DHS Responses to Public Comments Regarding Rebalancing Services for Clients with Intellectual and Developmental Disabilities and Behavioral Health Needs

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Joel Landreneau, Executive Director
Arkansas Council for Behavioral Health
Public hearing held remotely on October 27, 2022, at 1:00 p.m.

Comment: We have a number of observations to make about these rules, but I'm going to keep my remarks today brief and focus on one that I think is the probably one of the most concerning and that is the definition of enhanced services on page five of the draft includes the Service Adult Rehabilitation day, and that is, that was a lot of discussion about where it should go. DHS was telling us that this was a facility Deli delivered service, and that's why it was an enhanced section, because the other two sections are home and community-based delivery only, which we take issue with because we do individual therapy in those settings as well in the clinic. And that's a home and community-based service offered there. But the concern is, with respect to the facility requirements set forth in section one thousand and three specifically subsection, c. On page seventy-one. This section applies the facility requirements on all CSPS that are going to be enhanced, which would have to require those agencies that provide a built rehab date now, and page seventy-one subsection, c. Imposes a facility requirement that requires every client to have an individual bed and have that furnishing a lockable door. These are requirements that are only appropriate for those people who reside in the facility, and that isn't the case for those clients who receive services. Yeah, it only through Rehab day they are in it. It looked to me as though some of that section was appropriate when he was talking about requiring hot water requiring air conditioning, requiring no foul odors. Those things that aren't overnight oriented appear to be appropriate to us; but the ones that are aimed at overnight stays and residential adult Rehab day is not a residential service. We don't think it belongs in the enhanced section at all for this reason, but it certainly doesn't need to have the imposition of residential type physical requirements when that's the only service being delivered in the enhanced suite of services. I am concerned that if this isn't changed, there are adult rehab day programs that will stop providing services and that will create a gap in the service continuum that doesn't presently exist. Like I said, we have a number of other concerns with these rules as well, and some questions as well. We'll be setting for those in written submitted comments in the days ahead, but I wanted to make it. I wanted to put an exclamation point next to this facilities section because it's one of the biggest concerns that we have. Thank you.

Response: Adult Rehabilitative Day Service will remain under the CSSP Enhanced certification due to the location of the service being limited to facility settings. The CSSP Certification manual will be updated to indicate the regulations related to treatment programs in which the client is provided with treatment twenty-four (24) hours per day and seven (7) days per week.

Ada Sochanska, MPAS, PA-C
President Elect, Arkansas Academy of Physician Assistants

Comment: The Arkansas Academy of Physician Assistants (ARAPA), on behalf of over 150 Physician Assistants (PAs) throughout Arkansas, appreciates the opportunity to provide comments on amendments associated with Rules for the Division of Developmental Disabilities Services Community and Employment Support (CES) Waiver Providers. By including PAs in the updated section, this will continue to encourage PAs to practice with clients with high needs and continue their recognition as providers in a healthcare team. These updates will also align with PAs current scope of practice and ensure we are not excluding PAs from important rules or amendments pertaining to medical care and allow for improved quality of care across the state of Arkansas.

We would like to draw your attention to Section(s) 292. 471, 210.160, 211.200, 252.111-252.119, 252.111-252.119, 252.121-252.123 and 255.001 and respectfully ask that the Department update terminology in these sections to include PAs.

In section 292.471 "Behavior Health Screen" the language mentions "Physician's Assistant" however, ARAPA would recommend updating the language from "Physician's Assistant" to the official legal title of "Physician Assistant" as PAs are referred to by the Arkansas State Medical Board.

Response: Thank you for your comment. We are currently in the process of adding physician assistants as rendering providers and will review all codes and rates at that time.

Comment: In section 210.160 "Treatment Plan", ARAPA would recommend the inclusion of Physician Assistants as a new subsection, in addition to the current subsections C and D which include Advanced Practice Nurse (APN) and Physician, respectively.

Response: Thank you for your comment. We are currently in the process of adding physician assistants as rendering providers and will review all codes and rates at that time.

Comment: In section 211.200 "Staff Requirements", ARAPA would recommend that the chart include Physician Assistants and specifications into licensing. Licenses would include "Certified Physician Assistant" and "State Certification Required would include "Must be employed by a certified Behavioral Health Agency, or Community Support System Agency", similar to the APNs and Physicians, while "Supervision" would entail "Delegation Agreement"

Response: Thank you for your comment. We are currently in the process of adding physician assistants as rendering providers and will review all codes and rates at that time.

Comment: In section(s) 252.111 "Individual Behavioral Health Counseling", 252.112 "Group Behavioral Health Counseling", 252.113 "Marital/Family Behavioral Health Counseling with Present " 252.114 "Marital/Family Behavioral Health Counseling without Present Client", 252.115 "Psychoeducation"

252.116 "Multi-Family Behavioral Health Counseling" , 252.117 "Mental Health Diagnosis" , 252.118 "Interpretation of Diagnosis", 252.119 "Substance Abuse Assessment", 252.121 "Pharmacologic Management", 252.122 "Psychiatric Assessment", 252.123 "Intensive Outpatient Substance Abuse Treatment", and 255.001 "Crisis Intervention": ARAPA would recommend ensuring that language that incorporates "allowable performing providers" to include PAs along with the current listed providers of Physicians and Advanced Practice Nurses.

Response: Thank you for your comment. We are currently in the process of adding physician assistants as rendering providers and will review all codes and rates at that time.

Comment: ARAPA would kindly ask that in any other sections that have excluded PAs as healthcare providers that render services, Physician Assistants be included to accurately reflect our role in the healthcare team.

Thank you for your attention to these details and comments. ARAPA welcomes the opportunity to provide further clarification of the role of PAs or be of any further assistance.

Response: Thank you for your comment. We are currently in the process of adding physician assistants as rendering providers and will review all codes and rates at that time.

DeAnna Doherty, Executive Director
Advantages of Southeast Arkansas, Inc.

Comment Section 303 (2)(B)(ii)-Why is care planning for individuals with ASD required for all staff? If their client has a Cerebral Palsy diagnosis, ASD care planning training is not relevant. Please note that not all IDD clients are ASD.

Response: It is unclear which manual you are commenting on. The Community Support System Provider (CSSP) is a provider type designed to provide care to clients with IDD, BH, or both needs. Data is showing us that often, children and adults with Autism were not diagnosed prior to the PASSE program and have historically been treating by behavioral health services. We believe the misdiagnosis is lack of diagnosis is prevalent enough to focus a module specifically on this disability. The training modules were promulgated under CSSP and have been in place since January of 2021 when this new provider type was established and available for application.

As for CES Waiver Providers, the approved CMS waiver only requires: employees must pass a drug screen, a criminal background check, a child maltreatment registry check, an adult maltreatment registry check, AND have a high school diploma, GED or equivalent, and have at least one (1) year of experience OR complete the training sessions outlined in the CES provider licensure manual.

We will internally discuss making the change in the CES Waiver certification manual to specify that the twelve (12) hours of training is required if the staff member does not have one year of experience working with persons with developmental disabilities. However, we do not think twelve (12) hours of training is overly burdensome and will continue to require it for CSSP.

Comment: Section 303 (2)(B)(iv)-Why is behavioral modification or prevention training required for all staff? If their client does not have behaviors or a PBSP, then this training is not relevant. Please note that not all IDD clients have behaviors.

Response: While not all clients with IDD have significant behaviors, it is imperative that clients with IDD with behaviors have highly trained staff available to prevent institutionalization. Under the 2023 Agreement between DHS and the PASSEs, each PASSE will utilize a Risk Mitigation Screen for each member that will analyze all risk factors, not just behavioral health needs. If a member is identified as having a low level of risk of BH, a Behavioral Prevention and Intervention Plan will be required. If a high

level of risk of BH is identified, a more robust clinical Positive Behavioral Support is required. We believe this is best practice to support all members.

Comment: Section 303 (c)(2)(A)-Why do providers have to train on the PCSP, we do not create it, and we do not always get a copy of it from the care coordinator, even after asking for it multiple times.

Response: Please see comment above regarding the twelve (12) hours of training requirements and the required modules. Also, even if a provider does not receive the member's overall PCSP, a provider's treatment plan is incorporated into the member's PCSP. Training will ensure that staff understand the federal requirements associated with a Person-Centered Service Plan.

Comment: Section 305 (b)(4)-Providers should not be responsible for maintaining name, phone number, and email address of the client's assigned care coordinator as they change FREQUENTLY and without notice to clients and providers. Typically to find a care coordinator we have to reach out to a supervisor to find the correct care coordinator.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: Section 305 (c)(1)-As stated previously, providers are not always given copies of PCSPs that are written by care coordinators, and therefore it is more than difficult to maintain current copies.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: Section 305 (c)(4)-Again, behavioral prevention and intervention plans are not necessary for every IDD client. This should read, behavioral prevention and intervention plan; if applicable.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: Section 502 (B)(ii)-Should read current Treatment Plan, as again, providers do not write PCSPs and are not always given, even after requesting, current PCSPs.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: Section 601 (d)(1)-Should read, a provider must maintain a medication log for each client to document the administration of all prescribed and over the counter medications, IF the client is prescribed medication or routinely takes over the counter medications and does not elect to self-administer. There is no reason for a provider to have to maintain a medication log for a client that elects to self administer or for a client that takes no medications.

Response: Thank you for your comment. The language in the approved CES Waiver can be found on page 130 or 183.

Comment: Section 602 (a)-Providers should not be responsible for the development of a written behavioral health plan, as this is a care coordination duty and was (pre PASSE) a case management duty.

The state determined there to be a conflict when providers provided both case management and waiver staffing duties; therefore determining the need for PASSE care coordination. And these plans, developed by care coordinators and implemented by providers are only necessary for clients that exhibit behaviors. Again, not all IDD clients have behaviors.

Response: We disagree that there is a conflict, and this is different from the federal Conflict Free Case Management Rule. Supportive living providers are in the home and are responsible for writing, training and implementing a member's Behavioral Prevention and Intervention Plan. You can bill for this service under Consultation.

Comment: Section 602 (2)(A)-Again, providers should not be responsible for developing these plans. Implementing, yes, but not developing.

Response: Thank you for your comment.

Comment: Section 806 (a)- Which department receives the monetary penalties? What are those funds used for?

Response: Funds are used in accordance with state law.

James Scott

Comment: It is evident by the many, many mentions of behavioral health that CES Waiver providers were not invited to the table to give input regarding these rules. My comment is that providers work in the field daily with IDD clients and it is in the best interest of all parties to utilize providers as stakeholders and value their input when creating rules.

Response: This promulgation contains changes to ten (10) manuals, primarily behavioral health services. The Community Support System Provider (CSSP) type was promulgated and available to providers to apply back in January of 2021. The base level services are historic IDD services and were not altered for IDD providers. The CES Waiver certification manual was sunsetted in 2018 under the assumption that the PASSE would be taking over licensure/certification of their PASSE providers. However, prior to the PASSE taking over full risk, it was determined that this was not feasible. For that reason, DDS asked the PASSEs to place the sunsetted CES waiver licensure standards in their provider manuals and as providers sign agreements to be in network with PASSEs, they also agree with that signature to abide by the PASSE provider manual. This has not been ideal, and we are now standing back up a CES Provider certification manual to bring clarity to the rules. The certification manual nearly mimics the language in the approved Community and Employment Supports Waiver that also went through public comment earlier this year and has been approved by CMS.

Kathy Weatherl, Director of Compliance

BOST

Comment: Page 2 – Complex Care Home – who determines if the person meets qualifications for Complex Care Home? Provider or passe or state? Is there a certain assessment tool that needs to be used to make this determination? Will there be extra funding since you are setting ratios of 1:4 for a complex care home?

Please clarify that current group homes will not fall under the category of complex care home unless a provider chooses to request certification for that group home, and it meets the requirements.

Response: The PASSEs will determine medical necessity for Complex Care Homes similar to how they determine medical necessity for the other services they pay for. We agree that a rate still needs to be established for Complex Care Homes because additional requirements are associated with this service.

As for current group homes, they will continue to be grandfathered in.

Comment: Page 9 302 b1 – A provider must meet any minimum staff to client ratio included in a clients treatment plan. Is this the provider treatment plan or the passe PCSP?

Response: This is referring to the Treatment Plan for the service you are providing. Also note that we changed Consultation to include Treatment Plan so IDD can be paid for Treatment Plans to be consistent with allowing BH providers to be paid for Treatment Plans.

Comment: Page 10 – 1E – Added Arkansas Sex offender registry check upon hire and every 2 years. Please confirm that you will only be requiring an ARKANSAS sex offender registry check and not a national registry check.

Response: Thank you for your comment. Section 302(c)(1)(E) only requires an Arkansas Sex Offender Central Registry search.

Comment: Page 10 2(d)2 – Employees must have HS diploma or GED – Didn't they take this out of the waiver application? It was taken out of ADDT standards. What do we do for employees who did not have to have this during the Covid exception period? This will impact our ability to hire staff and in our current staffing crisis this rule does not make sense. A high school diploma or GED does not qualify a person to do these jobs or assure quality care will be provided.

Response: Please see response above concerning language in the CMS approved CES Waiver that was also state promulgated earlier this year. Concerns around employee language at that time, and when filing Covid policies did not discuss High School or GED. The discussion was around the required years of experience. We are allowing an exception for years of experience. To my knowledge, we have never waived High School Diploma or GED for CES Waiver.

Comment: Page 11 303 2(a)(b) – 12 hours of training before having contact with client and at least once every 12 months thereafter. Can this training include on the job shadowing with current staff?

Response: Yes, the twelve (12) hours can include job shadowing as long as all training requirements are met.

Comment: Page 11 - 303 2 B – Why require training on autism spectrum disorders if the staff is not working with someone who has autism? Should this not be a consumer specific training instead? If a consumer has spina bifida or Epilepsy more training should be provided in that area, not autism.

Response: Thank you for your comment. Please see response to a similar comment above.

Comment: Page 11 - 303 2C – Why can the initial required training in 303(a)(1) not be counted in the 12 hours required in 2(c)? With the staffing shortage that we all face, it does not make sense to not count those hours if you are requiring those trainings. We all want staff to be trained to provide good care, it should not be about the number of hours, but about the quality of the training and topics.

Response: Please see comments and responses above regarding training for CSSP and CES Waiver provider types.

Comment: Page 12 – 303 Employees who have not completed the required certifications cannot be counted towards staffing requirements. For recertifications are you saying if a staff is past due by a few days they cannot be counted as staff? Again, with the staffing crisis we are in that does not make sense. Consumers will be left without staffing and services. Staff know how to call 911 in emergencies and 911 operators will instruct them on care to provide and even walk them through doing CPR.

Response: The trainings are required annually. Staff should not work if any training is past due or lapsed.

Comment: Page 14 – 305 (b) (4) -Face sheet must contain name, phone number, email address of assigned passe care coordinator. CC's change frequently. Can we just note general Passe information vs specific CC info.

Response: Please see DHS' response to a similar question above.

Comment: Page 15 ©1 – PCSP must be maintained in client file – It is often very difficult to get this from the PASSE. The provider should not be held accountable for the PASSE responsibility. If we have documentation showing, we have requested the information from the PASSE multiple times is that acceptable?

Response: Please see DHS' response to a similar question above.

Comment: Page 15 C4 – Behavioral prevention and intervention plan – should state if applicable, because everyone does not need a plan.

Response: Please see DHS' response to a similar question above.

Comment: Page 18 – Financial management of client funds – e(1) states the provider must maintain separate accounts for each client -what about when there is 1 account but funds are distinguished by client? Social Security allows this for rep payee and we are required to followed rep payee guidelines. Providers who are rep payee are audited every year by Social Security to assure we are handling funds correctly.

Response: Thank you for your comment. "Separate accounts" does not mean separate commercial bank accounts. A single commercial bank account may hold multiple individual clients' funds, so long as there as separate accounts maintained for each individual client through software programs or other means that otherwise comply with these Rules.

Comment: Page 18 309 Emergency Plans and Drills – a1 emergency plans for all locations, including client residences – do you mean private homes or only provider owned homes, please clarify.

Response: Thank you for your comment. This requirement applies to provider owned and/or controlled homes/apartments.

Comment: Page 19 – 309(a1) – Are you stating that the provider must have a written emergency plan for all private residences where clients live (family home), or are you just referring to the provider owned homes?

Response: Thank you for your comment. This requirement applies to provider owned and/or controlled homes and apartments.

Comment: 309 2(a) Fire drills must be conducted monthly in provider owned homes or leased residential settings – We need procedures for all emergencies but only required to do fire drills – am I understanding that correctly?

