PUBLIC COMMENTS ON ADULT DEVELOPMENTAL
DAY TREATMENT (ADDT) PROGRAM

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)(I) 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.