EXHIBIT L

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: Provider-Led Arkansas Shared Savings Entity (PASSE) Program-1915(b) and (c) Waivers and 1915(i); State Plan Amendment #2018-17

DESCRIPTION: The 1915(b) and (c) waivers and 1915(i) State Plan Amendment are being sought pursuant to Arkansas Code § 20-77-2708, derived from Acts 2017, No. 775. These waivers will provide authorization from CMS for the Department of Human Services (DHS) to implement the PASSE Program, required by Acts 2017, No. 775.

These waivers and the State Plan Amendment authorize the following:

- PASSE entities continue to provide care coordination as that is defined by Act 775 of 2017. The four essential "case management" functions (independent assessment, plan development, referral for services, and service monitoring) must be performed in compliance with the CMS conflict-free case management rules. While this has been in place under Phase I, Phase II provides more detail on the conflict free case management rules. Additionally, under Phase II, the care coordinator is responsible for development of the Person Centered Service Plan (PCSP).

- PASSE entities become responsible for the provision of all services under Phase II, including all CES Waiver services and Medicaid State Plan services, including all home and community based services (HCBS) provided through the 1915(i) state plan amendment. The only services excluded from payment by the PASSE are:

1) Nonemergency medical transportation in a capitated program;
2) Dental benefits in a capitated program;
3) School-based services provided by school-employees;
4) Skilled nursing facility services;
5) Assisted living facility services;
6) Human development center (HDC) services provided to clients fully admitted to an HDC; or
7) Waiver services provided to adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices program, or any successor waiver for the frail, elderly, or physically disabled.

- Individuals will no longer be "attributed" to a PASSE based on their claims history and/or provider relationships. Instead, individuals will be "auto-assigned" to a PASSE using a round-robin methodology. PASSE's may be pulled out of auto-assignment if they are not in good standing or if they reach a certain percentage of market share (53%).

- The PASSE entity will receive a Per Member/Per Month (PMPM) global payment to cover all needed services for each assigned member. The PMPM will be based on historical utilization.

- The Network requirements were enhanced to reflect that PASSEs are now responsible for providing all services. These network requirements now include distance requirements, time-frame requirements, and provider to member ratio requirements. This now includes requirements for use of out-of-network providers.

- Each PASSE is now required to develop an internal appeal process, in addition to the grievance process, and the beneficiary must exhaust that appeal process before appealing to the state Medicaid agency.

- The PASSE entities will now be required to submit monthly encounter data so that service utilization can be tracked. This will be in addition to the quarterly reports that were submitted in Phase I, which will continue in Phase II. These will be used to monitor and improve quality of the PASSE program under the enhanced quality provisions of the PASSE model.

- The PASSE will now be responsible for credentialing all network providers, including Home and Community Based Services Providers that provide services to their enrolled members.

- The 1915(i) State Plan Amendment details the home and community-based like services that the PASSE will be required to provide to eligible beneficiaries. Those services are: Supported Employment; Behavior Assistance; Adult Rehabilitation Day Treatment; Peer Support; Family Support Partners; Residential Community Reintegration; Outpatient Substance Abuse Treatment; Crisis Intervention; Planned Respite; Emergency Respite; Mobile Crisis Intervention; Therapeutic Host Home; Recovery Support Partners (for Substance Abuse); Substance Abuse Detox (Observational). Beneficiaries are eligible for the 1915(i) services if they meet the following criteria:

Dually diagnosed clients:
1) Must have a documented behavioral health diagnosis and a documented developmental disability. These diagnoses must be made a physician and be contained in the individual's existing medical record;
2) Must meet the institutional level of care criteria set forth by the Division of Developmental Disabilities Services for admission into an ICF/IID or CES Waiver;
3) Must have been deemed a Tier 2 or Tier 3 by the independent assessment of functional need related to diagnosis; and
4) Must be determined appropriate for HCBS State Plan services by the DHS Dual Diagnosis Evaluation Committee. The DHS Dual Diagnosis Evaluation Committee will be made up of clinicians and programmatic experts that work for or contract with the Division of Developmental Disabilities Services, the Division of Aging, Adult, and Behavioral Health Services, and the Division of Medical Services within the Arkansas Department of Human Services. This committee will be responsible for reviewing any cases presented for consideration to place the individual into a dual-diagnosed rate cell within the PASSE program and deemed eligible for the 1915(i) HCBS services.

Behavioral Health clients:
1) Must have a documented behavioral health diagnosis, made by a physician and

contained in the individual's medical record; and
2) Must have been deemed a Tier 2 or Tier 3 by the independent assessment of functional need related to diagnosis.

Developmentally disabled clients:
1) Must have a documented developmental disability diagnosis, made by a physician and contained in the individual's medical record; and
2) Must have been deemed a Tier 2, or Tier 3 by the independent assessment of functional need related to diagnosis.

PUBLIC COMMENT: The Department of Human Services (DHS) held two public hearings, one in Springdale on October 26, 2018, and one in Little Rock on November 5, 2018. The public comment period ended on November 12, 2018. DHS provided a summary of the public comments received and its responses; that summary, due to its length, is attached hereto.

Additionally, Kathryn Henry, an attorney with the Bureau of Legislative Research, asked the following question: I saw in the newspaper that this rule will not be fully implemented until March 1, 2019. Why is March 1st the date for full implementation? **RESPONSE:** DHS determined that in the best interest of the 40,000 Arkansans who will be served by the PASSEs, an additional two months to finalize operational preparedness was most appropriate. DHS made this decision based on a number of factors including readiness reviews of each of the PASSEs.

DHS has sought approval from CMS, and formal approval is pending.

The proposed effective date of the rule is January 1, 2019.

FINANCIAL IMPACT: For a March, 2019 implementation:

There will be a savings of $21,288,426 ($6,277,957 in general revenue and $15,010,469 in federal funds) in the current fiscal year and a savings of $63,989,034 ($18,870,366 in general revenue and $45,118,668 in federal funds) for the next fiscal year.

For the current fiscal year, additional revenue generated due to premium taxes from PASSE entities - $9,372,709 ($4,686,355 for use to offset general revenue of PASSE payments and $4,686,354 for use to reduce DDS wait list). For the next fiscal year, additional revenue generated due to premium taxes from PASSE entities - $29,846,433 ($14,923,217 for use to offset general revenue of PASSE payments and $14,923,216 for use to reduce DDS wait list).

The above amounts reported are updated to reflect March 1, 2019 implementation as opposed to the original January 1, 2019 implementation. Additionally, the original financial impact was based on July 30, 2018 databook supplied by the actuary. Updated numbers are based on October 1 2018 rates finalized by the actuary.

The total estimated savings by fiscal year to the state government to implement this rule is $30,661,135 for the current fiscal year and $93,835,467 for the next fiscal year. These figures result from the savings from the PASSE in addition to the premium tax that will be generated. Legislation concerning the premium tax for PASSEs can be found in Sections 4-6 of Act 775 of 2017.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 20-76-201, DHS shall administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it. *See* Ark. Code Ann. § 20-76-201(1). DHS shall also make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76, Public Assistance Generally, of the Arkansas Code. *See* Ark. Code Ann. § 20-76-201(12). DHS may promulgate rules as necessary to conform to federal rules that affect its programs as necessary to receive any federal funds. *See* Ark. Code Ann. § 25-10-129(b). Arkansas Code Annotated § 20-77-107(a)(1) specifically authorizes DHS to "establish and maintain an indigent medical care program."

Act 775 of 2017, sponsored by Representative Aaron Pilkington, required DHS to submit an application for any federal waivers, federal authority, or state plan amendments necessary to implement the Medicaid Provider-Led Organized Care System. The Act authorized DHS to promulgate rules necessary to implement the system. *See* Ark. Code Ann. § 20-77-2708.

DHS Responses to Public Comments Regarding PASSE Phase II 1915 (i) and SPA 18-017 and Waivers b & c

Katy Loyd Wilson, Attorney with Mitchell, Blackstock, Ivers, & Sneddon on behalf of Developmental Disabilities Provider Association (DDPA)

DDPA Comments on 1915(b) Waiver

Page 4 – IDSR – States it includes "Beneficiary Support," which will provide guidance to beneficiaries on the PASSE system. On page 32, it says specifically that DHS' member support team will assist enrollees in making the choice of which PASSE to join. Choice counseling again is mentioned on page 33 under B.

Comment: Please define "guidance." Will they be assisting individuals with changing or choosing PASSEs or providers within the PASSEs? If so, what assurance will there be that they do not sway individuals to a particular PASSE or provider? Can you provide a copy of the training materials for these individuals?

Response: The Beneficiary Support team will be assisting the beneficiary in changing a PASSE by offering information on the existing PASSEs. The individuals and agents chosen to perform these functions have no affiliation with any of the four PASSEs and have no incentive to sway the decision one way or the other. The training materials are available by contacting the PASSE office.

Page 9 – IDD Tier II and III

Comment: Please explain the distinction between Tiers II and III –is the "most intensive" level 24/7 care or something less? Where is the line?

Response: The Tiers are determined by the Arkansas Independent Assessment (ARIA), an independent functional assessment conducted by our third party vendor, Optum. For more information on the logic applied to arrive the Tier determination, please see the Arkansas Independent Assessment Manual.

