER BLOCK (AT PUBLIC HEARING)

COMMENT: My name is Jennifer Block. I am in Hope, so rural southwest Arkansas. I do oppose the one therapy rule. I think that it is wrong to take children that are presently diagnosed with developmental
disabilities and tell them they have a year left of services when they are a year old now. So, that troubles me for my area and for these children. Some of our population right now is under the age of three. So,
when you are looking at discharging them next year in June of '19, there are no birth-to-two programs to take these children on, take them in their center. There are no other day cares in one of my counties that we serve. That is very troubling. We talk about ABC a lot; we talk about Head Start. I am not aware of any new Head Start funding coming from the feds or Early Head Start. So, that is very troubling to me that these young children that have a diagnosed developmental disability will not receive services.

Also, just to make a comment to the children, the 3,300 that have not been tested for PT, OT, speech. I can tell you the children in my center that do not qualify presently for PT, OT, and speech have been tested and are tested annually for that, and they just do not qualify, but they do qualify for day habilitation. Also, we talk about these children moving to alternate programs. These alternate programs are not year-round; they are based on a school year. So, you have three months of regression that they have to start all over again when they come back into a new school year. So, I think that is very important to point out. Thank you.

RESPONSE: Thank you for your comment, please see previous responses.

50. LAINEY MORROW, PARENT, MEDICAID SAVES LIVES (AT PUBLIC HEARING)

    COMMENT: I'm a parent, not a provider at all, so excuse me if I don't speak correct terminology or with the education that you all might speak. I think that it has been adequately addressed some of the concerns about children losing services and transportation. So, I would like to address a couple of other concerns. I would like to see parents officially notified that their child would be affected. Because of the differences of opinion, there are parents who don't realize whether they would be affected or not. So, they aren't speaking up because they don't know, they aren't making alternate plans because they don't know. Another area of concern that I have heard is that -- and it has been discussed tonight -- whether slots can be opened up at different programs around the state. I would just like to see a plan for how that would be so that if a parent is in an area where there isn't currently a slot, that they would understand how it would become available or how they, themselves, could enact that. I would also like to request a specific plan for what parents can do in the case that after they were to be transitioned to another center, if that's not working for their child, what would they do then. And I think that -- I have seen parents who agree with this proposal because they are concerned for the longevity of the program, I but I have also seen parents who disagree because they are concerned about loss of services for their own child. And I think that these particular things might help with this, assuming the rule goes through. Thanks.

    RESPONSE: Thank you for your comments. Please see comments above, specifically those related to the panel being created to track children transitioning out of EIDT into federally funded daycare.

51. TERESA LITTLE, MILESTONES SERVICES, INC. (AT PUBLIC HEARING)

    COMMENT: I forgot my notebook, which is par for the course. So, I'm going to wing it for just a second. I won't talk very long. I have been at Milestones for 35 years. I was the Early Childhood Director for 33 years. I have been around a long time. If you know me, you know I love children. There has kind of been intimated that we take children and we keep them and we don't let them go where they need to go, and that is not true. If that is the problem, then I think then those programs need to be looked at, not all the children in the state punished. We have three children right now that this will affect. And so, talking with my legislators and talking with people, it's like, well, I've just got three right now. But I have those three. And I'm not just speaking for them, I'm speaking for all the children in Arkansas. I'm speaking for those 3,300, in three years, those 10,000. I know this state, I'm from rural Arkansas. I'm from Perry County, I'm a Perry County girl. And I'm worried about those children. In Perry County, there are 17 slots in Head Start, it's all the way at the other end of the county, they do not have any more spots. The ABC is all at the other end of the county in East End. They do not have any more ABC slots. In the middle of the year, when we refer in Conway, those programs are full in the middle of the year, and those kids have got six more months to see if they can get in in the fall. We don't hold our children hostage. The parents are the dictators of that child, where they are. Those parents can decide to go other places. They know their options. We give them their options. A wise man once said to me, "These programs, these DDPA programs are the heart of some of these counties, they are the heart and soul." And I think he was right. So, I just want to say that I am opposed to the one therapy rule, I am also an old speech therapist. And I see the children that we have all been fully evaluated. So, to say that these children aren't evaluated and offered therapy. A lot of times, we will get them in -- I will try to make this short. We will get them in, sometimes they will come from foster homes or they have been dropped with