Response: Thank you for your comment. This requirement applies to provider owned and/or controlled homes and apartments.

Comment: Page 19 310 Infection Control – (b)1 Will Covid fall under this? If yes, what about when we have families who say they still want their staff to work and just wear a mask and staff wants to work. We have families who must work to support their family. Ultimately providers should be following CDC guidelines, and those change. We think it would be appropriate for wording to be that provider follows CDC guidelines in place at the time.

Response: Yes. During Covid, the Arkansas Department of Health followed the CDC guidelines.

Comment: Page 21 401 – There are specific requirements for complex care homes to meet under 402 but there are no site-specific requirements for current group homes or provider owned apartment complexes. Are you considering all current group homes and provider owned apartments to be complex care homes? Or will these standards also apply to group homes and apartments already in place? My assumption is that only 42 CFR 441.301 © (4)-(5) will apply to current group homes and apartment complexes that are provider owned but please clarify.

Response: Complex Care Homes is a new service with different requirements. Please previous response to group home comment above.

Comment: Page 26 502 Exits and Transitions – (b) A provider must document the exit of all clients regardless of reason – Please elaborate on what you mean by document the exit.

Response: Thank you for your comment. This would depend on the reason the client exits. Documenting a client exit due to a client's voluntary request to change provider would be different than an exit due to a client death. Specifics are not listed to allow providers maximum flexibility in documenting and demonstrating how and why a client exits its program.

Comment: Page 27 502 Exits and transitions -502 C - Needs to put WRITTEN request by client for records.

Response: Thank you for your comment. Section 502(c)(3)(C) of the Rules for the Division of Developmental Disabilities Services Community and Employment Support (CES) Waiver Providers will be changed to add the word "written" between the words "a" and "request".

Comment: Page 27 (d) 1 and 2 – If a client or their family refuses to allow us to provide services during the transition period how can the provider be responsible for the health, safety, or welfare of the client. We have encountered this very situation on several occasions.

Response: Thank you for your comment. While transition from one provider can be contentious, the health and safety of the individual must be assured in accordance with waiver regulations. The agency is willing to provide technical assistance on a case by case basis as warranted

Comment: Page 29 Mediations – (a)2(A) goes beyond CDCA requirements. We need to stick to CDCA requirements and do the self-administration form that individual and/or family sign off on but it does not require that meds be listed.

Response: Please see Appendix G of the Waiver. We will mimic this language. The current CES waiver does not include self-direction as part of the operational components of this program. Each state that offers Consumer Directed Care as part of its operational allowances varies depending on the state and state defined Nurse' Practices Act. See below for guidance regarding this from the Consumer Directed Care amendment to the Arkansas Nurse Practices Act of 2005
CONSUMER DIRECTED CARE 1. 2. 3. 4. 5. 6. 7. 8. Health maintenance activities may be provided by a designated care aide for a competent adult at the direction of the adult or for a minor child or incompetent adult at the direction of a caretaker. Caretaker means a person who is directly and personally involved in providing care for a minor child or incompetent adult, and the parent, foster parent, family member, friend, or legal guardian of the minor child or incompetent adult receiving care. Designated care aide means the person hired by the competent adult or caretaker to provide care for the competent adult, minor child, or incompetent adult. Health maintenance activities mean activities that the minor child or adult is unable to perform for himself or herself. The attending physician, advanced practice nurse, or registered nurse must determine a designated care aide under the direction of a competent adult or caretaker can safely perform the activity in the minor child's or adult's home. Home shall not include nursing home, assisted living facility, residential care facility, an intermediate care facility, or hospice care facility. Health maintenance activities that are not exempted by the Consumer Directed Care Act of 2005 include: a. Physical, psychological, and social assessment which requires nursing judgment, intervention, referral, or follow-up; b. c. d. e. f. Formulation of the plan of nursing care and evaluation of the client's response to the care rendered; Tasks that require nursing judgment or intervention; Teaching and health counseling; Administration of any injectable medications (intradermal, subcutaneous, intramuscular, intravenous, intraosseous, or any other form of injection) or intravenous therapy. Receiving or transmitting verbal or telephone orders. The designated care aide must demonstrate the ability to safely perform the health maintenance activity.

Comment: Page 29 – 2b – when you say other health care professionals authorized to administer medications are you referring to those trained according to CDCA? This should be more specific as far as what authorizes a person to administer medications.

Response: This is a scope of practice question. However, please Appendix G of the approved CES Waiver, we outline regulations around medications. We will mimic this language.

Comment: Page 30 I – Med errors are reported on incident reports as required by DHS regulations, not on the MAR.

Response: Thank you for your comment. We will internally review to see if language should be amended.

Comment: Page 32 – 602 Behavior plans

602 (a)- Is this referring to the providers risk assessment or something the PASSE will be doing?

602 (a)(1) and 2(A) who determines the risk level?

We have concerns if this is based off PASSE risk mitigation plan since we often do not get copies of the PASSE plan or get invited to the individual's PCSP meeting. How can a provider be held accountable for requirements of the PASSE?

Will there be a specific risk mitigation plan that will be used by all PASSES so determination of a Tier is the same across all PASSES?

The requirements for who can do these plans, especially positive behavior support plans are concerning. There is a staffing crisis in this state and the training through Partners requires 5 days of training, that's 5 days that most managers do not have time to be out of the office as they are often serving as Direct Support staff right now or trying to find and train direct care staff so daily supports can be provided to individuals.

The licensed individuals who you have on the list will want to do behavior plans their way according to their training and license, so it will be difficult to find licensed professionals who will want to do these plans as you have them defined. We have run into this issue in the past when behavior plans had to be done by licensed professionals. Plus, licensed mental health professionals and board-certified behavior analysts are hard to find in this staffing crisis. This service will not be a priority for them.

Response: Thank you for your comment. Please see previous responses on this topic. DHS is working with the PASSEs to develop one risk assessment tool. We amended the definition in Consultation and expanded the clinicians who can develop a Positive Behavioral Support Plan for this very reason.

Comment: Page 37-43 Regarding specific waiver services it states the provider must maintain documentation in the client service record: date ordered, name of CC who ordered, and other info based on each specific service, etc. The Passe does not provide all this information to the provider, so how can the provider be held accountable for it? Will documentation showing our attempts to get the information be enough?

Response: The provider is responsible for their information. Please see other responses regarding these sections and the role of the care coordinator.

Comment: Page 41 – PBSS- States that the person must be trained by Partners to write the plans. Why is there only 1 entity able to do this training? Will the state require Partners to offer this training so many times a year in all regions of the state so there are enough trained PBSS? Will the state assist with funds to get staff trained to do these plans?

Response: Thank you for your comment. We will discuss internally. PBS can write a Positive Behavioral Support Plan. We agree this should not mandate one provider offer the training if other providers are available to provide this training.

Comment: Page 47 Incident Reporting- 703 B Provider must maintain documentation evidencing notification to guardian of incident – Is the notification section on the IR enough for this documentation?

Response: Yes.

Comment: Page 52 901 Closure – (a) 2B – this would be the role of the PASSE CC not the current provider.

Response: The standards are for providers so if a provider is closing their business, then it is the provider's responsible to follow what is outlined under this section.

Comment: Medicaid Manual

220.310 Complex care home – Who will make the determination that a person qualifies for a complex care home? Will that be the provider? The PASSE? Is there an assessment tool we'll need to use?

Will there be extra funding since you are setting ratios of 1:4 for a complex care home?

Please clarify that current group homes will not fall under the category of complex care home unless a provider chooses to request certification for that group home, and it meets the requirements.

N under 220.340 – Positive Behavior Support Plan for higher level risk consumers can be done by PBSS or licensed MH.

***On N - Concerned that only partners can provide the training for PBSS. Will the state require them to offer the training so many times per year in each region so there are enough PBSS who have been trained to do these plans?*

Response: Please see responses above to similar questions.

Pam Edison, Director of Home and Community Based Services
Shana Fryar, Director of Quality Assurance
Pathfinder, Inc.

Comment: On the waiver portion (page 14), it states we need the PASSE care coordinator information (name, address, email, phone number) in our client service record. All of the information required on the client service record is on our Face Sheet, except the care coordinator information. This is something

we would need to add to our Face Sheet. It should be noted we have a difficult time keeping care coordinator information updated due to high turnover in the PASSE's.

Pages 37 - 45 states the Provider must maintain the following documentation in our files: Specialized Medical, Adaptive Equipment, Environmental Modifications, Supplemental Supports. Unfortunately, some of those documents go directly from the PASSE to a vendor so we never see the documents and cannot maintain a copy for our files. The only time we have this documentation is if we (the Provider) pays for something as a pass-thru. In addition, we have trouble getting copies of the PCSP from some of the care coordinators.

(Also see attached exhibit A)

EXHIBIT A.pdf

Response: Thank you for your comment. We will review this language based on public comments.

Bess Heisler Ginty, Chief Executive Officer
Kids for the Future, (Pediatric Day Centers, Counseling Services, Therapy Group, Inc.)

Comment: I have grave concerns about the way some of it is written that it does not allow for true diagnostics. For example, I think adding the word "suspected and / or qualifying disability" could open doors for initial testing.

(Also see attached exhibit B)

EXHIBIT B.pdf

Response: Thank you for your comments in the PDF. We will look at clarifying this language.

David Ivers, J.D., VP for External Affairs & General Counsel
Easterseals Arkansas

Comment: The proposed rules are causing a lot of confusion among providers. We believe more work is needed to make the rules clear and understandable. We urge the Department to go back and convene a workgroup with providers to get more input from those of us who have to provide services under these rules.

We understand DDS is taking the CES licensure role back from the PASSEs through these proposed rules. Will there also be a Provider Manual again? We ask because this promulgation includes a Provider

Manual for "Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs" that contains services provided through the PASSEs.

Response: Please see responses above about CES certification standards and what has been in place since 2018. We are running a Provider manual in this packet entitled Home and Community Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs that outlines the HCBS under the PASSE program. That manual is applicable to Outpatient Behavioral Health Agencies, CES Waiver Providers, and Community Support System Providers. The certification manuals for those provider types (CES Waiver and CSSP) outline what services may be performed under those provider certifications.

Comment: 103. Definitions-"Adverse action" – This definition does not take into account the Medicaid Fairness Act. The MFA applies to actions, including "(g) Desk audits; (h) Field audits and onsite audits; and (i) Inspections or surveys." "To constitute an adverse decision, an agency decision need not have a monetary penalty attached but must have a direct monetary consequence to the provider." Thus, if a DDS decision under these rules results in a monetary penalty or is an action such as no new admissions, suspension or termination of license that would have a direct monetary consequence, that action would fall under the MFA. 20-77-1702(2).

Response: Thank you for your comment. It was not our intention to bifurcate or go around the standard appeal process. We will review this language. We elaborate more on this topic below in the public comments.

Comment: 103. Definitions- "Change of Ownership" – What is the meaning of the qualifier "within a twelve (12) month period"?

Response: Thank you for your comment. All transactions within the prior twelve (12) month period are aggregated for purposes of determining whether there has been a fifty percent (50%) or greater ownership change. In other words, the fifty percent (50%) threshold cannot be circumvented by using multiple transactions spread out over a short time period.

Comment: 103.Definitions-"CES Waiver Service" – Since the waiver is amended from time to time, we would recommend just reference the list in the approved 1915(c) waiver as it may be amended.

The approved 1915(c) waiver being referenced in this promulgation is called the Community and Employment Support Waiver. The name has changed once in the past ten years and there are no plans to amend the name. The Department administers several 1915(c) waivers and want to state the specific name.

Comment: 103. Definitions- "Complex Care Homes" -- What if a group home has individuals who meet this criteria of having an IDD diagnosis and a co-occurring deficit. Does that automatically make them a complex care home or do they have to self-designate, and if so how? Has DHS provided additional funding to the PASSEs for this model?

Response: Please see previous responses to this question.

Comment: 103. Definitions-"Licensed professional" – What does "general contractor" in this list mean?

Response: Thank you for your comment. You are correct. General contractor should be removed from this list.

Comment: 302. Employee and Staffing Requirements-In regards to 302 b.1 regarding minimum staffing requirements. Is this reg stating that we must staff what's in the treatment plan? What happens if we cannot due to the staffing crisis? Will we be held accountable or penalized because we cannot staff a position even though it may be out of our control? Also, some family staff member (e.g. parent/guardian) may use this to assert that they must be paid for hours that are in the service plan but are intended for alternate staff. This is already becoming a complex area to navigate without this added language.

Response: The treatment plan is intended to outline what service the provider is providing and for what duration and time. If ratio's change, the treatment plan should be amended or outline what will occur if staffing ratios cannot be met.

Section 302.d.2 – Employees must have a high school diploma or a GED. – In light of the workforce shortage, can qualified experience can be accepted in lieu of a HS diploma or GED?

Response: Please see previous responses on this topic.

Comment: 309. Emergency Plans and Drills- Are all items, drills, procedures and reporting listed required for an individual's home? Some may be unnecessary in a private residence.

Response: Please see previous responses on this topic.

Comment: 501. Request to Change Provider-Section (b) Says that a provider remains responsible for delivery of services until such time as the client's transition to the new Provider is complete. There should be a deadline on the PASSE to complete this process, otherwise there is no incentive to make it happen timely, and the client is left in a situation where the provider has already determined they cannot meet the client's needs.

Response: Please see previous response on this topic.

Comment: 502. Exits and Transitions- Section (d)(1) says a provider remains responsible for the health, safety and welfare of an existing client until all transitions to the new provider are complete. However, the reason the transition is occurring is because the current provider CANNOT ensure health, safety and welfare. Also, often clients will not cooperate to let the current provider continue. Please reword to accommodate these realities.

Response: Please see previous response on this topic.

Comment: 503. Refusal to Serve- What office at DDS does the provider notify of a refusal to serve?

Response: Notification of unable to serve may be submitted to DDS CES Waiver Member Support Unit via email at dhs.dds.southeast@arkansas.gov .

Comment: 601 Medications-(b)(2) This section says a provider can administer medications only through a licensed nurse or "other healthcare professionals authorized to administer medication." However, under the Consumer-Directed Care Act (Arkansas Code Ann. 17-87-103(12) and the ASBN Rules, Chapter 5, Delegation) authorize individuals or caregivers to delegate certain medication administration and other health maintenance activities to unlicensed direct care aides. Considering reviewing the old DDS waiver certification rules that had a section on the CDCA.

(c)(2)(C)– Is this stating the plan must give a physical description of the medication or what description is it referring to? This may need to be worded differently as to state what the medication is primarily treating, otherwise if they are wanting a physical description of the medication this can change with each pharmaceutical company and there will not be any consistency in this circumstance.

(c)(2)(D) -- This may need to be more clear to state route of administration i.e. by mouth, inhalation, per tube, etc..... versus delivery.

(c)(2)(E) – Is this stating we need to indicate on the plan that it will be charted on a Med Log?

(c)(2)(F) – Potential side effects are numerous for most drugs. Why not require client-specific side effects unless said individual is starting a new medication and does not know if there will be side effects from this particular med. And then, we suggest limit to most common or the list will be way too long.

(d)(2)(B) -- This should be indicated on the med management plan not the med log -- there is only so much room on a medication log, and the DSPs are not medical professionals and do not perform assessments, unless it is pertaining to a PRN drug that is only used for certain symptoms and that will be listed on the original pill bottle/container.

(d)(2)(H) **–** Regarding transfer of meds from original container into individual dosage containers by the guardian **--** Will this need to be indicated on a med log even if the individual administers their own medication?

Response: Please see other responses on this topic.

Comment: 602. Behavior Management Plans--This section has become extremely complicated and may prove difficult for staff to implement. The rules make it sound as though every client has to have some type of behavior plan. Many clients do not need a behavior plan. Can you clarify this?

602. What is the difference between a "behavioral management plan", "behavioral prevention and intervention plan", and a "positive behavioral support plan"?

602.a.1. If a client is "low risk," why would you write a behavior plan? It seems different wording is needed. Who is qualified to develop a "low risk" behavior plan?

602a.1.C – Does this mean the person writing the behavior plan must be qualified or certified in the areas listed in, I, ii, and iii? This may limit who can write behavior plans.

Response: Please see previous responses on this topic.

Comment: 604. Supported Living--We have no problem with daily progress notes, but (b)(5) seems excessive – having to describe every day the relationship of the service to the treatment objectives. That changes much less frequently than every day and should be addressed in the treatment plan.

Response: Thank you for your comment. We will review this internally and determine if an amendment to the language can or should be made.