Pages 9-10 – Voluntary Enrollment

Comment: Please clarify who is eligible to voluntarily enroll, e.g., must the individual first have an independent assessment that assigns them to Tier I or may anyone receiving day treatment or other DD services outside Tiers II and III qualify? Estimates are that approximately 100,000 individuals receiving BH and DD services could qualify – what parameters will the state use to control this potential influx?

Response: After conversations with CMS, it was determined that the language about voluntary populations would be removed from this version of the Waiver and re-inserted when those populations are to be enrolled. More information will be provided at that time.

Page 11 – Excluded Services – lists school-based services provided by school employees.

Comment: Does this mean public schools will no longer be able to bill Medicaid for a student's therapy while in school? Or will they continue to bill fee for service outside the PASSE?

Response: If the service is provided by a school employee or a contracted employee of the school and the school bills Medicaid, then the service will be billed under the traditional fee for service Medicaid system. For all other services provided in the school setting, the PASSE will be billed.

Pages 14-15 – You discuss providing both "Care Coordination" and "Case Management" services. It says that for those enrolled in CES 1915(c) waiver or 1915(i) the PASSE will also provide "case management services."

Comment: The ongoing usage of these terms in different ways continues to cause confusion. Also, there is a reference to "conflict-free case management" rules in 42 CFR 441.330. This appears to be an erroneous citation.

Response: The citation is incorrect, it should be 42 CFR 440.169. This will be corrected in the Waiver. This citation sets out the four functions of "case management" that must be conflict free. Specifically, the assessment process, case plan development, referrals for services, and monitoring of services. The PASSE must ensure that these four functions are provided by the care coordinator in compliance with the conflict free case management rules.

Page 24 – This says that for enrollees with "special healthcare needs," the state requires the PASSE to produce a treatment plan developed by the PCP and which meets state QA and UR standards.

Comment: Is this something different than what a PCP would ordinarily do for a patient?
Response: No, the PCP involvement in the PCSP development process is not changing. CMS requires the State to make assurances that primary providers will be involved in the development of that process.

Pages 28-29 – Quality – CMS asks the state how it will ensure quality in the PASSE program. In responding, DHS addresses access to certain services, including PCP, physician specialty, behavioral health, and home health.

Comment: We believe IDD services should be included in a program designed specifically for the IDD and BH population.
Response: The intent was always to monitor these programs. We agree, they should be added to this list and the change will be made.

Pages 29-30 – Marketing. "The State permits the PASSE to market to potential enrollees through a website or printed material distributed through DHS choice counselors. ....The PASSE may also produce written marketing materials to distribute to enrollees and potential enrollees. The written materials may be distributed by DHS choice counselors. All marketing materials and marketing strategies must be approved by DHS."

AND

Page 31 – "A PASSE may only directly distribute information to a current member of their PASSE. Other than the welcome information if a member transitions to their PASSE, a PASSE cannot provide any information to a Medicaid member that is a member of another PASSE. Participating providers and direct service providers cannot distribute information to a Medicaid member about enrolling in a specific

PASSE. The only allowable information that can be distributed to Medicaid beneficiaries by participating providers and direct service providers will be information that is provided by DHS choice counselors."

Comment: The marketing section still is not clear. May the PASSE distribute approved written marketing materials? May providers do so? The communication efforts about the PASSE program have rested almost exclusively with the PASSEs and providers since inception of the program back in 2017. Yet we have been unable to say or do almost anything without fear of sanctions or without formal approval from the State—even for simple "conversational" meetings. This approval takes an enormous amount of time and has slowed efforts to a) educate about the PASSE, and b) help relieve the anxiety of members who still do not understand the PASSE model. We need to have some leniency for a direct avenue for communicating in simple venues with our clients. Telling them we cannot say anything or go look on the web is not a reasonable approach for this population.
Response: Written Materials, other than those included in the welcome packet, may not be distributed to beneficiaries by the PASSE or its providers. The PASSEs have additional details about marketing in the PASSE Manual. The marketing rules apply to PASSEs and their Provider network.

Page 36 – Enrollment and Disenrollment.

Comment: What is the rationale for changing to auto-assignment? DHS' previous response was that most individuals will be "new" after Phase I. However, they still will have a relationship with a DD provider – and it is this close relationship that was touted as important to the success of the provider-led model.
Response: It is anticipated that all current Waiver and Waitlist clients, as well as those currently in an ICF, will be attributed during Phase I. This means that any new PASSE enrollees will not have established relationships with providers of DD services. Auto-assignment allows for quicker enrollment into the PASSE and facilitates beginning services more quickly. Each individual still has the 90-day choice period to change their PASSE.

Page 37 –C – Last paragraph states if the member elects to change PASSE's the change will take effect 7 days after the request is processed.

Comment: At what point do you consider the individual's request to be "processed".
Response: The effective date is seven (7) calendar days from the date the client is assigned to a PASSE. The request is processed on the day that the assignment change is made in the DHS system of record.

Page 38 – The template says "Please describe the reasons for which enrollees can request reassignment."

Comment: What are the reasons? The box is blank.
Response: The response is not blank, enrollees may request reassignment for any of the reason listed in 42 C.F.R. 438.56(d)(2).

Page 38 – "Auto assignment will be proportionally distributed across all four PASSE's. Market share will be taken into account to ensure fair competition among PASSE's."

Comment: Why is DHS involved in allocating market share? Previously, DHS officials have stated that the free market should control a PASSE's success or failure.

Response: DHS considered all factors when determining what market share would be allowed and set it very liberally to allow for competition. However, DHS must ensure that there are at least two PASSEs to continue the model.

Page 42 – Grievance and appeals.

Comment: There is no mention of Section 190.000 (Provider Due Process), only 191.000)(Beneficiary Due Process).
Response: This was an oversight, this citation will be added.

Page 53 – Consumer Self-Report Data.

Comment: Please provide a copy of the "state-developed survey."
Response: This is under development and will be shared at a later time.

Page 58 – Services included in cost-effectiveness analysis.

Comment: Why are DD waiver services listed as "State Plan Service"?
Response: These boxes will be unchecked.

DDPA Comments on 1915(c) Waiver

General Comment:

Comment: For the new "HCBS" provider type, are there limits on what services a provider can provide, i.e., Does HCBS status mean you can automatically provide BH and DD services both?
Response: The new provider type must be credentialed as an HCBS Provider and the criteria is dependent upon the service type that is provided.

Comment: Under the new guidelines, care coordinators are responsible for the development of the PCSP for all enrolled members. Can you please clarify the distinction between the PCSP that the care coordinator develops and the treatment plan the provider develops?
Response: The PCSP is the total plan of care for that patient and would need to incorporate all other treatment plans.

Request for an Amendment to a § 1915(c) Home and Community-Based Services Waiver.

2. Purposes of Amendment

Comment: Pg. 1: states that care coordination "is provided administratively by the PASSE. How will this impact the ability of PASSEs to satisfy medical loss ratio (MLR) expectations?
Response: The term administratively in this context means that care coordination is a service provided by the PASSE entity. The care coordination expense is accounted for in the numerator (benefits) for MLR calculation.

Application for a § 1915(c) Home and Community-Based Services Waiver:

2. Brief Waiver Description

Comment: Page 4: The description of a PCSP is confusing. It describes what sounds like the traditional DD treatment plan, with measurable goals and objectives, but then says it is to be "created" by the PASSE care coordinator. The care coordinators are not in a position to develop treatment plans. This is contrary to the most recent information provided in Webinars and discussion with DHS staff.
Response: The PCSP must include the traditional plan of care that has always been developed by case managers. This duty is now transferring over to the PASSE care coordinator.

6. Additional Requirements

Comment: Pg 6-7: A. Service Plan – How does this plan differ from a PCSP referenced above?
Response: The term "service plan" is part of the application itself and cannot be changed. It is not different from the PCSP, as is explained in the body of that paragraph.

Comment: Pg. 7: I. Public Input – This says DHS conducted a formal public comment period, which is not true for the waiver. Some of the meetings and sessions described in here did not address the waiver in any significant way.
Response: The Waivers ran for public comment from October 14, 2018 to November 12, 2018. Two public hearings were held during this time, one in Springdale on October 26, 2018, and one in Little Rock on November 5, 2018. Additionally, the Waivers were posted on the Arkansas PASSE webpage for review and comment around August 31, 2018. In addition, letters were sent out at that time soliciting comments on the Waivers.

8. Authorizing Signature

Attachments

Comment: Pg. 11: States clients currently on CES waiver wait list are also being enrolled in a PASSE and will begin receiving care coordination, so as those clients are placed in a CES waiver slot, the care coordinator will continue working with them to create a PCSP under the CES Waiver. **Does this only apply to those who are anticipated to come off in tobacco settlement or to all on the wait list?**
Response: This applies to all clients on the waitlist who are also receiving Medicaid State Plan services.

Comment: Pg. 12: States the PASSE care coordinator "*facilitates* the development of the person-centered plan." This may be a good approach, but other sections of the waiver, PASSE Manual and other rules need to be aligned to match.
Response: The PASSE Care Coordinator is responsible for facilitating the PCSP development meeting and ensuring the development of the PCSP.

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities

Comment: Pg. 15: This says "development of the PCSP" is by the PASSE care coordinator. These different descriptions are confusing.

Response: The PASSE care coordinator facilitates the planning meeting and develops the PCSP in coordination with those in attendance at this meeting. It is ultimately the responsibility of the care coordinator to ensure the PCSP is developed.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served

Comment: Pg. 30-31: Addressing the wait list does not appear to be reflected in the "number of individuals" projections. Can you explain?
Response: At this time, we are not able to anticipate the number of waiver slots the premium tax will purchase. We will amend the waiver to add these slots.