Grandma or they have been dropped with an aunt, they have been dropped with a family member, they bring them to us and they say, "Hey, we can't" -- "We don't know what to do with this child." We evaluate them. And at that point, they receive all services. Now, of course, with the referral from a doctor. But they receive OT, PT, speech, and day habilitation. Within six months of being in a structured setting with the therapies, they test out of the therapies. We are not going to keep them in therapies just to hold them. So, they go back, they are in the classroom, and then they have the support of the therapists, so we say, "Okay. Now, they were doing this in therapy, but they are not doing it in the classroom." So, then, the OT or PT can say, "Well, if you will position them this way, then they are going to be able to hold their spoon better." But they passed the objective one on one, but now they are in a classroom that is full of children and they are distracted arid they aren't -- they aren't doing what they need to do in the classroom. And so, then you have the therapists there as support, but you are not charging that big price of having a therapist work with the child that doesn't really need therapy, but they do need those supports, they need those lower ratios, and they need the talent and the training that our staff has. Thank you very much.

RESPONSE: Thank you for your comment, please see previous responses.

52. KARLA CURRY, PROGRAM ADMINISTRATOR, FRIENDSHIP COMMUNITY CARE PEDIATRIC SERVICES (AT PUBLIC HEARING)
COMMENT: I'm here to speak out against the one therapy rule. That rule will affect eight to ten children in my building currently. These children qualify for day habilitation services. They were evaluated with a prescription; they were evaluated by a qualified early childhood special educator that said that they had severe needs for day habilitation. They didn't qualify for therapy. We don't want to force that. There are children that need our services that do not qualify for stand-alone therapies. That's almost like saying, "Okay. To qualify for your mental health, you are going to first have to qualify for substance abuse therapy." It's a stand-alone therapy, just like OT, PT, and speech. It's just going to be a catastrophe for Arkansas. It's going to be a catastrophe for my families, for my children. And Jamie said', she was baffled. I have to say that I'm a little bit offended by this rule. I am a Masters trained early childhood special educator. I attended school to evaluate children and their development. And the one therapy rule says that my degree, my training, my expertise is not valid, because the child has to have therapy for it to be real. That's all I have to say. Thank you.

RESPONSE: Thank you for your comment, please see previous responses.

53. JAN CHAMBLESS, PATTILLO CENTER SCHOOL AND DDPA (AT THE PUBLIC HEARING)

COMMENT: I do not agree with the one therapy rule. I oppose it with all the other changes. It could potentially shut our center down, this one therapy rule. I have 41 kids that it is affecting. We have no ABC slots available, the Head Start was closed years ago. And I'm really concerned about the OHS and Arkansas early childhood. Ms. Williams' comments about quality. My center is quality. I have just the same ratings as the ABC centers in our area. And I'm also concerned about their comment about investors, because I have talked to the investors in my county, I have talked to superintendents, ABC, all these people, .and they have no idea this is coming, and they have no place to put these children. So, another big concern of mine is, how are you guys going to address the transition to these 41 families in Arkansas County? And if you have a plan, how is that going to be done? And, you know, with a year, I don't see that as enough time to transition these 41 families in my county to other services, because with Optum and all the road blocks they have hit, we are way behind on that, way behind. So, that is my major concern, is transition. Where is the plan, who are these investors that OHS and Ms. Russell and them have talked to? I would like to see the list and I would like to see the plan. Thank you.

RESPONSE: Thank you for your comment, please see previous responses.