Comment: 607. Specialized Medical Supplies; 608 Adaptive Equipment; 609 Community Transition Services; 610 Consultation; 611 Environment Modifications; 612 Supplemental Support

The Department seems to be saying PASSE care coordinators will now be fully responsible for handling and ordering these services instead of the direct service provider? Is that what the Department intends? Although providers would welcome this, the Department should be aware that in many instances this is not current practice.

Response: We disagree that those sections are insinuating that the PASSE care coordinator is solely responsible. Those definitions were pulled from the approved CES Waiver.

Comment: 700. Incidents to be Reported**--**702.a.2 – This say submit reports of all other incidents within 48 hours of the event. -- Does this mean if an incident occurs on a Friday, it must be reported by Sunday, or will the following Monday suffice?

Response: Thank you. We will discuss internally and check the language in the approved waiver.

Comment: 803. Enforcement Actions--This section should reference the Medicaid Fairness Act for adverse actions that fall under that Act. (See comment under "Adverse Action" definition.)

Response: Please see previous response above on this topic.

Comment: 1002 Appeal of Regulatory Actions**--**(a)(1) Says the appeals under Medicaid Fairness Act are those "related to the payment of Medicaid service claims." However, as explained above, the wording of the statute is broader than that.

Response: Thank you for your comment. Section 802(a)(1) of the Rules for the Division of Medical Services Licensure Manual for Community Support System Providers shall be changed to read "A CSSP Agency may administratively appeal any adverse regulatory action to the DHS Office of Appeals and Hearings (OAH) except for provider appeals governed by the Medicaid Fairness Act, Ark. Code Ann §§ 20-77-1701 to -1718, which shall be governed by that Act."

Section 1002(a)(1) of the Rules for the Division of Developmental Disabilities Services Community and Employment Support (CES) Waiver Providers shall be changed to read "A Provider may administratively appeal any adverse regulatory action to the DHS Office of Appeals and Hearings except for Provider appeals covered by the Medicaid Fairness Act, Ark. Code Ann. §§ 20-77-1701 to -1718, which shall be governed by that Act."

David Ivers, J.D., VP for External Affairs & General Counsel
Easterseals Arkansas

Comment: We support the Department's goal of breaking down silos between IDD and behavioral health. However, these proposed rules are extremely confusing and raise many questions. While well intentioned, they contain provisions that all but shut out IDD provider organizations from obtaining a CSSP license. We strongly urge the Department to pull these proposed rules down and convene a workgroup with IDD providers to work out the problems identified below.

Which services? Please clarify which services a CSSP agency can provide that a CES Waiver provider cannot. (The "HCBS for Clients with IDD and Behavioral Health Needs" says that CES Waiver providers can provide the services in that manual. There is no indication they have to obtain a CSSP license. However, the Counseling Services Manual is limited to various BH provider types or CSSP. It sounds like that is the only service that a CSSP agency can provide that a CES Waiver provider cannot, but please clarify.)

Response: All services listed under the Intensive Level, all services except Complex Care Homes for IDD listed under the Enhanced Level, and all services listed in the Base Level that are contained in the 1915i state plan amendment for behavioral health are not allowed to be performed with a CES Waiver provider certification. The CSSP type was implemented in January of 2021. CES Waiver providers could have chosen to become a Base level CSSP and provide more services than they can under the CES Waiver provider type. However, only two CES Waiver providers applied and enrolled as CSSP. This is not a mandatory provider type. CES waiver providers can remain a CES waiver provider type only. The services you are licensed to provide are outlined in the CES waiver certification manual or the CSSP certification manual. All HCBS and service descriptions are listed in the HCBS for Clients with IDD and Behavioral Health Needs manual.

Comment: Which individuals? Can CSSP providers provide any medically necessary service listed under their level of CSSP certification to *any eligible individual regardless of whether the individual has a diagnosis of IDD only, BH only, or IDD with behavioral health needs*?

Response: Please refer to the service descriptions in the manual mentioned above but yes, HCBS under the PASSE is based upon functional deficits not diagnosis.

Comment: Barriers for IDD organizations. The requirements for CSSP Base Level certification do not appear to provide any significant new service that an IDD provider cannot offer now through their CES Waiver license. And the requirements imposed for a provider to offer Intensive or Enhanced level services, including Counseling, require a CEO with a behavioral health degree or related field, a Certified Peer Support Specialist on staff and other provisions that basically shut out IDD organizations from becoming a CSSP Agency. This is a major problem that must be addressed for CSSP to work as intended.

Response: There are additional services available under the Base Level that can be performed without clinical oversight. These include Adult Life Skill Development, supportive housing, support life skill development (individual or group), and therapeutic host homes. We have several IDD providers who are planning to become Intensive level CSSP providers. Remember that you can contract with the required staff. They do not have to be full time employees. Further, the services outlined in Intensive and Enhanced are intended to have clinical oversight due to the nature of the service being provided.

Comment: 103. Definitions--Adverse Agency Action -- This definition does not take into account the Medicaid Fairness Act. The MFA applies to actions, including "(g) Desk audits; (h) Field audits and onsite audits; and (i) Inspections or surveys." "To constitute an adverse decision, an agency decision need not have a monetary penalty attached but must have a direct monetary consequence to the provider." Thus, if an adverse decision under these rules results in a monetary penalty or is an action such as no new admissions, suspension or termination of license that would have a direct monetary consequence, that action would fall under the MFA Ark. Code Ann. 20-77-1702(2).

Response: Please see previous response.

Comment: 103.Definitions--CSSP Location **–** This term is used frequently but not defined and its meaning not clear.

Response: Thank you for pointing this out. The current version defines CSSP location and it appears we missed defining in this promulgation. A CSSP location is a physical location of a program that falls under the Enhanced level of CSSP.

Comment: 103. Definitions--Base Services, Enhanced Services, Intensive Services –

Here it says that Counseling Services require an Enhanced level certification. But at 902(3) [numbering is off, should be 5?] it says Counseling Services come under Intensive level.

Response: Thank you for pointing this out. You are correct that Counseling Services are allowed under Intensive Level. It appears that Intensive and Enhanced are out of order in the definition section which may be causing some confusion. The progression is BASE-more than base-Intensive-more than intensive-Enhanced. The requirements continue to grow as you lead up to Enhanced.

Comment: Under which level of certification does Pharmacological Counseling by RN go?

Response: It is located under Base with the understanding that you would need to contract or hire an RN to do perform this service, but it does not require the clinical oversight requirements found in Intensive or Enhanced.

Comment: Home and Community-Based Services – This definition seems overly broad. There are many services that can be obtained through the PASSE Provider Manual that are not HCBS since the PASSEs cover all Medicaid services except the six excluded ones to any individual who meets the medical necessity criteria.

Response: The services and descriptions can be located in provider manual also in the promulgation packet. We agree that PASSEs pay for services beyond home and community based. We do agree that the wrong manual is cited in (r) under the definitions. We need to reference the new HCBS manual in this promulgation packet. We will make that change.

Comment: Licensed Professional – There are many types of licensed professionals who have nothing to do with healthcare. It seems like some narrowing of the definition is needed.

Response: Thank you for your comment.

Comment: Qualified Community Support Provider – This section is confusing. The terminology used elsewhere in the promulgation is "Qualified Community Support Staff" not "Qualified Community Support Provider." Staff is less confusing for this purpose. Can you identify which services such staff may perform? Is it any service that does not require a licensed professional to perform?

Response: A Community Support Staff is defined as an employee who provides direct care services or assistance to clients. The manual has been corrected to be consistent in terminology.

Comment: In criterion #3 are you saying that every QSSS must be an Arkansas Certified Peer Support provider or is that simply a voluntary alternative to item #2, i.e, someone working under the direct supervision of a Mental Health Professional or as part of a multidisciplinary team under a licensed professional?

Also, this definition says every QSSS must work under a MHP or License Professional. Does this mean that staff must become a CSSS and work under a mental health professional in order to bill any service under CSSP even if the service is a traditional IDD service for someone with IDD?

Response: Criterion 3 has been removed for clarity. Peer Support Specialist requirements are addressed elsewhere in the manual. Yes, for Intensive and Enhanced CSSP Levels.

Comment: 201. Certification Requirements. (c) and (d) appear to be duplicates.

Accreditation requirements**.**

> Paragraph 201(e) says "A CSSP Agency must be accredited by an approved accrediting organization for **all** home and community-based services offered or intended to be offered by the CSSP Agency before DPSQA may issue any CSSP Agency certification."
>
> Paragraph 201(f) says: A CSSP Agency must demonstrate its accreditation or accreditations cover each
> home-Home and community-based service the CSSP offers or intends to offer.

Please clarify this section. It appears to contradict informal guidance we have received that any CARF accreditation "in the HCBS arena" will suffice. CARF accreditation categories do not line up exactly with the HCBS service list. Please clarify which CARF accreditations will suffice for which HCBS and Counseling services. This will be a major obstacle to CES providers getting into CSSP if it is not relaxed.

Also, if the accreditation language is not modified then another dilemma is created: CARF requires a provider to provide a service for at least 6 months before it will accredit the organization. But these rules require the accreditation prior to issuing a license. Please explain how this catch-22 will be resolved if the accreditation requirement is not modified.

Response: As stated above, the CSSP type has been in existence since January of 2021, and we are not requiring that providers become a CSSP. If a provider would like to become a CSSP, you can remain in your current provider type while you become accredited. The accreditation is in the area of home and community-based services. We will review the above and determine if the language should be amended for clarity.

Comment: 302. Employees and Staffing Requirements-(a) and (b) regarding minimum staffing requirements. Is this reg stating that we must staff what's in the treatment plan? What happens if we cannot due to the staffing crisis? Will we be held accountable or penalized because we cannot staff a position even though it may be out of our control?

(c) and (d) appear to be redundant with (e) and (f), regarding requirement for maltreatment and criminal background checks.

(g) says employees must be at least 18 and have a high school diploma or GED. In light of the workforce shortage, can experience or training substitute for the diploma/GED requirement? Suggested wording "or have additional certifications required for Qualified Community Support Providers in Definitions (dd)."

Response: Thank you for your comments and please see previous responses to these topics above.

Comment: 303. Employee Training--(b) requires 12 hours of training before having contact with client and at least once every 12 months thereafter. Can this training include on the job shadowing with current staff?

(c) says the 12 hours in (a) cannot count toward the 12 hours in (b). Why impose this hurdle? With the staffing shortage that we all face, it does not make sense to not count those hours if you are requiring those trainings. We all want staff to be trained to provide good care, it should not be about the number of hours, but about the quality of the training and topics.

(e) says employees who have not completed the required certifications cannot be counted towards staffing requirements. For recertifications are you saying if a staff is past due by a few days they cannot be counted as staff? Again, with the staffing crisis this does not make sense. Consumers will be left without staffing and services. Staff know how to call 911 in emergencies and 911 operators will instruct them on care to provide and even walk them through doing CPR.

Response: Please see previous responses to these similar questions above.

Comment: 304. Employee Records-Please define searches and timeline for searches if this is not part of annual and continuing background checks.

Response: Thank you for your comment. Section 304(a)(2) through (6) is referring to those required checks, searches, etc. set out in Section 302.

Comment: 309. Emergency Plans and Drills-This section says providers must have emergency plans for all locations, including client residences – do you mean private residences, provider-owned homes, or only congregate residential sites where services are provided? This may be overkill for private residences. Section (b) seems to recognize this, but does not say specifically which procedures and which drills are required in which type of setting. Can you clarify?

Response: Please see previous response above.

Comment: 312. Emergency Response Services-These requirements seem to reflect traditional 24-hour emergency response services required for OBHAs. Not all HCBS services would seem to warrant this level of emergency staffing and services. This may deter many providers from becoming CSSP agencies.

Also, can telehealth be used in place of in-person contact?

Response: Thank you for You Comment. Yes, telehealth may be used in place of in person contact.

Comment: 313 Restraints and Seclusions-- This section seems to be written from a BH standpoint. CES Waiver providers are not allowed to use seclusion. This may need clarification as to which HCBS services a seclusion can be used for, if any.

Response: Thank you for your comment.

Comment: 402. Exits--This section says a provider remains responsible for the health, safety and welfare of an existing client until all transitions to the new provider are complete. However, the reason the transition is occurring is because the current provider CANNOT ensure health, safety and welfare. Also, often clients will not cooperate to let the current provider continue. Please reword to accommodate these realities.

Response: Please see previous response to this question above.

Comment: 501 Incidents to Be Reported-With regard to items (6) and (7), why are they 1 hour here but 2 hours in CES Waiver?

Response: Thank you. We will discuss internally and ensure that the language is consistent with the approved waiver.

Comment: 502. Reporting Requirements-With regard to the 48-hour reporting requirement, please clarify what happens when the deadline would fall on a weekend or holiday.

Response: Thank you. We will discuss internally and ensure that the language is consistent with the approved waiver.

Comment: Subchapter 9. Intensive Level Services

As an organization considering CSSP, the service we are most interested in providing for our clients that we cannot provide as a CES Waiver provider would be Counseling, and perhaps Family Support Partners, both of which this section says requires an Intensive Level Certification. But in order to obtain this certification, it says the CEO must have a degree in *behavioral health management* or a related filed and experience. Also, we would have to have a full-time Clinical Director who must be a MHP, even though our mix of clients may not justify a FTE. It also says we must have a Certified Peer Support Specialist. If this section is not modified, it it seems unlikely that any CES Waiver provider will provide any service they are not providing today. In other words, no silos will be broken down.

(Also, why is this level called Intensive and the higher level Enhanced. The common meaning of those words would indicate the reverse.)

Response: The services under the Intensive level of certification require the provision of services focused on behavioral issues and require professional oversight the agency must meet the requirements to obtain certification and deliver services. Providers who are not interested in providing services to address symptoms of a behavioral health condition can apply to become a CSSP Base level provider or remain a CES waiver provider.

Comment: Subchapter 10. CSSP Enhanced Certification

Since this level requires the provider to meet both Base and Intensive level requirements as well, the same problems arise as listed under Subchapter 9 Intensive.

Response: Agree. See previous response that these services are in the wrong location in the definition section.

Comment: 1002(b) seems to be describing Complex Care Homes for IDD. Why is the name not used? Or is it intended for any group setting of IDD?

Response: Yes, you are correct and this needs to be amended.

Comment: Section (b)(1) states that a Therapeutic Communities or Community Reintegration program can house no more than 16 individuals, but (b)(2)(8) says no more than 8. Please explain the rationale for the difference. It still seems like these are siloed approaches for IDD and BH.

Response: Therapeutic Communities and Community Reintegration are behavior health programs approved under the 1915i state plan amendment and must remain sixteen (16) beds or less to avoid the designation of Institution for Mental Disease. CMS only approved Complex Care Homes for IDD being eight (8) person maximum. Members who live in a Complex Care Home must be IDD and need supportive living which is the primary service in this setting.

Comment: At various places in this subchapter, there are requirements that a "CSSP Location" must meet, but it is not clear if that applies to Complex Care Homes for IDD as well as TC and CI.

Response: Please see previous response on this topic. Yes, a CSSP location is an enhanced physical location.

Comment: Section (b) say a CSSP facility housing one or more CES Waiver clients can house more than 4 clients if the requirements are met (for a Complex Care Home). This is extremely confusing. What about clients with IDD who are being served through 1915(i)/wait list. And does this mean that all existing group homes must now meet this requirement if they want to serve more than 4 under the recent waiver amendment that increased maximum size to 8.

Response: There is no definition for group home in the approved CES Waiver. Prior "group homes" will be grandfathered in. The only addition to the CES Waiver was the service of Complex Care Homes that definition can be found in the service description under Supportive Living.

Comment: (c) says males and females cannot share a bedroom. What if they are adults?

Response: We disagree. Thank you for your comment.

Comment: 1005. General Nutrition and Food Service Requirements

Sections (b)(9) and (10) refer to a licensed professional being on site or on call and available within certain time frames. Is this in the wrong section?

Response: Thank you. You are required. It appears that those sections are in the wrong location and need to be relocated in the appropriate section of the manual.

Comment: 1006 Medications

Why is this section limited to Enhanced Certification? The Consumer-Directed Care Act (Arkansas Code Ann. 17-87-103(12) and the ASBN Rules, Chapter 5, Delegation) authorize individuals or caregivers to delegate certain medication administration and other health maintenance activities to unlicensed direct care aides. In light of that, it would seem this needs to be under the Base certification, and the CDCA provisions should be addressed.