Comment: Pg. 31: If an individual who is assessed for the DD waiver was previously attributed to a PASSE based upon Tier II/III BH assessment will they be reassigned?
Response: The individual will not be assigned to another PASSE.

B-6: Evaluation/Reevaluation of Level of Care

Comment: Pg. 41: (minimum number of services): This requires at least monthly monitoring if waiver services are furnished on less than monthly basis. Who will do the monitoring?
Response: The care coordinator will monitor the provision of CES waiver services during their required monthly contacts with the beneficiary.

Comment: Pg. 43: A QDDP assures that an annual evaluation of the person's institutional level of care is submitted to DDS. This person is likely an employee of the direct care provider. It also indicates that the PASSE care coordinator prepares and signs documentation annually to request from DDS the Annual LOC determination. Wouldn't it be more functional to the direct care provider do this?
Response: While it is ultimately the responsibility of the PASSE Care Coordinator to assist with annual LOC determination, the PASSE may enlist and pay the direct service provider to complete this function.

Comment: Pg. 43: f. states that the provider handles documentation to send to DDS for annual level of care determinations. h. states that the PASSE care coordinator is responsible.
Response: While it is ultimately the responsibility of the PASSE Care Coordinator to assist with annual LOC determination, the PASSE may enlist and pay the direct service provider to complete this function.

Quality Improvement: Level of Care

Comment: Pg. 50: This states that the Intake Specialist sends a notice to families to notify them that information is due. Will this not be handled by the care coordinator?
Response: The Intake Specialist is an employee of DDS. DDS will continue to notify families and PASSEs when eligibility determinations are due.

Comment: Pg. 51: This says beneficiaries will be auto-assigned. Shouldn't the individual be told which networks the provider they have chosen is in?
Response: Information on networks can be found on each PASSE website. Additionally, the Beneficiary Support Team can assist beneficiaries with determining which providers are in which networks.

Comment: Pg. 51: What is the rationale for auto-assignment in a program that DHS leaders assured assignment would be tied to the lead DD or BH provider because they have the most contact with the client? If clients are to be assigned, the assignment should be deliberate and further the goals of the program rather than being simply proportional.
Response: It is anticipated that all current Waiver and Waitlist clients, as well as those currently in an ICF, will be attributed during Phase I. This means that any new PASSE enrollees will not have established relationships with providers of DD services. Auto-assignment allows for quicker enrollment into the PASSE and facilitates beginning services more quickly. Each individual still has the 90-day choice period to change their PASSE.

Comment: Pg. 51: Auto-assignment can provide a significant amount of hardship for residential programs of 10-14 persons. Direct Care Supervision funding has been removed and Case Management funding and positions have been removed. Significant additional functions required by the waiver program for providing/coordinating activities and the significantly enhanced third-party, DDS, and DMS monitoring has also been added. Outside of a few consultants they have no remaining administrative/professional staff to address these issues. The on-site managers of the residential facilities have full responsibility for the operation of the programs. It places a significant additional burden on them if they have to try to deal with multiple care coordinators and the differential requirements with respect to forms, procedures, etc. This environment is a major obstacle to trying to initiate efficiencies.
Response: It is anticipated that all current Waiver and Waitlist clients, as well as those currently in an ICF, will be attributed during Phase I. This means that any new PASSE enrollees will not have established relationships with providers of DD services. Auto-assignment allows for quicker enrollment into the PASSE and facilitates beginning services more quickly. Each individual still has the 90 day choice period to change their PASSE.

Appendix C: Participant Services

C-1/C-3: Service Specifications: Respite

Comment: Pg. 53: States respite may be provided in a licensed respite facility (4). Can you tell us who licenses respite facilities in Arkansas and whether they exist?
Response: Thank you for your comment. This section of the waiver has not been amended.

C-1/C-3: Provider Specifications for Service: Respite

Comment: Pg. 54: (Other Standards) – Why is person specific training no longer a training requirement?
Response: The requirements have not significantly changed for individuals providing respite services.

C-1/C-3: Service Specification: Supported Employment

Comment: Pg. 55: (Service Definition): Please clarify what is meant by "tailored array." This should not be an all or nothing list of services or it will deter usage of this important but greatly underutilized service option. The PASSEs need flexibility in determining service options.
Response: The definition for Supported Employment did not change in this waiver amendment. The tailored array referred to are the components of supportive employment described in the definition.

The Care Coordinator along with other providers may tailor these components to fit the individual's needs.

Comment: Pg. 55: This section can be very confusing when working within the DDS/ARS partnership program. Individuals have to go back and forth between ARS and DDS throughout this process. For CES waiver discovery is optional; however, ARS will not accept the person if a discovery plan has not been done, yet for this group ARS will not pay for the discovery plan process. Individual gets Discovery and Employment Path (optional through CES waiver), then goes to ARS for further eligibility and potentially goes through their 4 stages, only to come back to CES Waiver in the end if extended services are needed. Can this process be streamlined once under the PASSE? There should be a smooth flow for this service.
Response: Thank you for your comment. DHS will continue to monitor the provision of this service and make changes as needed.

Comment: Pg. 55: Also, nowhere, does it state for CES waiver that the job coach has to be ARS Certified. Is that no longer a requirement for the job coach under CES Waiver or is that what you are considering credentialing?
Response: Yes, ARS Certification will be a requirement for job coaching.

C-1/C-3: Provider Specifications for Service: Supportive Living

Comment: Pg. 59: (Supportive Living Staff Qualifications) – Need to add "or equivalency" to 1)
Response: The wording "or equivalency" will be added.

C-1/C-3: Provider Specifications for Service: Community Transition Services

Comment: Pg. 64: (Other standards) - – requires 2 years of college credit and at least 2 years' experience working with DD or have 4 years of experience as case manager/care coordinator. Why are these requirements different from care coordinator?
Response: DHS will amend the qualifications to match the qualifications of the QDDP or Care Coordinator.

C-1/C3: Service Specification: Consultation

Comment: Pg. 65: 3) Mastered Social Worker needs to be revised to match OBHS and 1915(i)
Response: This will be changed to reflect Licensed Clinical Social Worker may provide services.

C-1/C-3: Provider Specifications for Service: Crisis Intervention

Comment: Pg. 69: This says individuals who perform this service must have Masters or Doctorate level clinician or APN or Physician. This would likely disqualify ArkSTART. This is the only existing potential option for DD recipients.
Response: This matches the current performing requirements of the OBHS manual and 1915(i). Crisis Intervention provided by the PASSE is designed to serve both the BH and DD population and as such the requirements are the same. The PASSE model is designed to increase access to and expand the number of performing providers for all DD and BH services.

C-1/C-3: Service Specification: Supplemental Support

Comment: Pg. 71: (Service Definition) – This definition is vague.
Response: This definition was left intentionally vague to allow flexibility of the PASSE to address members needs as they arise.

C-1/C-3: Provider Specifications for Service: Supplemental Support

Comment: Pg. 72: These qualifications differ from care coordinators.
Response: DHS will amend the qualifications to match the qualifications of the QDDP or Care Coordinator.

C-2: General Service Specifications

Comment: Pg. 73: (Employee definition) – 6) lists a person who resides in an alternative living home in which services are provided to individuals with developmental disability. **How does just living there make them an employee? And if you do consider them an employee shouldn't it state for age 18 and over?**
Response: The purpose of this section, employee is defined as anyone who is required to have a background check. This does include anyone who lives in the home with the client. The definition of employee is taken directly from ACA 20-38-101.

Comment: Pg. 73-74: There is discussion on criminal background checks. **Can you please clarify who is responsible for this function? Is it DDS or the PASSE?**
Response: The language in this section of the waiver was not amended. The provider would submit the request for criminal background check, but DDS would still make the determination of employment eligibility.

Comment: Pg. 86: (Care coordinator credentials) –shouldn't it state a high school diploma and at least 1 year of experience working with ID/DD? This would make more sense to substitute for a bachelors.
Response: The language in this section matches the 1915(b) waiver.

Comment: Pg. 86: (Care coordinator credentials) –1 year of experience (even with H.S. diploma) does not equate to being a registered nurse or physician. If this is the standard the first two qualifications are not necessary.
Response: The language in this section matches the 1915(b) waiver.

Comment: For all CES waiver services – Person-specific training is not mentioned in the CES waiver. This training is just as important as CPR and Behavior Management and should be required. (On page 84 it states: When DDS or DMS staff determines, during a credentialing review or investigation, that the PASSE or HCBS provider has not provided required abuse and neglect training, or has not provided training on the specific needs of the person, the PASSE and provider is cited. But the requirements are not mentioned elsewhere.)
Response: As reflected in Performance Measure QPC2 HCBS are required to provide, at a minimum, training on the specific needs of the person.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development

Comment: Pg. 88: (d.C.5.) - Says the PASSE care coordinator is responsible for coordinating and monitoring the implementation of all services in the PCSP. Will DHS specify a tool, particularly for the monitoring?
Response: No, this will be determined by each PASSE.

Comment: Pg. 88-89: (e. Risk Assessment and Mitigation) - Need standard risk management format, specific tool to use or required content.
Response: The required content is listed in Appendix D-1.e. Each PASSE may require a specific tool to be used.