54. MIKE MCCREIGHT, DIRECTOR, PATHFINDER (AT PUBLIC HEARING)

COMMENT: I was a DDS Director for a number of years, and also supervised Craig Cloud. And all I can say is, we all have things in our past we are not really proud of. But anyway, I'm not going to get repetitive. I'm not going to do the repetitive on the therapy. I'm going to target, number one, START. There has been inferences that the START program would be an alternative. I talked with Larry Stang, which I think we all understand, he is the guru on it. He said, "No, that's not what the program is designed for. The program is to do short-term consultation to a third-party group of professional staff to provide some support. They only serve people who are on the waiver -- on the waiver waiting list." And his general statement is that START was not designed for this purpose. Okay. The other thing is, I'm going to talk a little bit, since I am a behavioral health provider. Right now in the RSPMI you almost can't get anybody served under the RSPMI program for under four. The OBHS program is basically designated to deal with people with attachment disorders. And I don't think we have any idea in the world how many of these people may or may not be eligible for that. I would suspect not many. But without any kind of screening, we don't know what that number is. Without an assessment under tier one, they are eligible for 12 encounters a year, individual, 12 encounters, I think, a year in group. Secondly, if you want to do anything more than that, you have to go to get an assessment done and get the tier designation. If they say they are tier two, then you get more services. And then, basically, what we are saying is, we are going to write a prescription for somebody for OBHS and we're going to say that they need services for attachment disorders and those things, and then we're going to provide developmental therapy. I mean, that, to me, is a pretty good example of Medicaid fraud. I mean, I don't know if they are I don't know how well they would integrate. There might be some crossover. But I think people, if they've got attachment issues with family, I'm not sure that they are even ready for developmental services. I would guess not. The other thing is, this is a brand new program, it has zero to 47 months, there's new criteria that people have to meet. Some people have those criteria, others are going to have to do additional training to qualify. So, we don't have any idea if that's 15 people or 3,000, and we don't know what the waiting list is going to be. So, I don't think either one of those yeah. The START, no, and probably not on the OBHS. And the other thing is, is that DDPA has asked for a lot of information through FOI about the plans and the details on options for these people next year. And we can argue the theory on concept about whether we should or should not have the rule on the one therapy, but I absolutely refuse to believe, unless there is information they have held from us, that you all are really prepared to place those 2,500 people in alternate settings. I don't believe it. And if you do, you have kept the secret information that you know how many of these people from different programs, you've kept it, and I don't think the schools were aware that they were throwing in with some of the people that would do that. To do this, you are basically going to have to say, "We are going to take control of everybody's vacancies, we're going to make determinations, regardless of level of need, on who gets admitted, we're going to move therapy slots from people." If you've got a program that's ABC and they've got 20 slots and you freeze five of them, I mean, what does that do to them financially? You may be able to do it, but you haven't really gone to anything that would even be a loose analysis to determine you can. Maybe you can. But you don't know that. Maybe God knows it. But nobody else in this room knows it, because you haven't done the work or else you have basically declined to provide the information we have asked for. I bet if I went to you -- and you are a Head Start program. Oh, by the way, are you aware that basically DDS is going to control your admissions so they can claim and even if they've got somebody that's a higher priority, they are going to keep that for somebody who is getting kicked out of the DDTCS program? And what if you go to an ABC program? I might point out, too the ABC programs are operated by the Department of Ed as a pass-through. Has the Department of Ed approved the things that would have to be done to do this? You will have to freeze slots to have enough vacant.

RESPONSE: Thank you for your comment, please see previous responses.

55. ZELDA HOAGLAN (AT THE PUBLIC HEAIRNG)

COMMENT: I want to say I appreciate the opportunity to comment, and I'm sorry I didn't sign it right. It has been a long day. Only two things. I was an old speech pathologist like Teresa, I worked for Jenkins when we used to work in all these programs, I'm the Executive Director of Jenkins, I have worked at Head Start and all those things for Jenkins. And I want to say something on behalf of the children who don't qualify for therapy. In our area I'm from northwest Arkansas, I'm from a little town, it's rural but it's rich, and everybody has a car and most people have three. It's not south Arkansas, it's a whole different world. And I just want to speak up for those people and say, many of the children you are talking about are African-American in my area, they are poor. Let me say first, I only have four of those children and I have a small pre-school program. So, right now, it's not going to affect us immensely financially. But those children get lost, as other people have said. But really, I hate it when people say everything is harassment and discrimination, but this is discrimination, there's no other way to look at it. And secondly, I just want to say one other thing. This may not be true, but I want to speak to it. I work from 6:00 in the morning to midnight, literally, all the time. And so, I don't see a lot of television except on the weekend. But people told me that it was on Facebook and on television that we don't have certified teachers. So, I just want to say that at Jenkins Center we have early childhood Special Education certified teachers that we paid for them to go to school, they make more money than I do, we pay them for 12 months. We sent them to school because –most of them had Masters degrees in Special Ed when this was required. And when it was required, I said a lot of awful things about how stupid it was. The things that the people learned from those early childhood Special Ed degrees were phenomenal and made immense differences in people's lives. And that's all I have to say. Thank you.

RESPONSE: Thank you for your comment, please see previous responses.