(b)b. [numbering glitches?] This section says a provider can administer medications only through a licensed nurse or "other healthcare professionals authorized to administer medication." However, under the Consumer-Directed Care Act (Arkansas Code Ann. 17-87-103(12) and the ASBN Rules, Chapter 5, Delegation) authorize individuals or caregivers to delegate certain medication administration and other health maintenance activities to unlicensed direct care aides. Considering reviewing the old DDS waiver certification rules that had a section on the CDCA.

(c)(h)(iii)– Is this stating the plan must give a physical description of the medication or what description is it referring to? This may need to be worded differently as to state what the medication is primarily treating, otherwise if they are wanting a physical description of the medication this can change with each pharmaceutical company and there will not be any consistency in this circumstance.

(c)b.(v) – Is this stating we need to indicate on the plan that it will be charted on a Med Log?

(c)b.(vi) – Potential side effects are numerous for most drugs. Why not require client-specific side effects unless said individual is starting a new medication and does not know if there will be side effects from this particular med. And then, we suggest limit to most common or the list will be way too long.

(d)b.(iii) -- This may need to be more clear to state route of administration i.e. by mouth, inhalation, per tube, etc..... versus delivery.

(d)(b)(ii)-- This symptom to be addressed should be indicated on the med management plan not the med log -- there is only so much room on a medication log, unless it is pertaining to a PRN drug that is only used for certain symptoms and that will be listed on the original pill bottle/container.

(d)b.(vii) **–** Regarding transfer of meds from original container into individual dosage containers by the guardian **--** Will this need to be indicated on a med log even if the individual administers their own medication?

Response: Please see other responses on this topic.

Comment: 1007 Daily Service Logs-We have no problem with daily service longs, but (b)(5) seems excessive – having to describe every day the relationship of the HCBS service to the treatment objectives. That changes much less frequently than every day and should be addressed in the individual treatment plan.

Response: Please see previous response on this topic.

Comment: 801 Reconsiderations and 802 Appeals--These sections also should reference the Medicaid Fairness Act for adverse actions that fall under that Act. (See comment under "Adverse Action" definition above.)

Response: Please see previous response on this topic above.

David Ivers, J.D., VP for External Affairs & General Counsel
Easterseals Arkansas

Comment: We agree with the Department's efforts to find a way to break down silos in order to meet the needs of individuals with complex needs. However, the proposed manual is extremely confusing. The service descriptions continue to reflect the input of behavioral health providers but little if any input from intellectual and developmental disability providers. We believe the proposed manual needs to be pulled back and addressed with a workgroup of IDD providers who can help the Department to supplement the service descriptions with appropriate language that will benefit individuals whose primary diagnosis is IDD but who have behavioral health needs as well.

Which providers/which services? Also, it is not clear which providers can bill which services for which clients. For instance, can CES Waiver providers bill any service in this manual provided it is medically necessary? If so, does it matter whether the client qualifies under 1915(i) or CES Waiver? If they cannot bill any services in the list, which services are CES providers limited to? What services can OBHA providers bill and for which clients? Can CSSP agencies bill any service under their level of certification for any client regardless of whether the client qualifies under CES or 1915(i)? If not, please explain.

Response: Thank you for your comment and the state believes that services and levels of certification have been added to address the needs of the behavioral health population as well as individuals with IDD that have symptoms of a behavioral health condition. Service descriptions for the majority of services did not change and instead were moved from a PASSE manual to a new HCBS manual to work in concert with the 3 levels of CSSP certification. Also see previous responses above.

Comment: Accreditation issues. Finally, the proposed CSSP Rules state that a CSSP agency must have accreditation to provide any HCBS service. Does that mean CES Waiver providers also must have accreditation to provide any HCBS service in this list? If so, which ones? And which CARF accreditation sections will suffice for which services?

Response: Accreditation is required for CSSP at this time. It is not a requirement in the CES Provider certification manual.

Comment: What is the status of the state's 1915(i) State Plan Amendment? We could not locate a copy online.

Response: It is with CMS waiting for approval.

Comment: Section 202.000 Participation Requirements. This says the individual must tier at a level 2 or 3. Hasn't a Tier 4 been added?

Response: Thank you for your comment. Tier IV is not an eligibility determination and therefore was not included.

Comment: Section 203.00 Provider Certification Requirements. This section says participating providers must be certified under as either OBHA, CES, or CSSP. Many of the services taken from the proposed 1915(i) SPA pertain solely to behavioral health needs or to a mixture of BH and DD needs? In the August 2, 2022 promulgation of 1915(i), the Department removed CES Waiver providers as eligible providers for these services. *Are you saying that CES providers can provide any service in this manual?* That would seem to allow CES Waiver providers to provide any of these services without having to meet the heightened requirements of CSSP. Is that what was intended? What would be the need to become a CSSP Agency if so?

Response: No, see previous responses to this question above.

Comment: 210.000 Home and Community-Based Services Under ABHSCI**.** Elsewhere in this promulgation the Department proposes to repeal ABHSCI. Thus, we are confused as to how this section can be limited to ABHSCI.

Response: ABSCHI will be replaced with Behavioral Health Adults receiving HCBS services outside of the PASSE.

Comment: 220.000 Home and Community-Based Services Under PASSE**.** 220.100 Behavior Assistance – Is this limited to clients whose primary diagnosis is BH? The wording indicates it is ("rehabilitative and restorative in nature," children and adolescents at risk of out of home placement after return form residential placement, "offending behaviors, aggressions, and oppositional defiance." etc.) If it were reworded, it could be useful for clients with IDD who have challenging behaviors.

Response: Services have not been reworded due to the ability of each PASSE to authorize services based on the member's individual needs.

Comment: 220.110 Crisis Stabilization – Is this limited to clients whose primary diagnosis is BH? Also, the last two sentences appear to be a section of the CMS template that was left in.

Response: This service is used to address a behavioral health crisis. Each PASSE may authorize services to meet the member's need regardless of diagnosis.

Comment: 220.120 Assertive Community Treatment – Is this limited to clients whose primary diagnosis is BH? The wording says it is typically targeted to individuals who have "a serious mental illness or co-occurring disorders, multiple diagnoses, and the most complex and expensive treatment needs."

Response: Please see above. All HCBS under the PASSE model will have the same response.

Comment: 220.130 Intensive In-Home for Children – Is this limited to clients whose primary diagnosis is BH? The wording is heavily BH-oriented.

Response: Please see responses above.

Comment: 220.140 – Adult Rehabilitative Day Service -- Traditionally, this service has been for individuals with chronic mental illness, and the wording still reflects that. Is there a comparable service for individuals with intellectual and developmental disabilities who have complex, higher needs that cannot be met easily in the traditional waiver HCBS setting?

Response: Adult Developmental Day Treatment.

Comment: 220.150 Peer Support – Is this limited to clients whose primary diagnosis is BH? Again, the wording is BH-oriented.

Response: Please see responses above.

Comment: *220.160 Family Support Partners ("intensive" CSSP level) – Thank you for specifically referencing "developmental disabilities" in this description. The service should prove helpful. However, why is it limited to "*Intensive Services*" certification under CSSP if a CES Waiver provider can offer the same service without meeting any additional requirements?

Response: Thank you for your comment.

Comment: *220.170 Pharmacological Counseling by RN – Thank you for including this service since this could apply to individuals with both IDD and BH needs. Does this mean CES Waiver providers can now provide this service to any client or only those under 1915(i)?

Response: No, please see responses above. The specific services for each provider type are outlined in the certification manuals. A CES Waiver provider would need to be enrolled as a CSSP to provide this service since it is a 1915i and not available under the CES Waiver provider type.

Comment: 220.180 Respite – This is a much-needed services. However, unless the reimbursement rate is increased above current levels, providers will not be able to afford to provide to any significant extent. Families definitely need relief. Please re-evaluate whether the rates being paid are sufficient to meet access requirements.

Response: Thank you for your comment.

Comment: *220.190 Supportive Life Skills Development – Thank you for including "or habilitative plan." However, please clarify how this service differs from Adult Life Skills? From Supported Living under CES Waiver? From Personal Care?

Response: Supportive Life Skills Development is a service for transition aged youth that have experienced behavior issues that have prevented them from obtaining skills for adulthood.

Comment: 220.200 Child and Youth Support Services – Is this limited to clients whose primary diagnosis is BH? The wording indicates yes. Along with "symptoms of illness" we would suggest adding "challenging behaviors" or words to that effect.

Response: Please see previous responses above in regards to HCBS and who can receive the service.

Comment: 220.210 Supportive Employment – Why is there a separate CES Supported Employment? We are not opposed to that but are confused as to whether we are blending service lines or not and if so, how.

Response: While supported employment is focused on helping clients with IDD, supportive employment under the 1915i is focused on helping address behavioral health concerns in the workplace or community. Again, the PASSE can determine which HCBS to approve for the member.

Comment: 220.220 Supportive Housing –Is it limited to clients whose primary diagnosis is BH? It seems to be taken from substance abuse services ("transitional housing" and "chemical free living,").

Response: Please see previous responses above in regards to HCBS and who can receive the service.

Comment: 220.230 Partial Hospitalization –The wording is heavily BH-oriented – is it limited to clients whose primary diagnosis is BH?

Response: Please see previous responses on why we did not reword service descriptions.

Comment: *220.240 – Therapeutic Host Homes – Thank you for including and for referencing "developmental disability needs." Without some sort of certification/inspection process, providers may be reluctant to refer clients to a host home and families may be reluctant to utilize.

Response: Thank you.

Comment: 220.270 Therapeutic Communities –Is this limited to clients with a primary diagnosis of BH? The wording indicates that it its, but we have heard from various parties of the need to provide this type of service to individuals with IDD with complex needs.

Response: Please see previous responses regarding who can utilize HCBS under the PASSE.

Comment: 220.280 Residential Community Reintegration Program -- Can this be revised to better accommodate individuals with IDD? For instance, the first sentence says it is an intermediate level of

care between inpatient psychiatric care and outpatient behavioral health services. Individuals with IDD who have behavioral challenges make transitions from various settings as well.

Response: Please see previous responses regarding who can utilize HCBS under the PASSE.

Comment: 220.290 to 220.300 and 220 through 220.380 CES Supported Employment; Supported Living; Adaptive Equipment; Community Transition Services; Consultation; Environmental Modifications; Supplemental Support; Respite; Specialized Medical Supplies –These services are taken from the CES Waiver. Are they limited to members whose primary diagnosis is IDD. Why would a provider bill under this program rather than under CES? It seems like we are maintaining most of the same silos since the services continue to be defined differently for BH and IDD.

Response: No, any PASSE member may receive an HCBS under the PASSE if the PASSE authorizes the service to meet a member's functional need.

Comment: 220.130 Complex Care Homes for IDD – Thank you for including this service (see our comments on the CES Waiver seeking more clarification).

** indicates the only 4 services that are not in CES Waiver that seem by their wording to be written to include individuals whose primary diagnosis is IDD.*

Response: Thank you for your comment.

Comment: REIMBURSEMENT**.** This section seems to pre-date the decision to repeal AHSCI. Can you clarify?

Response: ABHSCI will be replaced with Behavioral Health Adults receiving HCBS services outside of the PASSE Program.

David Ivers, J.D., VP for External Affairs & General Counsel
Easterseals Arkansas

Comment: 211.200. Staff Requirements. For Non-Independently Licensed Clinicians, Physician, etc. – please add "or contracted with" after "employed by."

Response: Thank you for your comment. We will review internally.

Comment: 212.000 Scope. Shouldn't "or CSSP Agency" be included as an eligible provider type along with a BH provider?

Counseling Services definition – shouldn't allowable settings include "outpatient-based setting" as in 214.000 since new providers who are not BH agencies may not fit within the other named locations.

Response: Allowable location codes are attached to each service and should be used for all eligible provider types.

Comment: 213.000 Counseling Services Program Entry--This section says, "The intake assessment, either the Mental Health Diagnosis, Substance Abuse Assessment, or Psychiatric Assessment, must be completed prior" to starting Counseling. Does this mean any one of those three suffice as an intake assessment? Section 252.122 Psychiatric Assessment says it is NOT required to receive Counseling Services.

Response: Yes, any of those three assessments can be used to establish a diagnosis and begin counseling services. A specific psychiatric assessment is not required.

Comment: 214.100 Parent/Caregiver & Child (Dyadic treatment). It says providers must be certified by DAABS to provide this service. Earlier the manual says they can be a CSSP provider for the services in this manual.

Response: Dyadic treatment requires a separate certification for the rendering provider.

Comment: 217.100 PCP Referral--Shouldn't the third sentence in the second paragraph say no services except Crisis Intervention may be provided without a PCP referral "after the initial ten (10)?

Response: Crisis Intervention service definition has been updated for clarification.

Comment: 216.100 Documentation--Daily documentation is understandable, but "F" seems excessive – having to describe every day the relationship of the services to the treatment regimen described in the treatment plan. That changes much less frequently than every day and should be addressed in the treatment plan.

Response: Thank you for your public comment.

Comment: 229.000 Medicaid Client Appeal Process--Where is the section for Provider Appeals, which should reference the Medicaid Fairness Act?

Response: Thank you for your comment and please see other DHS responses pertaining to the appeal language and needed amendments.

Comment: 202.110 Counseling Level Services--This appears to be a heading for all the services descriptions that follow, not a separate section in and of itself.

Why is CSSP Agency site not mentioned in the allowable settings under each service?

Response: CSSP is not a setting, it is a provider type. Provider would use the applicable location code.

Comment: 252.121 Pharmacological Management-How does Pharmacological Management here differ from Pharmacological Management by an RN in the HCBS Manual?

Response: Pharmacological management in this manual is a service provided by a licensed physician or APN to prescribe and monitor medications. Pharmacological Management by an RN is a HCBS service provided by an RN to assist with medication compliance.

James Atkins, Pediatrician

Comment: My name is James Atkins, and I am a pediatrician in Monticello. Integrated behavioral health matters to me due to inaccessible mental health care for children in our state, especially the rural area of our state. Pediatricians, like many providers, are caring for children and youth experiencing the current behavioral health crisis. Screening, assessing, and treating children for emotional and behavioral needs in real time in the primary care setting is an effective way to remove barriers to access and ensure quick action for children and youth in crisis. I support the concept of integrated behavioral health and applaud the rule changes that have been proposed to permit employment of licensed therapists in physician offices. In particular, I support activating payment for depression screenings and maternal/caregiver depression screenings in the pediatric primary care setting, which aligns with American Academy of Pediatrics recommendations. I do my best to provide the best possible care to my patients and closely follow AAP recommendations. I have screened numerous mothers of infants and diagnosed them with postpartum depression. I spend time screening and finding them assistance so it would be nice to receive reimbursement for my services. We would love to be able to provide time-limited, preventive counseling or psychoeducation services without a diagnosis to prevent escalation of risk factors as well.

Response: Thank you.

Jared Sparks, PhD, LCSW, CHC, Vice President of Quality & Compliance
Arisa Health

Comment: Why is the state of Arkansas rejecting the successful and nationally recognized Certified Community Behavioral Health Center model for Behavioral Health in favor of this one designed for Intellectual and/or Developmental Disability populations? We know the PASSEs serve approximately 55,000 beneficiaries, only 6,000 who are IDD. Why design a system based on 11% of the total population?

Response: Thank you for your comment. It is unclear from the question if you are referring only to the additions made to the Community Support System Provider (CSSP) Certification manual and if that is the case the original CSSP certification and provider type was created and promulgated in January of 2021. Updates to this manual include the addition of a new level of certification to provide professional oversight of services delivered to individuals with a behavioral health diagnosis or an intellectual disability and symptoms of a behavioral health condition. The system has been designed to support the rural workforce in AR in the delivery of HCBS across all populations and enabling new providers to provide HCBS to broad or narrow populations within the PASSE.

Comment: There are no new published daily rates for Community Support System Providers. This prevents planning for sustainable service delivery.

Response: Rates are not published for provider types and instead published separately for services. Rates are not included in AR Medicaid service or certification manuals.

Comment: Page 5. 103. Definitions (m) CSSP Agency Enhanced Services means one of the following services each as defined in section 280.000 of the Provider-Led Arkansas Shared Savings Entity (PASSE) Medicaid Manual (3) Adult Rehabilitation Day Treatment and 1003. Specific Requirements (c) CSSP Agency Enhanced owned or leased facility must provide each client with:

(1) An individual bed…bedroom furnishings…

In this manual there is no provision for Rehabilitation Day Treatment to be provided outside of an Enhanced level or Intensive level of care. Rehabilitation Day Treatment Services are an essential component of treatment for those clients with functional deficits due to qualifying illnesses and disabilities. In a state where 41% of the population live in rural counties, access to a day program enables more service for a broader geographic region than would be possible through individual services, especially given the nationwide shortage of behavioral health workers. Making this available only for residential clients creates a gap in care that cannot be filled by other services or a combination of services. Can these level of care and facility requirements be removed for Rehabilitation Day Treatment, so that Rehabilitation Day Treatment can be provided in the CSSP Base Services?