Comment: Pg. 89: (f. Informed Choice of Providers) – States beginning on the first day of enrollment, the PASSE is responsible for providing all services to all enrolled members and may limit a member's choice of providers based on its provider network. **Since members are being auto assigned in phase 2 there should be a period of time for the member to keep their current provider while they are either changing PASSES in that 90 day period or while they are changing to a provider within their auto assigned PASSE. The member should not be penalized if they are being auto-assigned.**
Response: DHS requires the PASSEs to coordinate transition of care for newly enrolled members. All enrolled members who have an existing PCSP or MTP will carry that care plan with them when they are enrolled into the PASSE. The PASSE must honor the existing PCSP or MTP, including authorizations for series under the PCSP or MTP that are verified, until the new PCSP is developed.

Comment: Pg. 89: (f. Informed Choice of Providers) – Please provide the criteria that the Beneficiary Support Office will use to perform their duties in assisting beneficiaries.
Response: The Beneficiary Support team will be assisting the beneficiary in changing a PASSE by offering information on the existing PASSEs. The individuals and agents chosen to perform these functions have no affiliation with any of the four PASSEs and have no incentive to sway the decision one way or the other.

Appendix F: Participant-Rights

F-1: Opportunity to Request a Fair Hearing

Comment: Pg. 102: Says members have right to change providers in a PASSE any time they wish. PASSEs need some ability to deter "provider shopping" abuses we have seen historically.
Response: The right to change providers is a requirement in the 1915(c) waiver.

F-3: State Grievance/Complaint System

Comment: Pg. 103: Says all grievances must be filed within 45 days. Should be within 45 days of discovery or knowledge of the event or issue giving rise to the grievance.
Response: These timeframes were put into place to match the timeframes the PASSEs are required to follow in the 1915(b).
Appendix G: Participant Safeguards

G-1: Response to Critical Events or Incidents

Comment: Pg. 103-104: (b) ***This section is confusing – is the provider reporting incidents to DDS or the PASSE reporting incidents to DDS? Also since most providers offer waiver and ADDT or EIDT services would be it possible to keep both reporting systems the same instead of different? These proposed regs leave the current incident reporting system in place for CES waiver, however the new ADDT and EIDT regs are set to be like OLTC regs with different reporting time frames and requirements. One system would work better for assuring reporting and accountability.***
Also, listings of incidents designated as critical includes some of the same incidents described as not necessarily critical, i.e. death, use of restrictive interventions, suspected maltreatment.
Response: The critical incident reporting system is not changing. This language will be placed back into the waiver application.

Comment: Pg. 105: (d) The APS investigator must see the individual within 24 hours of the report. In most cases no contact is made at all.
Response: Thank you for your comment. This section of the waiver was not amended.

Comment: Pg. 105: (d) If non-emergency, the investigation staff must see the individual who is the subject of concern within 3 working days. What if they do not? And the investigation must be completed within 60 days. This is too long. Does the alleged perpetrator continue working during that 60 day period?
Response: Thank you for your comment. This section of the waiver was not amended.

Comment: Pg. 105: (d) "If the nature of a child maltreatment report suggests that a child is in immediate risk...initiates an investigation immediately or "as soon as possible." This needs to be more specific. As soon as possible is subjective.
Response: Thank you for your comment. This section of the waiver was not amended.

Comment: Pg. 105: (d) Do both the Care Coordinator and the provider submit the DHS Form 1910? Who has the ultimate responsibility?
Response: The reporter will have the responsibility for submitting a DHS Form 1910 if a report has been submitted through the hotline.

Comment: Pg. 105: (d) Talks about DDS completing investigation within 30 days of a complaint and notifying the provider, PASSE, and person making the complaint of the results. **We have experienced this, but current when DDS notifies the provider of the results there is no identifying information on the report to let the provider know what individual or facility the complaint was about. This needs to be changed. Without identifying information we cannot fix the problem.**
Response: Thank you for comment. This concern cannot be addressed in the waiver application.

Comment: Pg. 105: (d) State staff must complete an investigation within 30 days. Does the provider staff stay working during those 30 days?
Response: Thank you for your comment. This section of the waiver was not amended.

Comment: Pg. 105: (d) Paragraph 6 starts out talking about death, then talked about investigating complaints and concerns. Related to death?
Response: Yes, this is all related to investigating the death of the individual.

Comment: Pg. 106: The last sentence of the 2nd full paragraph appears to be missing a word so this sentence does not make sense.
Response: DHS agrees and this will be updated.

Comment: Pg. 106: Is the PASSE required to notify the provider and vice versa when an incident report is completed?
Response: Each PASSE will have their own process for incident reporting.

Comment: Pg. 106: Will both the provider and PASSE be notified of identified trends for needed action?
Response: If action is needed the party required to perform the action will be notified.

G-2: Safeguards Concerning Restraints and Restrictive Interventions

Comment: Only approved CPI techniques should be used.
Response: Thank you for your comment. This section of the waiver was not amended.

Comment: Pg. 107: States behavior plan must be written and supervised by a person who at a minimum is a QDDP. ***Previously, behavior plans for pervasive level of care individuals (not due to medical issues) required licensed persons to complete. Has that standard changed and a QDDP can now write all behavior plans?***
Response: Thank you for your comment. This section of the waiver was not amended.

G-3: Medication Management and Administration

Comment: Pg. 111: What is "first line monitoring"? What is meant by "supervisory level staff"?
Response: Thank you for your comment. This section of the waiver was not amended.

Comment: Pg. 112: What is "second-line medication management?"
Response: Oversight of medication management and administration has been moved from DDS to the PASSE.

Comment: Pg. 112: This states that DDS and DMS staff review medication management plans and medication logs to ensure compliance with this waiver, the PASSE Provider Manual, and the PASSE Provider Agreement. If errors are found, state staffs cite the PASSE and the HCBS provider with a deficient practice and require a plan of correction. **Please be more specific on what you will consider an error. Will we will be cited for each medication error? Why are both cited even if only one is at fault?**
Response: Medication error has its general recognized meaning. The PASSE is providing oversight for medication management and may be cited for improperly doing so.

Comment: Pg. 112: Please change the title "Medication administration by waiver providers." Waiver staff do not "administer" medications except with the limited situations permitted under the Consumer Directed Care Act of 2005. Much of the language in this section needs to be adjusted in that regard.
Response: The title cannot be changed as it is a part of the application.

Comment: Pg. 112: The state has indicated "Waiver providers are responsible for the administration of medication to waiver participants who cannot self-administer." What is the funding source?
Response: Thank you for your comment. This section of the waiver was not amended.

Comment: Pg. 112: Says the Care Coordinator must develop and monitor a medication management plan. Care Coordinator is not the appropriate person to do this. If there are multiple care coordinators from different PASSEs involved at one site this would be too confusing.
Response: The development and the monitoring of the medication management plan has always resided with the Care Coordinator. This ensures continuity of care for the individual across multiple providers.

Comment: Pg. 112: There is a missing colon in the sentence: The direct service provider must ensure that designated staff report to a supervisor and record the following medication errors: missed dose, wrong dose, wrong time of dose, wrong route, and wrong medication.
Response: Thank you for your comment, a colon will be added.

Quality Improvement: Health and Welfare

Comment: Pg. 113: Providers report all medication errors for "those with potential for serious injury or harm."
Response: DHS is unable to provide a response as this appears to be an incomplete comment or question.

Comment: Pg. 114: QA training on abuse reporting members/legal guardians
Response: DHS is unable to provide a response as this appears to be an incomplete comment or question.

Comment: Pg. 115 Report critical incidents to DDS within time frames.
Response: DHS is unable to provide a response as this appears to be an incomplete comment or question.

Comment: Pg. 116: QA on critical incidents – how will they do this?
Response: Critical incident reporting will remain the same. The waiver will be updated to reflect that.

Comment: Pg. 117: QA corrective action critical incidents
Response: Critical incident reporting will remain the same. The waiver will be updated to reflect that.

Comment: Pg. 118: Complete investigation completed in a timely basis
Response: DHS is unable to provide a response as this appears to be an incomplete comment or question.

Comment: Pg. 129: Refers to QA committee that meets quarterly. Is DDS reviving this meeting?
Response: Yes, DDS will be reviving this meeting.

Appendix I: Financial Accountability
I-2: Rates, Billing, and Claims

Comment: Pg. 134: Rates were converted from a maximum daily allowance to an hourly rate to allow for more flexibility in the PCSP development for beneficiaries. We understand that the PASSEs are not required to use an hourly rate; please clarify.
Response: Based on comments received from CMS, this section has been changed to reflect that the PASSEs will receive a global payment to cover all CES waiver services.

Comment: Pg. 134: The rate for transportation is stated as ".42 cents per mile." It should be written as either "$.42 per mile" or "42 cents per mile." As written the rate is less than 1 cent per mile.
Response: Thank you for your comment. This will be changed.

DDPA Comments on 1915(i) SPA #2018-017

General Comments

Comment: It is extremely unclear which individuals will fall under this waiver and based on what criteria. Is it all BH Tier II and III or some subset of these individuals? If it's the latter, what is the criteria used to make that determination? For dually diagnosed DD, what is the criteria for making the determination they would be better served under the 1915(i)?
Response: For the dually diagnosed population, eligibility evaluations are completed by an eligibility committee made up of representatives from the Department of Human Services, Division of Behavioral Health Services (DBHS) and the Division of Developmental Disabilities Services (DDS). Before an application is reviewed by this committee the individual must have a documented behavioral health diagnosis and a documented developmental disability.