Response: Adult Rehabilitative Day Service will remain under the CSSP Enhanced certification due to the location of the service being limited to clinic settings. The CSSP Certification manual will be updated to indicate the regulations related to treatment programs in which the client is provided with treatment 24 hours per day and 7 days per week.

Comment: Page 7. Home and community-based services means services that are available under the provider-led Arkansas Shared Savings Entity (PASSE) program manual for Medicaid clients who have behavioral health, intellectual disability, or development disability services needs

In the past there has been confusion about whether the BHA manual, OBHS manual, and Therapeutic Communities manual governed CSSP TC providers services. What manuals govern services in the CSSP manual?

Response: The CSSP is a certification manual for an AR Medicaid enrolled provider type. The Outpatient Behavioral Health Agency manual is a certification manual for an AR Medicaid enrolled provider type. The OBHA provider is certified to provide the professional services now contained in the Counseling Services manual and the 1915 (i) services contained in the new HCBS for Clients with Intellectual Disabilities and Behavioral Health Needs. The CSSP certified provider can provide services in both manuals as well depending on their level of certification-Enhanced, Intensive or Base.

Comment: Are clients who have Medicaid Spend Down eligible for HCBS services under the PASSE manual in Therapeutic Communities? Previously these services were only available under the Adult Behavioral Health Services for Community Independence.

Response: ABHSCI will be replaced with Behavioral Health Adults receiving HCBS services outside of the PASSE Program.

Comment: Page 15. Certification Process. Will there be a grandfathering of current BHAs to CSSPs?

Response: All Outpatient Behavioral Health Agencies (OBHA) in good standing can be grandfathered as a CSSP Intensive level provider if they wish. The OBHA certification is not being sunset.

Comment: Page 19. 303. Employee Training. **T**raining requirements of "all employees" is excessive. Can this be limited to direct service providers?

Response: The intention of the state was to require training of direct service providers only. Language will be added to clarify.

Comment: Page 27**.** 308. Financial Safeguards-- a. … or the CSSP otherwise has the *legal authority* to limit a client's use or access of their own funds…".

Does "legal authority" mean only as approved as payee by the Social Security Administration? What is the definition of legal authority?

Response: Legal authority would be an individual or governmental entity that has the authority to dictate the use of a client's funds or other assets. Social Security Administration could be an example as it pertains to a client's social security funds. A court and legal guardian would be others.

Comment: Page 30**.** 310.a(3) – Employees and clients must wash their hands with soap before eating, after toileting, and as otherwise appropriate to prevent the spread of infectious disease. Is alcohol-based hand sanitizer permitted in place of soap?

Response: We believe best practice is to use soap and water but understand if sometime hand sanitizer is used instead. We will look at clarifying the language.

Comment: Page 32**.** 3112 Emergency Response Services**--**Emergency Response Services: Applicants/providers must establish, implement and maintain a site-specific emergency response plan, which must include:

3. Direct access to a mental health professional within fifteen (15) minutes of an emergency/crisis call and face to face crisis assessment withing two hours. Please clarify that telehealth may be used to provide access and assessment in the above requirement.

Response: We agree and will clarify the language.

Comment: Page 52. Subchapter 5. Incident and Accident Reporting-501. Incidents to be Reported.

(a) A CSSP Agency must report all alleged, suspected, observed, or reported occurrences of any of the following events.. Please clarify that incidents and accidents to be reported are incidents and accidents that occur only at the CSSP site and/or during the delivery of a CSSP service.

Response: Correct.

Comment: (7) Any situation where services to the client are interrupted for more than one (1) hour…

This is too broad of a category. Please provide some clarity on how this can be meaningfully applied, as it occurs on a regular basis for multiple reasons related to health, emotional lability, family issues, etc.

Response: Thank you for your comment. We will discuss internally and provide additional clarifications and guidance around incident reporting requirements.

Comment: (10) Any act or admission that jeopardizes the health, safety, or quality of life of a client. This is too broad of a category. Please provide some clarity on how this can be meaningfully applied.

Response: Thank you for your comment. We will discuss internally and provide additional clarifications and guidance around incident reporting requirements.

Comment: (11) Motor vehicle accidents involving a client**.** Please clarify that this is only during the time a client is transported by CSSP employees.

Response: Correct.

Comment: Page 54.DPSQA shall monitor a CSSP Agency to ensure compliance with these standards:

(a) Cooperation required under these standards…with respect to investigations, surveys, site visits, reviews, an other regulatory actions taken by DPSQA or any third-party contracted.

Over the past several years, the third party contracted to conduct audits has provided reports that are inconsistent with the content of the provider manuals, and there has not been timely feedback on inspections or reconsiderations. This creates an unnecessary administrative burden on providers. Can audit tools be made public as required? In these tools, can intent statements for ambiguous standards be created/made public so that there is some consistency between auditors and audits?

Response: Thank you for your comment. DPSQA is working with the vendor to ensure the tools they use are correct in accordance with the certification standards.

Comment: Page 64. Employees and Staffing Requirements. Multidisciplinary Team Leader (Individual who has licensure and training applicable to the treatment of the individual client indicated in the individualized plan of care) Is the individualized plan of care referenced in the CSSP manual developed by the CSSP provider or PASSE?

Response: The plan is developed by the provider.

Comment: There is no individualized treatment plan identified in this manual as it was in the previous CSSP manual. Outside of any medication management plan and behavior management plan, are there any specific requirements for a treatment plan and/or plan of care? For example, what is the review period, who develops, and who signs?

Response: Service providers develop treatment plans outlining the service you are providing the client. Treatment plans are incorporated into the member's overall PCSP if the person is in a PASSE.

Comment: Page 68. General Requirements. (a) (1) A CSSP Agency Therapeutic Community or Community Reintegration Program can house no more than sixteen (16) clients

Currently, Therapeutic Communities do not always have clients at one address. Some have 16 beds at one site. Others have individual homes or other residences that are geographically separated. Please clarify that this requirement allows for separate addresses that together house no more than 16 clients - to be connected to one certification.

Response: Thank you for this comment. We will discuss this internally and make amendments to clarify.

Comment: Page 71-1003 Specific Requirements--(13) A kitchen with equipment, utensils, and supplies necessary to properly store, prepare, and service three (3) meals a day.

(2) …a shower or bathtub

A CSSP offering only Base service does not need a kitchen or shower/bathtub. Can you clarify what specific requirements apply to a CSSP providing only Base services?

Response: The requirements you listed above pertain to the Enhanced level if a client is living in a CSSP location.

Comment: Page 71. 1003. Specific Requirements-(c) CSSP owned or leased facilities must provide each client with (5) One (1) or more windows that can open and provide an outside view. This eliminates the option for interior bedrooms, increasing the cost significantly of the facility.

Additionally, this is not advisable for some clients who are under court order, and the setting exceptions and variations in 1004 does not take into consideration facility structures designed to accommodate these clients. Can this be removed as a requirement?

Response: Thank you for your comment. We will need to discuss this more internally.

Comment: Page 74. 1005. General Nutrition and Food Service Requirements. a. (2) All food brought in from outside sources must be:

(A) From food service providers approved by ADH and transported per ADH requirements;

(B) In individual, commercially pre-packaged containers; or…

This eliminates the option to contract with local restaurants for meals and snacks. Can this be modified to allow for contracting with local restaurants?

Response: Thank you for your comment. We will need to discuss this more internally.

Haley Thomas MRC, LPC, Director of Clinical Operations
Families, Inc. Counseling Services

Comment: 217.100 Primary Care Physician Referral

Each ~~beneficiary~~client that receives ~~only C~~counseling ~~Level S~~services in the ~~Outpatient Behavioral Health~~Counseling Services program can receive a limited amount of ~~C~~counseling ~~Level S~~services. Once those limits are reached, a Primary Care Physician (PCP) referral or PCMH approval will be necessary to continue treatment. This referral or approval must be retained in the ~~beneficiary~~client's medical record.

A ~~beneficiary~~client can receive ten (10) c~~C~~ounseling ~~Level~~ services before a PCP/PCMH referral is necessary. Crisis Intervention (Section 255.001) does not count toward the ten (10) counseling ~~level~~ services. No services, except Crisis Intervention, will be allowed to be provided without appropriate PCP/PCMH referral. The PCP/PCMH referral must be kept in the ~~beneficiary~~client's medical record.

The Patient Centered Medical Home (PCMH) will be responsible for coordinating care with a ~~beneficiary~~client's PCP or physician for ~~C~~counseling ~~Level S~~services. Medical responsibility for ~~beneficiaries~~clients receiving ~~C~~counseling ~~Level S~~services shall be vested in a physician licensed in Arkansas.

The PCP referral or PCMH authorization for ~~C~~counseling ~~Level S~~services will serve as the prescription for those services.

Verbal referrals from PCPs or PCMHs are acceptable to Medicaid as long as they are documented in the ~~beneficiary~~client's chart as described in Section 171.410.

See Section I of this manual for an explanation of the process to obtain a PCP referral.

We would like to see the Arkansas Department of Human Services reconsider requiring PCP referrals for Counseling Services. Many ,if not most insurance companies, don't require these referrals, as they prolong the time it takes to get clients into services. They also add additional barriers to mental health treatment. Often the wait to see a Primary Care Physicians is weeks if not longer with the current shortage. The manual does allow for 10 visits at the beginning of treatment before a referral is needed but doesn't allow for that when the referral expires and an additional one is needed. Also, the manual requires in 224.000 that providers " must have relationships with a physician licensed in Arkansas in order to ensure psychiatric and medical conditions are monitored and addressed by appropriate physician oversight." One would argue that this oversight is enough to ensure appropriateness of clients into services. Not requiring a PCP referral would not only remove a barrier and ensure continuity of care but would also save money as the extra service provided by the PCP wouldn't be needed.

Response: Thank you for your comment. AR Medicaid enrolled physicians need to be part of the discussion to change this requirement.

Comment: In the Diagnostic and Evaluation Services Manual: 202.000

202.000 Eligible Clients for this Manual **1-1-23**

A. Clients who have received a mental health diagnostic assessment by an allowable licensed professional, and has begun mental health counseling services, can receive a psychological evaluation to confirm the diagnosis in order to guide continued behavioral health counseling services.

We would like to see the Arkansas Department of Human Services reconsider requiring that a client " has begun mental health services." Often providers for evaluation services have clients who receive

counseling services at another provider. It would cause an undue hardship to have to confirm these services. If providers decide to not take outside referrals for evaluation, then the very small pool of providers of evaluation would further shrink for the Medicaid clients who need these services. Furthermore, there are many legitimate reasons that clients may want evaluation services before any counseling services are provided (ie... to determine if medication only services will effectively treat the diagnosis). Clients also deserve the autonomy to have a diagnosis confirmed regardless on their choice of how to treat it.

Response: Psychological testing for individuals with Behavioral Health issues is being used for the clarification of diagnosis and to inform treatment planning of existing clients when a Diagnostic Assessment and Psychiatric Assessment have not clarified diagnosis and appropriate course of treatment.

Comment: 220:100

220.100 Client Requirements 1-1-23

A. The client is less than 21 years of age; and

B. The client is an enrolled in Arkansas Medicaid; and

C. The client has a referral from their primary care physician for testing to establish a diagnosis of Autism Spectrum Disorder.

On 220:100, we would like to recommended that the Arkansas Department of Human Services reconsider the requirement for a PCP referral for ASD evaluation. Often clients are referred from their Mental Health Professional and/or Psychiatrist , both of whom are trained to identify symptoms of Behavioral Health Diagnosis as well as symptoms of Autism. To then ask for an additional referral from a PCP provides a barrier to the service as well as additional cost to the system.

Response: We agree that this should be amended to reflect the statute.

Comment:

220.200 Evaluator Requirements 1-1-23

A. To perform an adaptive behavior and/or intellectual assessment to establish an Autism Spectrum Diagnosis, the clinician must be one of the following:

1. A Licensed Physician
2. A Licensed Psychologist (LP)
3. A Licensed Speech Language Pathologist

Lastly, We would like to recommend that the Arkansas Department of Human Services reconsider excluding LPE(I)s from the accepted list of clinicians who can evaluate for ASD. They are well trained and currently providing the service. The wait list in Arkansas for ASD evaluation is already very lengthy due to a small pool of evaluators. If you exclude LPE(I)s you will be effectively limiting the pool of evaluators and creating even longer wait times. This is detrimental, as it is well known, that early intervention produces the best outcomes for those diagnosed with ASD.

Response: We agree. A LPE may evaluate if it is within their scope of practice under a licensed psychologist.

Craig Cloud, Chief Executive Officer
Friendship Community Care

Comment: Thank you for the opportunity to provide public comment/ feedback on these proposed rules. All changes presented are extensive and represent significant changes that must be implemented by our provider network. Implementing these rules without fully reviewing and vetting the changes and the related impact only creates dysfunction. Friendship Community Care is committed to the provision of services to individuals with specialized and complex needs. Friendship supports these efforts to ensure proper access to services for individuals served

These changes and rules were not developed nor fully discussed with the providers, stakeholders, and consumers. As a provider that will be charged with implementing these new rules it is important the impact of said changes be communicated and understood by the provider network. Failure to ensure proper coordination between DHS, the PASSE, and providers on these changes only creates dysfunction for the consumer and our service system as a whole. I respectfully request that DHS hold on the approval and implementation of said rules until such coordination, communication, and education can occur.

Response: Thank you for your comment. We are taking all public comments very seriously and will be making adjustments based on these comments. Due to the short timeframe, we cannot postpone the promulgation package at this time.

Comment: Subchapter 1 103 Definitions--Item E Does a chemical restraint require all 3 requirements. For example, if a client has a PRN Xanax for anxiety is that considered a chemical restraint?

Response: A chemical restraint is the use of a medication outside of a client's normally prescribed, daily medication routine that is used to change a client's immediate behavior.

Comment: Item E-3 What is considered to not be a standard treatment?

Response: Not standard treatment is what is described above. The medication used is not part of the client's regular daily medication and is used in an emergent situation to change the client's behavior.

Comment: Item F--Can you explain what a complex care home is within the CES waiver and the difference from a CSSP complex care home? DHS was to request a waiver from CMS to allow 6 individuals in a home setting, has this been changed to 8? These new proposed rules do not address group homes or provider owned/managed apartments/ independent living units.

Response: A complex care home can be provided by a CES Waiver provider or a CSSP provider. It was our intention to make the certification standards the same in both manuals. We did receive approval from CMS to implement Complex Care homes. It is located in the Supportive Living definition in the

waiver itself. The waiver is silent on group homes, but DDS will continue to grandfather in existing group homes.

Comment: Item S Will Risk Mitigation Plans be developed with the providers input, and will this be shared with providers?

Response: We are continuing to work with the PASSEs to develop and utilize ONE Risk Mitigation Plan/Screen. We will invite IDD and BH providers to join into that discussion to provide input on the tool.

Comment: Subchapter 3 Administration. 302 Employee and Staffing Requirements- Item D Is experience no longer acceptable when no GED or HSD is available? Will current staff be grandfathered in?

Response: Please see previous response on this topic.

Comment: 305 Client Service Records. Item B-1-J This item states Medicaid Number, but no PASSE number? Item B-4 Care Coordinator information is difficult to get with turnover and no notification from PASSE.

Response: We understand. Please see previous response on this topic in regards to care coordinator information. As to Medicaid ID, Medicaid still validates claims and clients by Medicaid ID.

Comment: Item C-4 Please clarify what is the difference between Behavioral Prevention and Intervention Plan, Positive Behavior Support Plan, and Risk Mitigation Plan?

Response: Please see response on this topic above in the document.

Comment: 309 Emergency Plans and Drills. Item A-1 Does this mean we are required to have emergency plans and evacuation drills a clients private home in the community?

Response: Please see previous response on this topic.

Comment: Subchapter 5 Entries and Exits. 503 Refusal to Serve. Will DDS be developing criteria for determining a refusal to serve?

Response: Please see previous response on this topic.

Comment: Item B What is considered a reasonable effort to recruit and retain qualified personnel?

Response: Thank you for your comment. The reasonableness of efforts is determined on a case-by-case basis depending on the applicable circumstances.

Comment: Item D What is considered a legitimate client health, safety, or welfare concern? Is there a process for appeal? What are the consequences of no longer being able to serve a client?

Response: Thank you for your comment. Legitimate concerns would be determined on a case-by-case basis depending on the applicable circumstances. If there is a violation, then potential consequences and appeal rights would be the same as any other violation of the Rules as set out in Subchapter 8 and 10 respectively.

Comment: Subchapter 6 Programs and Services. 602 Behavioral Management Plans

Item A-1-C Will DDS provide a list of acceptable trainings to be able to implement and develop behavioral prevention and intervention plans?

Response: We do not plan to provide a list. It is the provider's discretion. The required modules/topics are outlined in the approved CES Waiver.

Comment: Item 2-C Will a QDDP no longer be able to be considered to implement and develop a positive behavior support plan?

Response: The definition of Consultation was amended in the CES Waiver earlier this year. That waiver was run in public comment, promulgated and approved by CMS. In the waiver it states, screening, assessing and developing positive behavior support plans, assisting staff in implementation, monitoring, reassessment and plan modifications; is required when a high level of behavioral related risk is identified in the PASSE Risk Mitigation Plan; allowable providers include psychologist, psychological examiners. PBS, BCBA, licensed clinical social workers and licensed professional counselors. QDDP, if trained, can complete a Behavioral Prevention and Intervention Plan, which we anticipate a large number of IDD clients needing.

Comment: 604 Supportive Living. Item A-4 What is considered an acceptable staffing back up plan?

Response: This would be determined on an individual basis but could include having staff on call, temporarily using natural supports, etc. The goal is to staff our clients when it has been determined in the treatment plan that staff was needed at that time.

Comment: Item B-6 Please define an acceptable narrative.

Response: A daily progress note is required for supportive living that reflects that the activities conducted that day assisted the client with acquiring, retaining, or improving a skill that has been identified as an area of need that is hindering the client.

Comment: 605 Respite. Item B-2 What are considered acceptable Respite Activities would these be the same goals and objectives used for Supportive Living services?

Response: Correct.

Comment: Subchapter 7. 701 Incidents to be Reported

Item 7 Please define unscheduled situation. For example, if a client's family comes unexpectedly and takes the client out for the day/ weekend/ week, would this be considered an incident that needs to be reported?

Response: Incidents are required to be reported if the provider is providing a service at that time.

Comment: 702 Reporting Requirements. Item A-1-C Please elaborate on what is considered an interest of the public?

Response: We will cross check the waiver to make sure this aligns with the language.

Jack Hopkins, Manager, Government Relations
Arkansas Health Plan Association Comments

Comment: In the Community and Employment Support Waiver Providers Manual, 305 (d) Should the PASSE be listed as an entity able to access the record?

Response: We can clarify. We felt that you were included in "governmental entity."

Comment: 403 (a) Settings Exceptions and Variations – states "any client need or behavior that requires a variation or exception to the requirements set out in Sections 401 or 402 must be justified in the client's PCSP."

- Recommend this to state "…must be justified in their treatment plan and supported by the PCSP" as the items listed below this section go into detail about what would be included in the treatment plan, not the PCSP.

Response: We will look at the language.

Comment: 601 (b) (1) A provider can administer medication only as: (A) provided in the client's PCSP → would recommend this be removed…care coordination should not dictate any re: medication administration

Response: We agree. It should say treatment plan which is incorporated into the member's PCSP.

Comment: 602 defines Behavioral Management Plans and Positive Behavioral Support Plans that are the responsibility of the provider based on the PASSE's Risk Mitigation Plan.

- How will certified Behavioral Health Agencies (BHA) receive reimbursement for a Positive Behavioral Support Plan? Currently this can be billed by a CES waiver or CSSP provider as consultation, but not by a BHA. Will a code/rate be established for Positive Behavioral Support Plans? What about a Behavioral Prevention and Intervention Plan?
- 602 (a) (1) (C) Who can do these plans? This is very vague → individual who has documented training on the following topics: verbal de-escalation, trauma-informed care, verbal intervention training. Stratifies low and high risk (who determines this?)

Response: Correct. Consultation is a service billable under CES Waiver and CSSP provider types. Please see other responses regarding the PASSEs responsibility to perform a Risk Mitigation Plan/Screen to determine the level of risk. That risk will trigger the type of plan needed for the member. Also note that this will not be effective until the summer of 2023 while we continue to work with the PASSEs to utilize ONE tool for Risk. Providers will be included in those discussions.

Comment: 607 and 608: care coordinators should not always be responsible for placing orders of these types of supplies. The manual reads as if this is a requirement

Response: We agree and will amend (c)(2) on page 37.

Comment: 610 Consultation: (1) administering psychological and adaptive behavior assessments. Allowing providers to perform psychological testing through this route becomes problematic when they are also Medicaid providers or in network with the PASSEs. The reimbursement rate is higher for this route (than the psych testing codes) and providers frequently attempt to bill via consultation for higher reimbursement rates of the same service.

Response: This mimics the language in the approved waiver. We will need to further discuss.

Comment: 611 (e.8) Environmental Modifications – The Care Coordinator should not be certifying at job completion that the modification is complete, the property was left in satisfactory condition and any incidental damages to the property were repaired. This should be the responsibility of the billing entity, and or the property owner. Agree, care coordinator should NOT maintain this function.

Response: We agree and will amend.

Comment: 702 (b) states "A provider must submit all reports to DDS" It doesn't state that the provider must also submit to the member's PASSE in addition to DDS. Currently the PASSE is responsible for notifying DDS of all incidents that we are notified of. Does this mean the PASSE is no longer responsible for notifying DDS of incidents? How will the PASSE be notified of our member incidents? Currently the process is for the provider to notify the PASSE and DDS.

Response: We agree and will amend.

Comment: In the Home and Community Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs CBS manual for IDD/BH, Assertive Community Treatment (ACT) has been added as a service offered by the PASSE but not to ABHSCI why was ACT not added to ABHSCI?

Response: The ABHSCI manual is being sunset. ACT is an allowable services for individuals outside of the PASSE under the Home and Community Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs. We will make needed amendments.

Comment: 202.000: lists only Tier II and Tier III as eligible to receive services…what about Tier IV?

Response: Tier IV is not an eligibility determination and therefore was not included.

Comment: 230.100 Method of Reimbursement: they state they have fee schedule for services provided under ABSCI (210) but no mention of fee schedule for HCBS services provided under the PASSE model (220)

Response: ABHSCI manual is being sunset and therefore there will be no corresponding fee schedule. The fee schedule would be under the corresponding manual.

Comment: In the Diagnostic and Evaluation Services Manual, 240 Reimbursement: A: providers are not allowed to accumulatively bill for spanning dates of service. Comment: sometimes evaluations and feedback are performed on two different dates of service, depending on complexity of testing and need for feedback/reporting.

The manual does not address provider types. We have current issues with provider type mismatches and psychologists not being allowed to do psych 96136/96137 and neuropsych testing codes 96132/96133.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: In the Licensure Manual for Community Support System Providers, 103 Definitions (k) Should N and O be included in Base Services? This is Pharmacological Counseling and Therapeutic Host Home.

Response: Yes.

Comment: 103 Definitions (dd) Qualified Community Support Provider (QCSP). What is the difference between a QCSP and Community Support Staff which is defined in (h)?

Response: This has been updated to Support Staff to be consistent.

Comment: 305 Client Service Records- All of the original (c) was removed. These are still listed in the CES waiver provider manual. Please clarify why the documentation that should be included in a client's service record was removed. Agree, need minimum documentation standards for this, especially given it is brand new.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: 501 Incidents to be Reported - #6 and #7 differ from the CES waiver manual's Incident Reporting requirements, CES waiver manual states 2 hours for items #6 and #7. Please clarify if this should be 1 hour or 2 hours?

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: 1002 General Requirements (b 2B)- Is the CSSP Facility in this section referring to the "Complex Care Home" only or all CSSP facilities such as Therapeutic Community or Community Reintegration? Is it just the "Complex Care Home that can't have more than 8 CES waiver clients or all CSSP facilities can't have more than 8 CES waiver clients even though Therapeutic Committees can house 16 members? Please clarify.

Response: This should say Complex Care Home. We will amend.

Comment: In the Physician Manual, a behavioral health screen may be administered along with an office visit. The allowable screening is up to two (2) units per visit and is allowable up to four (4) times per state fiscal year without prior authorization. An extension of benefits may be requested if additional screening is medically necessary. If a client is under the age of eighteen (18), and the parent/legal guardian appears depressed, he or she can be screened as well, and the screening billed under the minor's Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling screening limit. The physician must have the capacity to treat or refer the parent/guardian for further treatment if the screening results indicate a need, regardless of payor source.

- Is the screening billable, is it only in a physician office? If it is a billable service is there a CPT code and accompanying rate for this to be billed?

Response: Yes, is it billable, only in physician's offices and the code and rate will be published.

Josh Wilson, Ph.D, Chief Executive Officer
Independent Case Management, Inc.

Comment: Section 303(b). We request the language governing CPR and First aid requirements be clarified to reflect employees who may be required to perform direct care services to clients. This change will remove any doubt about organizations being able to hire people with physical disabilities who cannot complete CPR and First Aid training and who will not be required to perform direct care

services. For instance, an organization should not be prevented from employing someone with a disability who is physically unable to perform CPR if they will never provide direct care services to clients.

Response: Thank you for your comment. The requirements of Section 303 apply to employees. Section 103(j) defines "employee" as, "…an employee or other agent of a Provider who has or will have direct contact with a client or their personal property or funds, including without limitation any employee, independent contractor, sub-contractor, intern, volunteer, trainee, or agent."

Comment: Section: 503(c)(1)(2) Each PASSE is responsible for providing care coordination that includes assistance with social determinants of health. Housing is considered a social determinant of health according to the Centers for Disease Control. Therefore, we request that this language be revised to reflect the PASSE, not the provider, be responsible for the housing requirements reflected in this section.

Response: Thank you for your comment. Once selected as the supportive living provider, it is part of a provider's responsibilities to assist the client in locating and securing appropriate housing. If the client's preferred dwelling options are not available, then it is the responsibility of the supportive living provider to propose potential available alternative housing arrangements and working with the client to locate and secure an available housing arrangement acceptable to the client.

Comment: Section: 601(e)(1). We request that the language be revised to include the client being able to transfer the medication if they do not have a court-appointed guardian.

Response: Thank you for your comment. We are internally discussing if the language should read as follows: Section 601(e)(1) of the Rules for the Division of Developmental Disabilities Services Community and Employment Support (CES) Waiver Provider will be changed to read, "Kept in the original medication container unless the legal guardian, or, the client, if no legal guardian is appointed, transfers the medication into individual dosage containers;"]

Comment: Section: 602(a)(C). There is not consistency between the CES Waiver Rules and Section II of the Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs manual concerning the qualifications of who can develop and implement a behavioral prevention and intervention plan. The CES Waiver Rules only require training in verbal de-escalation, trauma informed care, and verbal intervention, while Section II requires the individual be a Positive Behavior Support Specialist. We request Section II be revised by removing the Positive Behavior Support Specialist requirement and only requiring the training mentioned earlier.

Response: A Behavior Management and Prevention Plan can be performed by a QDDP or other direct care staff who has been trained in the introduction to behavior management, abuse and neglect, verbal de-escalation, trauma informed care and verbal intervention. Those modules are outlined the CES Waiver. If a Positive Behavior Support Plan is needed, licensed professionals write, implement and oversee the plan. Therefore, additional training is not required. Positive Behavioral Support Plans should only be used when a high-risk level is identified in the Risk Mitigation Plan.

Comment: Section: 610(a)(11). We request this section by revised to include behavioral prevention and intervention plans.

Response: Thank you for your comment. We agree.

Comment: Section: 610(b)(13). We request that certification to become a Behavior Support Specialist be expanded to include any entity offering the certification. Limiting certification to only Partners for Inclusive Communities could greatly inhibit certification thus reducing the number of certified professionals.

Response: Thank you for your comment. See previous responses on this topic.

Comment: In the CSSP certification manual, Section: 103(l) Does certification as a CSSP Enhanced or Intensive organization permit the organization to provide the services set out in the Counseling Services Medicaid Manual?

Response: Yes

Comment: In the CSSP certification manual, Section303(d). We request the language governing CPR and First aid requirements be clarified to reflect employees who may be required to perform direct care services to clients. This change will remove any doubt about organizations being able to hire people with physical disabilities who cannot complete CPR and First Aid training and who will not be required to perform direct care services. For instance, an organization should not be prevented from employing someone with a disability who is physically unable to perform CPR if they will never provide direct care services to clients.

Response: Our intention was for this to be a requirement for direct services providers.

Comment: In the CSSP certification manual, Section: 901(2) We request that language be added to clarify that Corporate Compliance Officer, Medical Director, and Clinical Director responsibilities only pertain to behavioral health-specific services, not other services such as those for people with intellectual and developmental disabilities.

Response: This is a requirement for Intensive and Enhanced Levels of Certification therefore agencies certified under this manual should meet all requirements as indicated.

Comment: In the CSSP Certification manual, Section: 903. We request more information pertaining to the role of a Qualified Community Support Staff including the scope of services delivered by this role,

the population of people served by this role, and if and how it is different from a Direct Support Professional for people with IDD.

Response: The services allowed are outlined in the manual. The population is those individuals who have behavioral needs which may benefit from these services.

Comment: In the Counseling Services Manual, Section: 252.112. We request the home of a client be included as a location for group behavioral health counseling.

Response: Thank you for your public comment. We will continue to work with stakeholders and providers as we improve the behavioral health system. No change will be made at this time.

Sabrina Woodson, CEO
Focus, Inc

Comment: Pg.2 (f) (1) physical health need needs to be defined, for example, peg tube? Uses wheelchair? Who determines what is deemed to meet this?

Response: Thank you for your comment. The PASSE will determine if someone meets medical necessity to be in a Complex Care Home.

Comment: Pg. 9 302 a. "a provider must appropriately supervise all clients based on each client's needs" What does this mean?

Response: Thank you for your comment. Client needs can change by the month, day, hour, or even minute. Providers must always ensure each client has the level of supervision necessary based on the client's needs at that time. For example, this might mean a more enhanced supervision level than that included in a client treatment plan when the client's needs at the time warrant.

Comment: Pg. 9b 1. "a provider must meet any minimum staff-to-client ratio included in a client's treatment plan" Where is this supposed to be documented? This is not included on master treatment plan or PCSP at this time? What does this mean?

Response: Thank you for your comment. Any required staffing ratio should be included in the master treatment plan.

Comment: Pg. 11 303 (d) Basic health and safety practices means what? First aid and infection control covers this. Give examples of what is expected for health and safety practices training

Response: Thank you for your comment. specific trainings have intentionally not been listed to allow providers maximum flexibility in selecting the best and most appropriate trainings. Industry best practices and available training offerings change with such frequency that mandating specific trainings would quickly become limiting to providers.

Comment: Pg. 11 303 (f) Identification and mitigation of unsafe environmental factors. What is this? Would workplace safety cover this?

Response: Thank you for your comment. Specific trainings have intentionally not been listed to allow providers maximum flexibility in selecting the best and most appropriate trainings. Industry best practices and available training offerings change with such frequency that mandating specific trainings would quickly become limiting to providers. Presumably for CES Waiver direct care employee identification and mitigation of unsafe environmental factors trainings that focused on a residential as opposed to an office workspace would be most appropriate, but there are no specific requirements.

Comment: Pg. 11 303 (g) Emergency restraint procedures. Is this CPI traininng for all? Every staff? Who pays for this training if CPI training?

Response: Thank you for your comment. Specific trainings have intentionally not been listed to allow providers maximum flexibility in selecting the best and most appropriate trainings. Industry best practices and available training offerings change with such frequency that mandating specific trainings would quickly become limiting to providers. Training would be required for each employee. "Employee" is defined in Section 103(j) as "…an employee or other agent of a Provider who has or will have direct contact with a client or their personal property or funds, including without limitation any employee, independent contractor, sub-contractor, intern, volunteer, trainee, or agent."

Comment: P. 11 303 2 A Are we going back to every 12 months, currently is every two years?

Response: Thank you for your comment. Correct, the trainings set out in Section 303 are required annually.

Comment: P. 11 303 2 B Are we going back to a designated 12 hours of training and this 12 hours exclude subsectin (a)(1), why? We got away from the hours requirement.

Response: Thank you for your comment. There are no specific hour requirements tied to the annual training mandated by Section 303(a)(1). Regardless of how much time is spent training on the topics in Section 303(a)(1), Section 303(a)(2)(A) requires an additional twelve (12) hours of annual training for each employee and Section 303(a)(2)(B) lists certain topics that are required to be covered as part of those twelve (12) hours**.**

Comment: p.11 2 B (ii)Why is EVERYONE having to have care planning for autism when a staff might not even serve a client with ASD?