Each individual must be determined to meet the eligibility criteria for ICF/IID, and be assessed by the DHS third party contractor and determined to be a Tier 2 or Tier 3 on the functional assessment for HCBS services. The dual diagnosis committee must review these determinations and find that the services offered by the 1915(i) will address the individual's functional deficits better than other HCBS service options.

For the behavioral health population, the individual must have a behavioral health diagnosis and have received a Tier 2 or Tier 3 on the functional assessment for HCBS behavioral health services conducted by DHS's third party contractor and be enrolled in a Provider-Led Arkansas Shared Savings Entity (PASSE).

For the developmental disabilities population, the individual must have a developmental disability diagnosis and have received a Tier 1, Tier 2 or Tier 3 determination on the functional assessment for HCBS developmental disability services conducted by DHS's third party contractor and be enrolled in a PASSE.

Comment: In reviewing the separate 1915(i) SPA for Dual Eligibles and Medically Frail, we are confused as to why the service array is so limited. If the person did not qualify for Medicare, they would be in the PASSE. If someone is dually eligible, why should they be penalized and limited to a lesser array of services merely because they also qualify for Medicare? Medicare does not cover the services that are excluded from the chart. If they are Medically Frail, they are placed into the regular Medicaid program because of their need for greater supports, yet they are being excluded from many supports here. Also, why are only those with BH and not DD diagnosis included in this 1915(i)?

Response: These individuals are all adults that fall into either the Medicaid Spenddown and AR Works Medically Frail eligibility categories and have received an independent assessment score that designates services needed in Tier 2 or Tier 3. Services will be available through the Outpatient Behavioral Health Program and this program. The services chosen are one that are currently being provided to these individuals. Based on this public comment, the Aftercare Recovery Support service will be added to the Adult Behavioral Health Community Independence Manual.

Section by Section Comments

Pages 36-41 Evaluation/Reevaluation of Eligibility

Comment: Can you be more specific on who will fall under this waiver? It states BH high needs and DD, but what if:

(a) DD individuals are already on DD waiver and are Tier 2, but assesses as Tier 3 for BH, will they remain on the current DD waiver or move to this waiver?
Response: A client that is assessed as Tier 2 or Tier 3 will remain on the DD waiver, but may be eligible to receive (i) services as a dually diagnosed client.

(b) A DD individual does not meet institutional level of care, but does assess for Tier 2 BH services, is this the waiver they will receive?
Response: This type of client will not receive a waiver slot but will be available to receive (i) services along with other appropriate services.

Page 36, 50 and throughout – The dual diagnosis committee must find that the services offered by the 1915(i) will address an individuals' functional deficits better than other HCBS service options.

Comment: What criteria will the dual diagnosis committee use to make these determinations? How many dually diagnosed individuals are your estimating will be in 1915(i)?
Response: The dual diagnosis committee will use historical clinical information to make the determination and an estimate is not available at this time.

Comment: You have listed three groups who are eligible for 1915(i): (1) Dually diagnosed; (2) BH; and (3) DD. What is the eligibility criteria for individuals who are DD but not dually diagnosed?
Response: For the developmental disabilities population, the individual must have a developmental disability diagnosis and have received a tier on the functional assessment determination conducted by DHS's third party contractor and be enrolled in a PASSE.

Comment: On page 40 you have stated that for DD population, the individual can be Tier 1, not just Tier II and III. Is that correct? Tier I for DD or BH?
Response: When the voluntary population is allowed to enroll, DD clients who received a Tier 1 on the independent assessment and enroll into a PASSE will be eligible to receive appropriate 1915(i) services as authorized by an individual's PCSP. Once the voluntary population is allowed to be enrolled into the PASSE, there will have to be an appropriate rate cell developed.

Page 36 -- Financial Eligibility – 150% of the Federal Poverty Level.

Comment: Since the individuals who are in the dually diagnosed DD/BH category meet institutional level of care, their threshold could be 300% of SSI. The 150% cap makes it difficult to serve individuals with increasing earnings as they transition to greater independence.

Response: The individuals who are enrolled in the PASSE must be Medicaid eligible and that eligibility may fall under different categories. Individuals eligible for the 1915(c) waiver are financially eligible for all Medicaid state services.

Page 36 – DHS will use at least 50% of the premium tax to fund additional 1915(c) waiver slots ,and also to fund the cost of serving dually diagnosed individuals under 1915(i) beginning July 1, 2019.

Comment: How much do you estimate the 50% will equate to? How many 1915(c) waiver slots do you estimate will be funded and when? How much will be spent on dually diagnosed individuals in 1915(i)? Why is the latter delayed until July 1, 2019?
Response: It will take 6 (six) months to collect the premium tax in order to be able to fund additional waiver slots. Current projections for the premium tax we will accrue over a 6 (six) month period should allow us to add an additional 500 CES waiver slots.

Page 10: Bottom paragraph you state under heightened scrutiny: "These setting include group homes located on the grounds of or adjacent to a public institution, numerous group homes co located on a single site, a disability specific farm like service setting and apartments located in apartment complexes also occupied by person who do not receive HCBS services."

Comment: An apartment complex should not be included if it's not a DD/IDD specific apartment complex.
Response: The intent of the heighten scrutiny, is to ensure inclusion into the community, thus the reason why apartment complexes that house individuals that do not receive HCBS services.

Page 37 – QDDP Qualifications

Comment: The reference to page 13 may be an error since this document starts with page 32.
Response: This reference is correct.

Page 44– Person-Centered Planning & Service Delivery

Comment: Under qualifications for Care Coordinator it requires at least one year of experience working with developmentally disabled or intellectually disabled clients or behavioral health clients. Shouldn't this also include a High School Diploma?
Response: The language in this section matches the 1915(b) waiver.

Page 45 -- (7) Informed Choice of Providers – It says "The PASSE ... may limit a member's choice of providers based on its provider network."

Comment: It is not clear what this means. It should be clarified by adding that the PASSE must comply with any willing provider.
Response: All PASSEs must comply with the Any Willing Provider laws.

-Page 45 and 46 – (8) Process for Making PCSP Subject to Approval of the State Medicaid Agency – This says an interim service plan may be effective for up to 60 days and a new PCSP must be developed within 60 days.

Comment: We thought 60 days was the minimum, not the maximum. It would be better to have more flexibility in light of all the uncertainties around the transition to Phase II.
Response: This is for newly enrolled members and not currently existing members.

Page 45 and throughout – Beneficiary Support Office

Comment: See comments on 1915(b) requesting the criteria they will use in helping someone choose a PASSE and how they will be restricted from swaying members to one PASSE over another.
Response: This has already been answered.

SERVICES CHART

Comment: Why is Partial Hospitalization, Adult Life Skills Development, and Supportive Housing not included for PASSE members, but is included for Dual Eligibles and Medically Frail?
Response: Adult Life Skills Development is included in the Supportive Life Skills Development service. Partial hospitalization and supportive housing are included in the service array and will be added to the 1915(i) SPA.

Comment: The PASSE 1915(i) uses the term Adult Rehabilitative Day Treatment, but the Dual Eligibles 1915(i) uses the term Adult Rehabilitative Day Services. Is there a distinction?
Response: No, there is not a distinction. DHS will amend to Adult Rehabilitative Day Services.

Comment: You have stated for each service: "All other provider standards and requirements in accordance with the 1915(b) requirements..." Which section(s) in 1915(b) are you referring to that contains these requirements?
Response: These requirements are in the 1915(b) waiver.

Comment: Supportive Life Skills Development says on page 54, "For clients with developmental or intellectual disability, life skills development may focus on acquiring skills to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as communication, bathing, grooming, cooking, shopping, or budgeting." For the DD population, this should be expanded to include other Supported Living type skills, not just ADLs and IADLs.
Response: The addition of IADLs and ADLs is to expand on the other life skills that were already included in the services for the BH population. The PASSEs will have the flexibility to determine how these services will be offered.

Comment: What is the difference between "Crisis Intervention" (p. 60) and "Mobile Crisis Intervention" (p. 63). The Crisis Intervention description says it is a mobile intervention service.
Response: The PASSEs will have the flexibility to determine how these services will be offered.

Comment: Thank you for including Therapeutic Host Homes for IDD not just BH. We believe this model is well suited to certain individuals and could save money.
Response: Thank you for your comment.

Page 68 - #2C – All relatives who are paid to provide services must meet the minimum qualifications set forth in this waiver and may not be involved in the development of the PCSP.
Comment: This doesn't make sense. These individuals would know the member the best when it comes to skills, goals, etc. Why wouldn't they be involved? Under CES Waiver they are involved.

Response: The PCSP will be created, monitored, and updated by the PASSE Care Coordinator. A relative of an individual cannot be the PASSE Care Coordinator but can still be a part of the input into the development of the PCSP.

Dr. Syard Evans, President, on behalf of Arkansas Waiver Association (AWA) Board of Directors

Comment: I am writing on behalf of the Arkansas Waiver Association (AWA) Board of Directors. AWA is an association of and for individuals with developmental disabilities, their advocates, their families, and the professionals who work in the field.

As we near the scheduled date of implementation of Phase 2 of the Provider-Led Arkansas Shared Savings Entity (PASSE) transition, AWA, on behalf of our members, maintains significant concerns regarding the current progress of the transition and the remaining areas of need that must be addressed in order to ensure that all providers continue to function effectively and all beneficiaries continue to be appropriately served.