Response: Please see responses to other comments on this topic.

Comment: P. 11 303 (b) CPR certification from one of the following: AHA, MFA, or ARC. What about trainings that follow AHA guidelines but not specifically AHA, for example, Pro Trainings is the certification and follows AHA. But since Pro Trainings is not listed will it be accepted?

Response: Trainings listed will be accepted.

Comment: P.12 c(1)and (2) This is repetitive of 2(a)(b). 2(a)(b) is general training for 12 hours of care planning and de-escalation techniques, behavior modification or prevention training and then we have to client specific train on this. And these training don't even count the other specific trainings staff is too receive on maltreatment, incident reporting, etc. And staff can't even work before this amount of significant training or if they are over the 12 months. This is a tremendous amount of training and needs to be consolidated at a minimum. It is taking so long now to train and get staff in that providers are losing the new staff before we can even get them started. The training and hiring has become so complicated that it is not even feasible to date. The training and requirement process is so long now that it takes almost three weeks to get a new staff to start working. Again, not feasible. And the costs keeps growing.

Response: Thank you for your comment. All time spent conducting the annual client-specific training required by Section 303 (c) may be counted toward the annual twelve (12) hour training requirement in Section 303(a)(2). See Section 303(c)(3).

Comment: P.12 c (2) a PCSP training- We again do not get the PCSP's from PASSE CC, even though we ask.

Response: Thank you for your comment. See previous responses to this topic.

Comment: P. 13 304 a 4 All required Adult AND Long-Term Care Facility Resident Maltreatment Central Registry checks. Why is all Waiver staff having to obtain a LTC Facility Resident Maltreatment when we are not in that setting? This should be and/or

Response: Thank you for your comment. These are not separate registry checks. It is just a single registry. The name of the actual registry is the "Adult and Long-term Care Facility Resident Maltreatment Central Registry" that was established and mandated by the Adult and Long Term Care Facility Resident Maltreatment Act.

Comment: p.15 305 c8 We do not get copies of all completed client assessments and evaluations? Where and who has these? What assessments and evaluations are these?

Response: Thank you for your comment. The client's PASSE should have copies of all assessments and evaluations related to a client.

Comment: p. 15 305 c10 Copies of any leases or residential agreements related to the client's care? What does this mean? Do you want this for every client that has a lease? Or what makes it applocable for their care?

Response: Thank you for your comment. Any client living in a house or apartment that is not owned by the client should occupy the dwelling pursuant to legally valid rental or lease agreement that ensures the client has all rights and benefits required pursuant to Arkansas Residential Landlord-Tenant Act and Arkansas law.

Comment: p.18 309 a1,2,3 This is impossible for all locations without in house case managers. Who does this? What is the reimbursement rate for this? And required annually is not feasible.

Response: Thank you for your comment. There are no specific requirements tied to who must develop/write the emergency plan. There is no reimbursement rate related to the preparation and evaluation of a written emergency plan.

Comment: P.23 402 Complex Care Home Specific Requirements. Are these rules for both complex and residential home setting because we do not see requirements for residential in these rules and some of the number bullets state "at the residential setting"? If so, please see comments below

P.23 402 12. A reasonably furnished living and dining area? Is the provider paying for this or is the client paying to furnish their home?

14. Have written instructions and diagrams Every 25 feet?

15. lighted exit signs in houses?

16. lockable storage containers or closets for any chemicals, toxic substances, and flammable substances that must be stored at the residential setting? This states residential setting and not complex care home so is this the same setting? We currently do not have to lock these up in the home but we have MSDS paperwork.

C 1. Bed measuring 36 inches wide?

C.1.1 Mattress 4 inches thick?

Response: Thank you for your comment. Section 402 only applies to Complex Care Homes. Section 402(a)(3), (a)(4), and (b)(16) will be changed to replace the words "residential setting" with "complex care home."

Comment: P. 26 501 (b) A provider will remain responsible for the delivery of services until such time as the client's transition to the new provider is complete. A timeline needs to be set for the tranistion time (30 days or 60 days or 90 days), not ongoing.

Response: Thank you for your comment. The health, safety, and welfare of client dictate the continuance of services until a transition is complete.

Comment: P. 27 503 (b) Provider must be able to demonstrate reasonable efforts to recruit and retain qualified personnel and the results of those efforts. What is the expectation of the documentation? Need form from DDS

Response: Thank you for your comment. Specific forms or requirements have intentionally not been listed to allow providers maximum flexibility in documenting and demonstrating all employee recruiting and retention efforts and the result of those efforts.

Comment: P.27 503 ©1 If a provider is unable to ensure a client's health, safety, or welfare because of adequate housing……provider must propose alternative housing arrangements….. Who is going to do this? We provider direct care services not care coordination . This is a CC's job duty.

Response: Thank you for your comment. Once selected as the supportive living provider, it is part of a provider's responsibilities to assist the client in locating and securing appropriate housing. If the client's preferred dwelling options are not available, then it is the responsibility of the supportive living provider to propose potential available alternative housing arrangements and working with the client to locate and secure an available housing arrangement acceptable to the client.

Comment: P. 27 503 © 2 Provider shall document the client ahs refused available resources. Again, the Care Coordinator should be doing this. We should not have to notify the CC, they should be completing this.

Response: Thank you for your comment. Once selected as the supportive living provider, it is part of a provider's responsibilities to assist the client in locating and securing appropriate housing.

Comment: P.28 305 (D) Whether a provider is refusing serve based on legitimate client health, safety, or welfare concerns is determined in the sole discretion of DDS. If a provider is telling DDS that they cannot serve a client of which they feel they CANNOT ensure health and safety or welfare, could DDS deny the refusal to serve and make the provider serve the client against their concerns?

Response: Thank you for your comment. DDS does retain the discretion to determine the legitimacy of a provider's refusal to serve claim. Ultimate resolution of how to handle a situation where a provider's claim was found to be illegitimate would be handled on a case-by-case basis. Providers would be free to pick and choose clients if DDS did not retain the discretion to evaluate refusal to serve claims.

Comment: p..41 610 (3) Training direct service staff or client family members in carrying out service strategies listed in the client's PCSP. We do not get these from the PASSE Care Coordinator's and we request them. We are also not being inlcuded PCSP meetings. The CC's do not communicate to us the date for most PCSP meetings and we do not get invited even though we communicate with them to invite us.
Response: Thank you for your comment.

Comment: p.46 701 a (7) Any unscheduled situation where a client's services are interrupted for more than (2) hours. Does this mean when staff calls in and there is an interruption in service? Does this mean an incident report for the client's with no staff? Does this mean when a client choose to be with natural supports we send in an incident report? What is the deifnition and examples of situation?

Response: Thank you for your comment. DDS feels the Section 701(a)(7) is written with sufficient specificity. This is the same description used across multiple Medicaid programs for incident reporting

purposes. If there is doubt as to whether a particular situation is reportable, it is always recommended to err on the side of reporting.

Comment: P. 46 701 (10) Any act or admission that jeopardizes……. This is subjective and too broad, needs to be more objective.

Response: Thank you for your comment. DDS feels the Section 701(a)(10) is written with sufficient specificity. This is the same description used across multiple Medicaid programs for incident reporting purposes. If there is doubt as to whether a particular situation is reportable, it is always recommended to err on the side of reporting.

Natalie N. Burr, MD
Little Rock Pediatric Clinic

Comment: My name is Natalie Burr, and I am a General Pediatrician in private practice in Central Arkansas. I care for children and adolescents who have been affected by the current behavioral health crisis on a daily basis. Usually several of my 30-40 patients seen during the day come to the office for behavioral or mental health concerns. Being able to screen, assess, and treat children for behavioral and mental health needs in the primary care setting allows us to address these concerns in real time. These interventions are an effective way to remove some of the barriers to mental health care access and ensure quick action for patients in crisis.
I support the concept of integrated behavioral health and applaud the rule changes that have been proposed to permit employment of licensed therapists in physician offices. In particular, I support activating payment for depression screenings and maternal/caregiver depression screenings in the pediatric primary care setting, which aligns with American Academy of Pediatrics recommendations. These screenings are one of the first steps in identifying our patients' needs and risk levels and allow us to begin the process of connecting them to mental health resources.
I would love to be able to provide time-limited, preventive counseling or psychoeducation services without a diagnosis to prevent escalation of risk factors. All too often, I will see patients at multiple visits for the same mental or behavioral health concern, and, despite multiple referrals, families are unable to access mental health care due to multiple barriers to access in the community. My patients are all too often in crisis by the time they can finally access care, and this results in more stress for families and more costly interventions, such as inpatient stabilization. I feel that we could avoid some of these poor outcomes if preventative counseling or psychoeducation services were available in the primary care setting, a setting where patients and families have already established communication and trust.
Thank you for your time and your dedication to children's health.

Response: Thank you for your public comment. We will take this into consideration as we continue to work with providers in improving the behavioral health system in Arkansas.

Kimberly Baltzell, QDDP/LMSW, Crisis Intervention, Consultation, and Billing Specialist
Above and Beyond Care, Inc.

Comment: Section 602, subsection C, outlines the credentials required to develop and implement behavior management plans for waiver individuals with behavioral health needs. This amendment disallows professionals who were previously qualified to perform these services, specifically Licensed Master Social Workers. The previous minimum qualification for providing this service was a Qualified Developmental Disabilities Professional, which is a bachelor-level credential. Now, masters-level, licensed mental health professionals are being excluded from providing this service. There are already so few mental health professionals in the state with experience and availability to develop these positive-behavior support plans. This has been demonstrated by several waiver providers and PASSEs reaching out to our agency to outsource the development of these plans, as they do not have a licensed professional to do this work. This amendment will only further restrict waiver providers' access to positive behavior supports. I am a Licensed Master Social Worker with ten years of experience in the waiver field, and I will now be disqualified from providing these essential services to our members, despite my demonstration of competence and experience in this area. Not only are the qualification standards for professionals being narrowed, but the indicators for individuals requiring a behavior management plan are broadening, which is going to exacerbate the currently existing, detrimental gap in this area of need.

Response: Thank you for your comment. The list of accepted licensed professionals included in Section 602(a)(2)(C) tracks those included the CES Waiver application approved by CMS. We will consider adding licensed master social workers in the future.

Anna Strong, MPH, MPS, Executive Director
Arkansas Chapter, American Academy of Pediatrics

Comment: The Arkansas Chapter, American Academy of Pediatrics (ARAAP) represents approximately 450 member pediatricians across the state of Arkansas. We wish to submit supportive comments regarding the proposed rules for "Rebalancing Services for Clients with IDD and BH Needs."

Pediatricians, like many other types of health care providers, are impacted by the current behavioral health crisis affecting children and adolescents, which has been well-documented by the American Academy of Pediatrics and other child-focused organizations. Our members who work in primary care report that they often spend the majority of their day discussing behavioral health concerns with youth and their families, including referrals, medication management, and anticipatory guidance. They also struggle with challenges with access to behavioral health care for their patients, reporting that patients with Medicaid coverage struggle to access therapy, psychiatric care, and inpatient care in a timely way. Central Arkansas physicians report wait times of more than four months in many cases. In rural areas, waits can be even longer.

We are supportive of the array of solutions in the proposed rules that address timely access to appropriate behavioral health care, but our comments focus primarily on the changes in the rules that impact physician office settings. While co-located behavioral health care services have previously been allowed, physicians had to create new corporations to employ behavioral health providers or contract with independently licensed practitioners or agencies to offer services on-site. This prevented true integration of behavioral and physical health care, with separate medical records and challenges with oversight and communication.

Specifically, we support:

- **Integrated, team-based behavioral health care**. We strongly support the proposed rules for the physician manual that permit billing by licensed, employed behavioral health care providers in the physician office. This will allow team-based care for children and youth with a behavioral health diagnosis to receive timely physical and mental health care in a location familiar to the patient. Screening, assessing, and treating children for emotional and behavioral needs in real time in the primary care setting is an effective way to remove barriers to access and ensure quick action for children and youth in crisis, preventing delays in care that lead to costly emergency services.
    - It does appear that the outpatient hospital place of service setting is missing from the Counseling manual updates, though outpatient hospital is newly listed as an option in the Physician manual changes.
- **Behavioral health screenings.** We strongly support timely implementation of the proposed rules permitting behavioral screenings for patients and caregivers in the pediatric primary care setting and under a minor's Medicaid number, including rate-setting and payment. This aligns with American Academy of Pediatrics recommendations; perinatal depression screening recommendations are fully outlined here and the child/youth behavioral health screening periodicity schedule is here.
    - There is a small typo in section 292.741 – in the next-to-last sentence, "parent/legal guardian session" should read "parent/legal guardian screening" and there is an extra "counseling" later in that sentence.
- **Evidence-based, preventive behavioral health services**. While these rules expand access to counseling, psychoeducation, and other services in the proposed Counseling manual for children and youth who have had an intake assessment and have a mental health diagnosis, ARAAP supports an additional offering of time-limited, evidence-based, preventive services for children without a mental health diagnosis. These services will prevent escalation of risk factors or determine need for a behavioral intake assessment. A new offering of evidence-based behavioral/social/developmental screening that incorporates integrated short-term behavioral health services, such as HealthySteps, is especially important for families with children under age 4. Currently, children under age 4 can only receive dyadic, evidence-based services that require prior-authorization, a specific dyadic assessment, and a diagnosis by specially trained, licensed individuals. While these services are an incredible benefit to families impacted by adverse experiences and trauma, a preventive approach is needed to support families more easily in integrated settings.

Thank you for this opportunity to submit comments.

Response: All allowable location codes have been included in this document. "Session" will be changed to "screening"; the word "counseling" will be removed in section 292.741. Thank you for your public comment. We will take information in reference to preventative behavioral health services into consideration as we continue to work with providers in improving the behavioral health system in Arkansas.

Joel P. Landreneau, Esq., Executive Director, The Council
Arkansas Council for Behavioral Health, Inc.

Comment: ISSUE 1: FACILITIES REQUIREMENTS FOR CSSP ENHANCED:

Section 103(m) enumerates the services included in the "CSSP Enhanced" license. It includes "Adult Rehabilitation Day Treatment" as a service that can only be provided by CSSP Enhanced. The Council's understanding of the Department's reasoning in support of the placement of this service in the Enhanced section of CSSP rather than in the "Intensive" manual is that it is facility-based. The Council notes that other services provided by "Base" and "Intensive" service providers are also provided within the physical confines of the CSSP's office. For example, Individual, Family, and Group Therapy can be provided in the CSSP's certified site. This fact does not make those services "facility-based." The same is true of "Adult Rehabilitation Day Treatment."

The problem with placing Adult Rehabilitation Day Treatment in the Enhanced section of the manual is the burden imposed on Enhanced CSSP providers who must meet the physical plant requirements set forth in Section 1003. Some of these requirements do make sense for CSSP providers who Adult Rehabilitation Day Treatment. For example, it makes sense to require a physical facility that has appropriate lighting, is well-ventilated, has a running source of potable water. The Council does not object to these requirements. Likewise, the facility's structure should be in good repair, and the grounds should be free of hazards.

However, there are requirements in the facilities' section 1003 that are non-sensical as applied to CSSP's whose only "enhanced" service is Adult Rehabilitation Day Treatment. For example, these programs do not need a "kitchen with equipment, utensils, and supplies necessary to properly store, prepare, and serve three (3) meals a day" as required by Section 1003 (b)(13) when no client is on the premises long enough to need three meals per day.

Likewise, the entire section labeled 1003(c) is inapplicable to "CSSP Enhanced" providers whose only "enhanced" service is Adult Rehabilitation Day Treatment. There is no need for individual beds because clients do not sleep in these facilities. There is no need for bedroom furnishings or for an entrance that can be accessed without going through a bathroom or another person's bedroom. And for the same reason.

This is a threshold issue for the Council. Some of our members will be faced with a decision either to discontinue their Adult Rehabilitation Day Treatment programs or embark upon expensive and unnecessary physical renovations to their physical plant. As a result, this issue will bring us to the Capitol in opposition to these regulations in a way that the other issues will not, because we anticipate that imposition of these absurd requirements will create a gaping hole in the mental health service continuum that does not currently exist today. This is a dramatic step backwards. The absurdity of imposing bedroom requirements on facilities who do not house clients on a 24-hour basis should be common sense.

The Department should amend this proposal in one of two ways: First, it should place the Adult Rehabilitation Day Treatment service in the "CSSP Intensive" section of the manual, because Rehab Day is no more a facility-based service than Individual, Family, or Group Counseling, which also take place principally within the physical confines of the CSSP providers' office. In the alternative, the Department should amend the proposed rule as follows:

b) CSSP owned or leased facilitys must at a minimum include:

(1) A functioning hot water heater;

(2) A functioning HVAC unit(s) able to heat and cool;

(3) An operable on-site telephone that is available at all hours and reachable with a phone number for outside callers;

(4) All emergency contacts and other necessary contact information related to a client's health, welfare, and safety in a readily available location, including without limitation:

(A) Poison control;

(B) The client's personal care physician; and

(C) Local police;

(5) One (1) or more working flashlights;

(6) A smoke detector;

(7) A carbon monoxide detector;

(8) A first aid kit that includes at least the following:

(A) Adhesive band-aids of various sizes;

(B) Sterile gauze squares;

(C) Adhesive tape;

(D) Antiseptic;

(E) Thermometer;

(F) Scissors;

(G) Disposable gloves; and

(H) Tweezers;

(9) Fire extinguishers in number and location to satisfy all applicable laws and rules, but at least one (1) functioning fire extinguisher is required at each residence;

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(10) Screens for all windows and doors used for ventilation;

(11) Screens or guards attached to the floor or wall to protect floor furnaces, heaters, hot radiators, exposed water heaters, air conditioners, and electric fans;

(12) A reasonably furnished living and dining area;

(13) A kitchen with equipment, utensils, and supplies necessary to properly store, prepare, and serve three (3) meals a day for those programs that provide three (3) meals a day;

(14) Have written instructions and diagrams noting emergency evacuation routes to be used in case of fire, severe weather, or other emergency posted at least every twenty-five (25) feet, in all stairwells, in and by all elevators, and in each room used by clients; and

(15) Lockable storage containers or closets for any chemicals, toxic substances, and flammable substances that must be stored at the facility.

(c) CSSP owned or leased facilitys must provide each client with:

(1) An individual bed measuring at least thirty-six (36) inches wide with:

(1) A firm mattress that is at least four (4) inches thick and covered with

Response: Please see response below.

Comment: Section 1003 (c) should be amended as follows:

(c) CSSP owned or leased facilitys which provide any CSSP Enhanced services in addition to Adult Rehabilitation Day Treatment must provide each client with:

(1) An individual bed measuring at least thirty-six (36) inches wide with:

(1) A firm mattress that is at least four (4) inches thick and covered with moisture repellant material;

(2) Pillows; and

(3) Linens, which must be cleaned or replaced at least weekly;

(2) Bedroom furnishings, which at a minimum include:

(1) Shelf space;

(2) A chest of drawers or dresser; and

(3) Adequate closet space for belongings;

(3) An entrance that can be accessed without going through a bathroom or another person's bedroom;

(4) An entrance with a lockable door; and

(5) One (1) or more windows that can open and provide an outside view.

Section 1003 (d) should be amended as follows:

(d) CSSP owned or leased facility which provides any CSSP Enhanced services in addition to Adult Rehabilitation Day Treatment must meet the following bathroom requirements:

(1) Each bathroom must have the following:

(A) Toilet;

(B) Sink with running hot and cold water;

(C) Toilet tissue;

(D) Liquid soap; and

(E) Towels or paper towels;

(2) At least one (1) bathroom in each facility must have a shower or bathtub;

(3) All toilets, bathtubs, and showers must provide for individual privacy; and

(4) All toilets, bathtubs, and showers must be designed and installed in an accessible

manner for the client

Response: Please see response below.

Comment: Section 1003 (e) should be amended as follows:

e) CSSP owned or leased facility which provides any CSSP Enhanced services in addition to Adult Rehabilitation Day Treatment that house more than one (1) client must:

(1) Provide at least fifty (50) square feet of separate bedroom space for each client;

(2) Provide at least one (1) bathroom with a shower/bathtub, sink, and toilet for every

four (4) clients; and

(3) Provide each client with their own locked storage container for client valuables.

QUESTION 1: If the Department declines to make these suggested changes, please describe the reasons for doing so, and please describe the reasons why bedroom and bathroom requirements are a sensible requirement for programs who do not house clients on a twenty-four (24) hour basis.

Response: Thank you for your comment. We will revise the CSSP manual to differentiate services provided 24/7 from Rehab day services.

Comment: ISSUE 2: Training for Paraprofessionals: Are current QBHP's grandfathered? What BH training is required for paraprofessionals whose experience is mainly in DD?

Response: Behavioral Health Agencies may voluntarily request to be grandfathered into the CSSP program. CSSP providers will be expected to comply with annual trainings as outlined in the CSSP manual as per their requested level of certification.

Comment: ISSUE 3: Incident Reporting: Incident reporting requirements are oppressive. The idea that an adult whose whereabouts are not immediately known for only an hour is a reportable event under Section 501(a)(5) is not realistic. Adults in treatment for serious mental illness should be able to leave to go into the community, and to consider that to be an "incident" is utterly inconsistent with the HCBS Settings Rule set forth in 42 CFR § 441.301(c)(4)-(5) which requires as much personal autonomy and individual choice as is appropriate for patient care. These rules lack the kind of person-centered language that is contemplated by the federal HCBS settings rule. Also, the expectation that providers should be able to predict when a matter is "of public interest" is vague. Section 502(a)(1)(C) should be deleted. It is often the case that public interest can be hard to predict, particularly if law enforcement chooses to post something on Facebook, which in and of itself creates public interest. Given the experience that Council members have had with the unreasonable enforcement of certification rules as overseen by DPSQA, the Council believes that more specific and less vague criteria for incident reporting are needed.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Requires any modification under 42 CFR 441.301(c)(4)(VI)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan.

Comment: ISSUE 4: Peer Support: Peer Support should be encouraged, but not required. It is not clear that the inclusion of "Peer Support" in the suite of services set forth in Section 103(o)(1) is elective for the CSSP Intensive provider, or whether it is mandatory. This needs to be clarified. There is great concern that the workforce to comply with this as a requirement does not even exist at present, particularly on the behavioral health side. The Council believes that trainings for Peer Support are much too infrequent to remedy this shortfall at this time.

Response: Criterion 3 will be removed for clarity. Peer Support Specialist requirements are addressed elsewhere in the manual.

Comment: QUESTION 2: Are Peer Support Specialists a required service to be provided by CSSP Intensive agencies? If so, will the training and available workforce meet this mandate?

Response: We will remove this as a requirement for certification.

Comment: ISSUE 5: Medication Storage: More flexibility would be desirable with the requirement that medication should be kept in the original container unless the transfer is done by custodian or guardian. This is often not practical, as the custodian or guardian is sometimes several states away. When this is the case, and the custodian is not available, the client will be forced to go to evening dinner with the entire inventory of their medication. This practice is burdensome and unnecessary, and introduces the

possibility that the client will lose the entire inventory of their medications if the custodian or guardian is not available.

A sensible alternative would be for the rule to allow for a nurse in the facility to transfer medications away from the original container when the custodian or guardian is not available. Remember: the federal HCBS rule requires you to maximize client autonomy. The following suggested rule change to proposed Section 1006 (d)(b)(vii) would remedy this issue:

a. A CSSP can administer medication only as provided in the client's ITP or

prescribed or otherwise ordered by a physician or other health care professional

authorized to prescribe or otherwise order medication.

b. A CSSP can administer medication only by licensed nurses or other health care

professionals authorized to administer medication.

c. A CSSP cannot administer prescription medication to a client without a prescription

documented in the client's service record.

(c)

a. A CSSP must develop a medication management plan for all clients, if applicable.

b. A medication management plan must include without limitation:

i. The name of each medication;

ii. The name of the prescribing physician or other health care professional if

the medication is by prescription;

iii. A description of each medication prescribed and any symptom or symptoms

to be addressed by each medication;

iv. How each medication will be administered, including without limitation

times of administration, doses, delivery, and persons who may lawfully

administer each medication;

v. How each medication will be charted;

vi. A list of the potential side effects caused by each medication; and

vii. The consent to the administration of each medication by the client or, if the

client lacks capacity, by the client's legal guardian or custodian.

(d)

a. A CSSP must maintain a medication log in a uniformly organized manner detailing

the administration of all medication to a client, including without limitation

prescribed medication and over-the-counter medication.

b. Each medication log must be available at each location in which a client receives

home and community-based services and must document the following for each

administration of a medication:

i. The name and dosage of medication administered;

ii. The symptom for which the medication was used to address;

iii. The method the medication was administered;

iv. The date and time the medication was administered;

v. The name of the employee who administered the medication or assisted in

the administration of the medication;

vi. Any adverse reaction or other side effect from the medication;

vii. Any transfer of medication from its original container into individual

dosage containers by the client's legal guardian or custodian or the facility's nursing staff;

viii. Any error in administering the medication and the name of the supervisor

to whom the error was reported; and

ix. The prescription and the name of the prescribing physician or other health

care professional if the medication was not previously listed in the medication management plan.

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: ISSUE 6: Seclusion/Restraint: There is concern about which settings this provision applies. By "CSSP location" does this refer to Enhanced only? Does it apply in the patient's own home? If so, how is placing a client in restraint in their own home consistent with HCBS settings rule?

Response: Yes, this would refer to secure Enhanced CSSP locations. No, it does not apply to patient's own home.

Comment: Issue 7: Emergency Drills: The Council has a similar concern with Section 309. This requires a CSSP to have a written emergency plan for all locations in which the CSSP offers home and community-based services, "including, without limitation client residences and CSSP facility." Section 309(c) goes on to state that "When a CSSP is providing home and community based services to a client in a CSSP location, a CSSP must conduct emergency fire drills at least once per month. Section 309(c)(2)(A).

QUESTION 3: Do the foregoing sections require a CSSP to enter the home of a client and conduct emergency fire drills in that client's home once per month? If so, what is the rationale for this level of invasive intervention into the client's own home?

Response: No, this section does not require a CSSP to enter the home of a client and conduct emergency drills in the home.

Comment: Issue 8: Background Checks: Are CSSP agencies required to conduct a check of the adult maltreatment registry if the worker only works with children? Council members have the same question in reverse if they only work with adults. In that case, are they required to conduct a check of the child maltreatment registry?

Response: CSSP agencies are required to conduct both adult and child maltreatment registry checks without regard to the population being served.

Comment: Issue 9: Employee Searches: Section 202 sets forth the requirements for what constitutes a complete application for certification to become a CSSP. Section 202(b)(5) includes that in order for an application to be deemed compete, the application must include "Documentation of all required registry checks and searches for employees and contractors." What is an employee search referenced on page 15? We have questions about what registry checks are required depending on our client based, but where is there a requirement for an employee search? This language is a new insertion into the existing language, so we must ask:

QUESTION 4: Where is the requirement for an employee or contractor search in addition to registry checks described in Section 202(b)(5), and what kind of search of employees is required?

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.

Comment: Issue 10: Settings Variations: In Section 1004, it is required that "any client need or behavior that requires a variation or exception to the setting requirement set out in Sections 401 or 402 must be justified in the client's PCSP. It is not clear who has the authority to authorize these. Also, spend down clients do not have a PCSP.

QUESTION 5: Which CSSP staff have the authority to authorize settings variations described in Section 1004? How does this requirement apply to spend down clients for whom there is no PCSP?

Response: Thank you for your comment and we will discuss this comment internally and determine if the language should be amended.
The PCSP is developed by the PASSE care coordinator in cooperation with the client, family, guardian, and provider as applicable and variations would be approved based on the client needs as set forth in the approved plan.

All clients receiving services under the 1915i must have a Person-Centered Service Plan.

Comment: Issue 11: Mobile Crisis: Why is this section stricken?

Response: Providers are required to operate under their scope of practice, ethical standards, and as per their accreditation standards to ensure the safety of their clients.

Comment: Issue 12: Client Records: Section 402(c)(2) sets forth the list of persons to whom a client's record is available. This list does not include the client themselves. It is conceivable that it might not be appropriate to provide a client with a copy of their record, but it seems that this should be demonstrated by particularized circumstances, and that the default position should be to make records available to the people about whom the records are compiled, absent a showing of circumstances why that would not be appropriate.

QUESTION 6: Is this intentional? Are clients not required to be provided a copy of their own record?

Response: Please see below.
"Providing copies of the client's service records to the client, the client's legal guardian or custodian, and the CSSP Agency or other service provider to which the client transfers after exiting the program. Records released at a minimum should include treatment summary, current IPOC, medication logs, and other records requested by the client in compliance with clinical discretion as allowed by law and accreditation."

Comment: ISSUE 13: Application for Certification by Existing BHA's These rules do not describe the process for how an existing BHA will communicate their decision to elect to be grandfathered into CSSP Intensive. What is that process? Must the BHA apply anew? How will those who wish to transition to CSSP Intensive achieve this seamlessly by January 1, 2023?

Response: Agencies wishing to become a CSSP agency must submit application for certification to DPSQA.

Comment: ISSUE 14: Monitoring: Council members have had difficult issues with DPSQA regarding their monitoring practices in conducting Inspections of Care. A particularly vexing problem is when small agencies are contacted by DPSQA with no notice, and the small provider, whose entire staff is a single therapist, has to cancel an entire day's worth of appointments in order to babysit an inspector from AFMC.

These rules do not address this problem. What notice, if any, is required before a routine monitoring visit is conducted pursuant to Section 601? At least 24 hours' notice should be provided for non-emergency enforcement actions.

Thank you for your consideration in this matter.

Response: The DPSQA may conduct routine monitoring without notification. CSSP agencies should employ sufficient staff to allow for the operation of the agency.

Laura Prondzinski, CEO
Hometown Behavioral Health Services of Arkansas, Inc.

Comment: Comments regarding manual proposals:

Counseling manual:

Is the attestation letter really necessary?

Response: Thank you for your comment. We will review this recommendation internally.

Comment: Quality Assurance committee meetings were removed. I do not see where anything similar was put in place anywhere else. Was this the intention?

Section217.100 – You can provide 10 visits without a pcp referral, but no services except crisis should be performed without a pcp referral. I am not sure this was really the intent, but if it is, that is not really helpful.

Also regarding crisis for a person who is not yet a client. It is not a billable service if the client does not complete an intake assessment within 7 days.

Response: Yes, the Quality Assurance Committee was removed intentionally.

We agree, the language referring to PCP referrals has been updated.

Comment: 224.000 what constitutes a "relationship?"

The language has been updated to clarify the role of the Primary Care Physician.

Can a LADAC practice as ILP?

Response: Yes.

Comment: Is it correct to say that there are no more IOCs and only retrospective reviews? If there are no more IOC and no one to site P&P, how does recoupment work?

Response: Please refer to the Retrospective Review Process noted in the manual for processes.

Comment: Since psych testing has been removed from counseling manual and moved to it's own manual, is int of dx still a billable service for LP?

Response: Yes.

Comment: 252.121 "Place of service (When ninety-nine (99) is used for telemedicine, specific locations of the beneficiary" Can you use 99 for telemedicine still?

(10) telehealth client home is not listed as a POS in the new manual

Response: No, 99 is no longer an allowable telemedicine POS. This has been removed from the manual.

Comment: Physician/Independent Lab/CRNA/Radiation Therapy Center Manual

Can counseling services in a physicians office be provided the same day as a physicians appointment?

Response: This is a billing process question and is not part of the promulgation of this manual.

Comment: Rules for the Division of Medical Services Licensure Manual for Community Support System Providers Manual

This manual references the PASSE manuals, which won't exist if I looked at the proposed PASSE manual correctly.

202 #4 – Are state and national background checks required for everyone or just those that have not lived in Arkansas for 5 years?

Response: The CSSP Manual has been revised to remove PASSE.

Comment: Did the 40 hour training for QBHPs really reduce to 12 hours for CSSP providers?

Response: Training requirements are individualized to the level of CSSP certification.

Comment: Page 51 – the CSSP provider is responsible for the client until they find new providers? I need clarification on how this works, especially on the BH side.

Response: The provider assumes the same responsibility for all clients receiving Home and Community-Based Services.

Comment: Page 74 – Medical Director qualifications: must participate in QA meetings, but it appears QA section has been removed.

Response: We will update the manual to remove the requirement.

Comment: Financial safeguard section:

Incidents to be reported on Page 52 - #6, 7, 11, 12 and 13 – are these meant to say incidents to be reported if the incident happens while in the CSSP setting?

Response: Though there is no CSSP setting, incident reporting requirement still apply.

Comment: CSSP Manual

202.001 ABSCI manual will not exist

Can someone be in CSSP program without being in counseling level service program? If so, please explain how they enter the program.

Response: Individuals become eligible for BH HCBS services through the referral and completion of an BH Independent Assessment.