Recently three of the four PASSE entities formally requested a short-term delay in the implementation of Phase 2 citing a number of legitimate reasons for delay, including numerous timeline delays from the beginning of and throughout Phase 1 and numerous operational delays which currently continue to impede the PASSEs' ability to establish contracts with developmental disability service providers. The state denied the PASSEs' request for delay citing that a three-month delay would potentially become a six-month or year-long delay as a result of General Assembly changes and promulgation requirements that could potentially come in the new year.

The AWA Board of Directors understands that a delay in transition would, no doubt, be problematic for the state, providers, and individuals receiving services. Currently, all billing prior authorizations for approved plans that providers possess are scheduled to end on 12/31/18. If the Phase 2 transition were to be delayed for three months as requested by the PASSEs, providers would not be able to continue to bill for services effective 1/1/19. However, based on the current lack of PASSE/provider contracting, provider training and provider billing infrastructure, AWA is seriously concerned that PASSEs will not be ready or able to reimburse claims on 1/1/19 either. A significant number of Waiver providers throughout the state do not have the financial means to operate with delayed reimbursement. If providers are not able to bill and be reimbursed for claims on the established timelines that providers have structured their operations around for decades, the threat of some individuals with developmental disabilities losing access to services is significant.

The AWA Board of Directors requests that, in light of the state's decision to deny the PASSEs request to delay transition, the state develop a plan to provide additional support through the transition and provide assurances to guarantee that no providers' operations nor individual's services will be negatively impacted by this transition.
Response: Yes, the State continues to work with the PASSEs and Providers to ensure that services are not disrupted during this transition time.

Tom Masseau with Disability Rights of Arkansas, INC, David Deere with Partners from Inclusive Communities and Sha Anderson with Arkansas State Independent Living Council

Comment: Thank you for allowing our agencies this opportunity to provide comments regarding the Department of Human Services (DHS) proposed rulemaking regarding the above- referenced manuals and services.

Arkansas State Independent Living Council

The Arkansas State Independent Living Council is a non-profit organization promoting independent living for people with disabilities. The Arkansas State Independent Living Council has a Board of Directors comprised of Governor appointed Arkansans, the majority with disabilities.

The mission of the Arkansas State Independent Living Council is to promote independence, including freedom of choice and full inclusion into the mainstream of society, for all Arkansans with disabilities.

Partners for Inclusive Communities

Partners for Inclusive Communities (Partners) is Arkansas' University Center on Disabilities. Administratively located within the University of Arkansas College of Education and Health Professions. Partners is a member of the nationwide Association of University Centers on Disabilities - AUCD.

Partners' mission is inclusion of people with disabilities in community life.

Disability Rights Arkansas, Inc.

Disability Rights Arkansas (ORA) is a private nonprofit organization designated by the Governor to implement the federally authorized Protection and Advocacy systems. Our mission is to vigorously advocate for and enforce the legal rights of people with disabilities in Arkansas. We assist people with disabilities through education, empowerment and protection of their legal rights. We serve all Arkansans with disabilities of all ages. We provide services through information and referral, direct advocacy and legal representation. ORA also provides training and outreach throughout the State.

Every year, the ORA Board of Directors solicits input into the development of the agency priorities. This solicitation is accomplished through public surveys and analyzing and reviewing prior year's request for assistance. In Fiscal Year 2019, the priorities established are as follows:

- Abuse, Neglect and Exploitation
- Community Integration
- Education
- Employment
- Access
- Self-Advocacy/Training

The priority that is most relevant to this issue is Community Integration. This priority focuses on the idea that individuals should receive quality support services, rights protection and be empowered to make choices in their lives.

Background

In 1999, the Supreme Court ruled in Olmstead v L.C. that public entities are required to provide community-based services to individuals with disabilities when, a) such services are appropriate; (b) the affected persons do not oppose community-based treatment and, (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services. Essentially state and local governments need to provide more integrated community alternatives to individuals in or at risk of segregation in institutions or other segregated settings. (US Department of Justice, Civil Rights Division, "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v L.C.") Further, the Olmstead decision required each state to develop a plan that would place individuals with disabilities in less restrictive settings.

Following the Olmstead decision, former Governor Mike Huckabee formed the Governor's Integrated Services Taskforce. This taskforce was charged with assisting the state OHS in writing an Olmstead Plan. In 2003, the Taskforce completed its charge and developed The Olmstead Plan in Arkansas. The plan contained over one hundred recommendations for the state OHS and members of the Legislature to consider. The report highlighted the intent of the state's movement towards providing services in less restrictive settings. Waiver services reduce the need for emergency care, increase quality of life for people with disabilities and their families and allow families to remain together in their communities.

Dual Diagnosis Committee

The application for a 1915(i) waiver establishes a (DHS Dual Diagnosis Evaluation Committee/! to determine whether an individual may receive services from both Behavioral Health and Developmental Disabilities Services under their respective waiver/state plan. It appears there are several barriers in place to ensure individuals who are dually diagnosed may begin services. First, an individual must meet the ICF/11D level of care; second, an individual must be assessed as a Tier 2 or Tier 3 on the Behavioral Health independent assessment; third, an individual must be assessed as a Tier 1, 2, or 3 on the Developmental Disabilities Independent Assessment; fourth, the individual must have a documented behavioral health diagnosis as well as a documented developmental disability; finally, that individual will then be subjected to a committee determination of whether services for their behavioral health and developmental disability would be appropriate.

The committee proposed by DHS specifies only that the committee will consist of "clinicians and programmatic experts that work for or contract with [DDS, DAABHS, and OMS]." There is not an indication of whether this will be a standing committee that will meet at designated times, or when the need arises. We encourage OHS to be specific about the persons involved in the eligibility process
Response: The dual diagnosis committee will use historical clinical information to make the determination. The makeup of the committee is being determined and more information will be upcoming.

Comment: From the calls we've received from individuals regarding assessments, we gather that the timing of the administration of the ARIA to the communication of an individual's tier assignment, to attribution to a PASSE and the receipt of services varies greatly. If there is a dispute regarding a beneficiary's tier assignment, the process can be much longer. We are concerned that this extra layer of evaluation is unnecessary, since an individual will already have been both dually diagnosed and assessed by the ARIA and found eligible for services under both behavioral health and developmental disabilities

services. There does not appear to be a timeline that would ensure individuals who are dually diagnosed will be evaluated by the committee in a timely manner. In addition, services offered through the PASSE will be individually determined as necessary or appropriate in the development of an individual's plan of care. Accordingly, the extra evaluation is simply another barrier between individuals and appropriate services. We recommend that OHS remove this unnecessary additional barrier to services for individuals who are dually diagnosed. To the extent that OHS fails to remove this barrier, we strongly encourage OHS to ensure that it does not delay individuals who wish to receive both behavioral health and developmental disabilities services.
Response: The independent assessment is a functional assessment. The dual diagnosis will only occur after assignment to a PASSE therefore there is no additional delay.

The standard by which individuals will be deemed eligible for dual services is extremely vague. Under Section 6 of the Evaluation section of the 1915(i) application, the committee "looks at the individual's level of need and whether or not the HCBS state plan services can address those needs better than other services" in order to determine whether an individual will be eligible for dual services. Such an important determination should require a level of predictability of the committee's decision. While DHS may intend for the vague standard applied to eligibility for dual services to permit flexibility to include individuals, we fear it is just as likely to be used to exclude individuals from dual services. Further, such a vague standard does not provide adequate notice to individuals regarding eligibility requirements for this Medicaid service. It lacks due process. We recommend, to the extent DHS continues to use the committee to determine eligibility, that the standard by which the committee will determine eligibility allow for more predictability of their decisions.
Response: DHS is using the same standard. Dual eligibles will have already deemed eligible for the DD waiver or will be referred to DD waiver. For those individuals already receiving DD waiver services, a committee of qualified professionals will complete a review of complete historical clinical documentation to confirm the DD individual has a comorbid behavioral health diagnosis. All dual eligibles will already be assigned to a PASSE and receiving services. The step of identifying them as dually diagnosed will be taken to ensure that appropriate services are identified for the Person Centered Service Plan.

Assessment and Development of the Person-Centered Service Plan

The qualifications for assessors and those charged with the development of an individual's person-centered service plan are very similar. We are concerned that an individual who has a developmental disability may be assessed by an assessor who has no experience working with individuals with a developmental disability solely because that individual also has a diagnosis of a mental illness. Further, an individual who has a mental illness may be assessed by an assessor who has no experience working with individuals with mental illnesses solely by virtue of the individual having a co-occurring developmental disability. We strongly encourage DHS to consider requiring that assessors who assess dually diagnosed individuals either have experience working with individuals who are dually diagnosed, or require that two assessors participate in the assessment process - one with mental health experience, and one with developmental disability experience.
Response: The independent assessment is not going to deem someone dually diagnosed. It is a functional assessment and not diagnostic in nature.

In addition, a similar problem exists with the development of the person-centered service plan for individuals who are dually diagnosed. We believe it is vital to · understand the unique needs of individuals who are dually diagnosed in order to create a person-centered service plan that will be

beneficial. While individuals' providers will be involved in the process of plan development, it is incumbent on DHS to ensure that beneficiaries' needs are identified by the care coordinator so that those needs are adequately addressed in the development of the care plan. This will clearly require an understanding of the needs of both those will developmental disabilities and those with behavioral health needs. Accordingly, we recommend that DHS ensure that individuals who are dually diagnosed have their plans developed by individuals who have experience working with individuals who are dually diagnosed, or require the participation of both persons who have experience working with individuals with mental illness and persons who have experience working with individuals with developmental disabilities.
Response: Because PASSEs are serving both populations, training to address both issues is occurring.

FQHC Services

Federally Qualified Health Centers (FQHCs) are community-based health care providers that receive funds from the United States Department of Health and Human Services to provide primary care services in underserved areas. The 1915(b) wavier application requires that each PASSE have at least one FQHC available to its participants. Further, FQHC's that are not included in a PASSE will not be furnished under the Plan. We believe that any action by OHS to limit the number of providers available to beneficiaries is unreasonable. FQHCs are valuable resources to individuals, and this restriction will possibly greatly limit the geographic areas of the state in which these services are provided. We would greatly appreciate OHS explaining the reasoning for excluding FQHCs from this program if they are not members of a PASSE.
Response: The PASSE is required to have at least one FQHC in their provider network. FQHC are not excluded from being participated providers.

Anticompetitive Practices

Throughout the development of the PASSE system, OHS has encouraged all providers to join all PASSEs. We obviously feel the same way. Individuals should be permitted their choice of providers, and not forced to choose between, for example, their primary care provider who will only participate in one PASSE, and their specialist, who will only participate in a different PASSE. We understand that OHS can conduct hearings regarding allegations of anticompetitive practices, but under Section ¥ !:i:ii@I{ yfilb J, 4; of the 1915(b) waiver, OHS will require providers or PASSEs to allege these practices. If all of the PASSEs are engaging in anticompetitive practices, it reduces the chance that those practices will yield a complaint. We are concerned that OHS offers no check on exclusive contracts between providers and PASSEs, and would strongly encourage OHS permit individual beneficiaries or their representatives to complain about anticompetitive practices. Further, we would suggest that OHS publish what it considers to be an anticompetitive practice other than the issues of marketing to PASSE eligible individuals identified in Section A, Part IV(A).
Response: This would not have been included in the waiver documents that are currently being promulgated. This would have been included in the PASSE Provider Manual.

Changing PASSEs

In order to change PASSEs at any time other than open enrollment, or within 90 days following initial attribution to a PASSE, a beneficiary must have "cause." Several reasons are listed as valid "cause" to change one's PASSE, including a failure to provide adequate or timely services. It is our understanding that the current arbiters for whether "cause" exists are informally Regina Davenport and Patricia Gann,

but the application does not indicate what will happen on January 1 if an individual alleges cause to change PASSEs. The application is not clear whether the Beneficiary Support Center will act as a factfinder in determining the presence of "cause" to change one's PASSE, whether there is a right of appeal from that decision, or whether an individual must engage in the grievance process through the PASSE before seeking assistance from OHS on this issue. Clarification on this point would be greatly appreciated.
Response: DHS must follow all federal regulations regarding a member's right to change their PASSE (42 CFR 438.56).

DMS Approval of DDS Policies

Appendix A to the 1915(c) application, Section (b)(i) indicates that OMS will review and approve DDS policies and procedures, including HCBS waiver amendments prior to implementation. This seems to be a mandatory requirement prior to implementation of a policy or procedure, yet there is (1) a performance measure that is intended to track the number of times OMS fails to review and approve a policy implemented by DDS prior to implementation, and (2) a description of how DMS's failure is remedied (which consists of reviewing the policy upon discovery). If this is a mandatory action, requiring OMS approval prior to implementation, why is there a provision for when it is not undertaken? Further, does this apply to policies or procedures that impact individuals' services, and accordingly should go through the public comment process? If so, is there any situation in which OHS can imagine that OMS would not have discovered the proposed policy prior to its implementation?
Response: Thank you for your comment. This section of the waiver was not amended.

Eligibility Criteria

The Eligibility Criteria indicated in Appendix B, Part B-1(b) differs from the description of the eligibility criteria listed in Appendix B, Part B-6(d). B-1(b) utilizes the criteria that is very similar to the ACS waiver eligibility criteria, which tracks Arkansas Code Annotated
§ 20-48-101, as well as 42 C.F.R. § 435.1010. B-6(d) is very similar, but for the addition of a requirement that adaptive functioning deficits must be "consistently measured by standardized instruments administered by qualified professionals." We believe this specific language will unduly exclude individuals who might otherwise be eligible for services.

First, there is no indication of a qualifying score, similar to that of the standardized test of intelligence being "two standard deviations below the mean." While DHS's intent might be to provide flexibility to promote inclusiveness, we have observed this provision used to exclude individuals who required services.

Second, this identification of eligibility requirements is more restrictive than how this population of individuals is defined by Arkansas Code Annotated§ 20-48-101, as well as 42 C.F.R. § 435.1010; consequently, there are individuals who meet the level of care criteria for ICF/IID under both state and federal authority who, by virtue of lacking consistent standardized testing for adaptive deficits that meet the unpublished expectations of the reviewers, would not be eligible for home and community based services. We recommend that OHS utilize the definitions endorsed by 42 C.F.R. § 435.1010 to determine eligibility for home and community based services.
Response: Thank you for your comment. Eligibility requirements and reevaluation requirements have not changed.

Data Collection

The proposed rules comprehend the collection of data from providers, PASSEs, and individuals, both through self-reporting and through external reviewers. We hope that, as part of this analysis, OHS collects data consistent with the National Core Indicators, and use an analysis of the indicators to compare our beneficiaries' outcomes and progress with that of other states' populations.
Response: DHS is using National Core Indicators.

Timing for Public Comment

The proposed rules represent more changes the programs whose implementation is uniformly described by stakeholders as "hurried." The proposed changes encompass several hundred pages of rules, regulations and technical applications to CMS.

The Arkansas Administrative Procedure Act requires that DHS allow at least thirty days for public comment. Ark. Code Ann.§ 25-15-204. Given the volume of information individuals are required to review, analyze, and consider, we believe that DHS and the public would both be better served by enlarging the period for public comment.
Response: The Waivers ran for public comment from October 14, 2018 to November 12, 2018. Two public hearings were held during this time, one in Springdale on October 26, 2018, and one in Little Rock on November 5, 2018. Additionally, the Waivers were posted on the Arkansas PASSE webpage for review and comment around August 31, 2018. In addition, letters were sent out at that time soliciting comments on the Waivers.

Arkansas Pest Management Association, President, John Force

Comment: While the bulk of our comments pertain to pest control covered under emergency goods and services under proposed Rule # 016.06.18-016, we would like to apply our recommendation of requiring that only certified, licensed, and registered pesticide applicators and pest control companies providing pest eradication services under CTS pursuant to proposed rule # 016.06.18019:
"Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institutional or provider-operated living arrangement, such as an ICF or group home, to a living arrangement in a private residence where the member or his or her guardian is directly responsible for his or her own living expenses.
Community Transition service activities include those necessary to enable a member to establish a basic household, not including room and board, and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the member's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses."

As written, it appears to APMA that pest control services could be provided by relatives. If unlicensed relatives are permitted or intended to be permitted to provide pest control services APMA disagrees with this. If relatives are in fact allowed to be reimbursed by Medicaid to perform pest control services it is incongruent with the existing Arkansas laws and regulations mentioned earlier. Please view the screen shot appended below describing CTS under the proposed rule.
Response: A licensing requirement will be added to the 1915(c) waiver.

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

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Medical Services

DIVISION DIRECTOR Tami Harlan

CONTACT PERSON Isaac Linam

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

PHONE NO. 501-320-6570 **FAX NO.** 501-404-4619 **E-MAIL** Isaac.Linam@dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Paula Stone

PRESENTER E-MAIL Paula.stone@dhs.arkansas.gov

INSTRUCTIONS

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

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

****

1. What is the short title of this rule?

Provider-Led Arkansas Shared Savings Entity (PASSE) Program—1915(b) and (c) waivers and 1915(i) SPA # 2018-17

2. What is the subject of the proposed rule?

Moves the PASSE program into Phase II, in which the PASSE is responsible for providing all CES Waiver services and State Plan services, including those Home and Community Based Supportive Services contained in the 1915(i) state plan amendment for Supportive Services for PASSE clients.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒

If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒

If yes, what is the effective date of the emergency rule?

When does the emergency rule expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?

Yes ☐ No ☐

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

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

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

These waivers and this State Plan Amendment are being sought pursuant to Act 775 of 2017. They implement Phase II of the PASSE model, in which the PASSEs begin operating as Managed Care Organizations (MCOs) under CMS's regulations and assume full risk for providing all Home and Community Based Services (HCBS) under the 1915(c) Community and Employment Supports (CES) Waiver and all State Plan Medicaid Services, including HCBS services provided through the 1915(i) State Plan Amendment. This model will allow for more flexibility in the provision of HCBS services to individuals with high behavioral health or developmental disabilities service needs. Under this model the PASSE will be responsible for developing the Person Centered Service Plan (PCSP) and delivery of all needed services.

The 1915(c) and 1915(b) documents are amendments to existing waivers. They are submitted through the CMS portal and cannot be submitted in a track changes or marked up version. The 1915(i) state plan amendment is a new document but is part of the overall PASSE program.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Acts 2017, No. 775, codified at § 20-77-2701 et seq.; § 20-77-2708; Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

7. What is the purpose of this proposed rule? Why is it necessary?
These waivers and the State Plan Amendment enact Phase II of the Provider-Led Arkansas Shared Savings Entity (PASSE) organized care program.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx

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

Date: October 26, 2018 / November 5, 2018

Time: 4:30 / 5:00

Springdale Public Library
405 South Pleasant Street
Springdale, Arkansas

Arkansas Enterprises for the
Developmentally Disabled
105 East Roosevelt Road
Place: Little Rock, Arkansas

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

November 12, 2018

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

January 1, 2019

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. *Attached*

13. Please provide proof of filing the rule with the Secretary of State and the Arkansas State Library as required pursuant to Ark. Code Ann. § 25-15-204(e). *Attached*

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. *Position unknown: PASSE entities, current CES Waiver providers, current OBH providers, beneficiaries who are going into the PASSE or their guardians/caregivers.*

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT David McMahon

TELEPHONE 501-396-6421 **FAX** _____ **EMAIL:** David.McMahon@dhs.arkansas.gov

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

SHORT TITLE OF THIS RULE **Provider-Led Arkansas Shared Savings Entity (PASSE) Program—and (b) waivers and 1915(i) SPA # 2018-17**

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

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

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

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

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

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

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

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

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

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	($6,915,805)	General Revenue	($14,177,435)
Federal Funds	($16,535,552)	Federal Funds	($33,897,964)
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	($23,451,357)	Total	($48,075,399)

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

Current Fiscal Year
Additional revenue generated due to premium taxes from PASSE entities - $11,820,950 ($5,910,475 for use to offset General Revenue of PASSE payments and $5,910,475 for use to reduce DDS wait list).

Next Fiscal Year
Additional revenue generated due to premium taxes from PASSE entities - $24,232,946 ($12,116,473 for use to offset General Revenue of PASSE payments and $12,116,473 for use to reduce DDS wait list).

The amounts reported for questions #4 and #5 are tentative pending final approval of rates for calendar year 2019 and 2020.

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

PASSE entities will negotiate with providers to set service rates under this model. Therefore, the rule itself does not impose any specific cost on the provider.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

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

Current Fiscal Year
$ (35,272,307)

Next Fiscal Year
$ (72,308,345)

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

Yes ☐ No ☒

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

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

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

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

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

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

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

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

Supplemental Information

PASSE Fiscal Impact Narrative

Introduction

The costs and savings presented here are based on reasonable assumptions about the current cost of the program and a reasonable level of savings to be achieved in the first year of risk-based capitation rates. The actual cost and savings presented may change from the estimates presented here.

DHS has not negotiated the final rates to be paid to the PASSE which must be approved by the Centers for Medicare and Medicaid Services (CMS). Each PASSE will receive a capitated per member per month (PMPM) payment to reflect all benefits for all covered services and administrative costs. Even after final rates are agreed to by the PASSEs and CMS, actual costs and savings may change. For example, each individual enrolled among the PASSEs has been designated a tier level of care as a result of their Independent Assessment (IA). Currently, there are active appeals for 317 individuals (less than 1% of assessments conducted for these populations).

The rates will be set only for Calendar Year (CY) 2019. DHS will use the experience of CY 2019 to set rates for CY 2020.

Costs

Estimated Medicaid expenditures for CY 2019 and CY 2020 have been projected using actual expenditures from State Fiscal Year (SFY) 2016 and SFY 2017 for the following population groups:

- Behavioral Health (BH) Adult Tier 2
- BH Adult Tier 3
- BH Child Tier 2
- BH Child Tier 3
- Intellectually/Developmentally Disabled (ID/DD) Adult Tier 2
- ID/DD Adult Tier 3
- ID/DD Child Tier 2
- ID/DD Child Tier 3
- Dual Diagnosis Adult Tier 2
- Dual Diagnosis Adult Tier 3
- Dual Diagnosis Child Tier 2
- Dual Diagnosis Child Tier 3

Service category (inpatient hospital, physician, professionals, waiver services, etc.) costs for each of these population groups in SFY 2016 and SFY 2017 have been indexed at variable growth rates based on recent trends.

In addition, DHS has imputed costs for children and adults for services to be provided through the 1915(i) state plan amendment. PASSEs are required to provide all state plan amendment services, which will include the 1915(i) services as well as all waiver services for the ID/DD populations.

Savings

The savings estimates are based on reasonable assumptions about the change in utilization patterns generally experienced in the adoption of managed care models. We expect, in general, an increase in utilization of community-based providers, especially physicians and professionals. Greater access to community services will reduce use of institution-based care. Improvements in organized care will have the greatest impact on the highest cost individuals. For example, individuals with high pharmaceutical costs will benefit from intensive medication management.

DHS estimates savings of approximately $47 million (State and Federal) in CY 2019 net of administrative costs included in the Global Payment. For comparison, in December 2016, the Health Care Task Force (HCTF) estimated that the first year of savings would not occur until SFY 2021. The net savings for SFY 2021 was estimated at $40 million.

Administrative expenses include human capital costs (salaries, wages, benefits, payroll taxes, etc.); operating expenses (equipment, occupancy, etc.); and taxes and fees (premium tax). The administrative component of the PMPM will be comparable with what other states pay for Medicaid managed care. DHS has not assumed net savings to the program in shifting from direct reimbursement to providers (claims processing, member enrollment, provider credentialing, grievances and appeals, etc.) to risk-based payments as each PASSE must perform the same administrative functions.

Revenues—Premium Tax

Each PASSE will pay a 2.5% premium tax. As specified in Act 775, at least 50% of these revenues must be used to reduce the waitlist for individuals with ID/DD. DHS will also use a percentage of revenues to fund a Quality Incentive Pool for the PASSEs. DHS may also use revenues as the nonfederal share to finance the program.

DHS estimates the premium tax will generate approximately $23.1 million in CY 2019. For comparison, the HCTF estimated a premium tax would generate $56 million in revenue in SFY 2021. As the premium tax is based on payments to the PASSEs, the lower revenue amount reflects lower expenditures compared to the HCTF estimates. Spending on the BH and ID/DD populations has decelerated from the HCTF timeframe, due, in part, to the Medicaid transformation initiatives that have been implemented per the HCTF recommendations.

Revenues—Provider Assessments

There is a relationship between supplemental payments to hospital providers and the amount of the assessments they pay. All supplemental payments to hospital providers have been included in the cost of services used to calculate the PMPMs.

There is no fiscal impact on the amount of supplemental payments the hospitals will receive in in SFY 2019, as payments to providers are based on the prior two years. DHS intends to consult with providers on the impact of the PASSE program on provider assessments. DHS estimates that a loss in provider assessment revenues to the General Fund will be offset by the new premium tax.

SUMMARY FOR 1915(b) AND (c) WAIVERS AND 1915(i) SPA # 2018-17

The 1915(b) and (c) waivers and 1915(i) State Plan Amendment are being sought pursuant to Arkansas Code § 20-77-2708, derived from Acts 2017, No. 775. These waivers will provide authorization from CMS for the Department of Human Services (DHS) to implement the PASSE Program, required by Acts 2017, No. 775.

These waivers and the State Plan Amendment authorize the following:

- PASSE entities continue to provide care coordination as that is defined by Act 775 of 2017. The four essential "case management" functions (independent assessment, plan development, referral for services, and service monitoring) must be performed in compliance with the CMS conflict-free case management rules. While this has been in place under Phase I, Phase II provides more detail on the conflict free case management rules. Additionally, under Phase II, the care coordinator is responsible for development of the Person Centered Service Plan (PCSP).

- PASSE entities become responsible for the provision of all services under Phase II, including all CES Waiver services and Medicaid State Plan services, including all home and community based services (HCBS) provided through the 1915(i) state plan amendment. The only services excluded from payment by the PASSE are:
    1) Nonemergency medical transportation in a capitated program;
    2) Dental benefits in a capitated program;
    3) School-based services provided by school-employees;
    4) Skilled nursing facility services;
    5) Assisted living facility services;
    6) Human development center (HDC) services provided to clients fully admitted to an HDC; or
    7) Waiver services provided to adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices program, or any successor waiver for the frail, elderly, or physically disabled.

- Individuals will no longer be "attributed" to a PASSE based on their claims history and/or provider relationships. Instead, individuals will be "auto-assigned" to a PASSE using a round-robin methodology. PASSE's may be pulled out of auto-assignment if they are not in good standing or if they reach a certain percentage of market share (53%).

- The PASSE entity will receive a Per Member/Per Month (PMPM) global payment to cover all needed services for each assigned member. The PMPM will be based on historical utilization.

- The Network requirements were enhanced to reflect that PASSEs are now responsible for providing all services. These network requirements now include distance requirements, time-frame requirements, and provider to member ratio requirements. This now includes requirements for use of out-of-network providers.

- Each PASSE is now required to develop an internal appeal process, in addition to the grievance process, and the beneficiary must exhaust that appeal process before appealing to the state Medicaid agency.

- The PASSE entities will now be required to submit monthly encounter data so that service utilization can be tracked. This will be in addition to the quarterly reports that were submitted in Phase I, which will continue in Phase II. These will be used to monitor and improve quality of the PASSE program under the enhanced quality provisions of the PASSE model.

- The PASSE will now be responsible for credentialing all network providers, including Home and Community Based Services Providers, that provide services to their enrolled members.

- The 1915(i) State Plan Amendment details the home and community-based like services that the PASSE will be required to provide to eligible beneficiaries. Those services are: Supported Employment; Behavior Assistance; Adult Rehabilitation Day Treatment; Peer Support; Family Support Partners; Residential Community Reintegration; Outpatient Substance Abuse Treatment; Crisis Intervention; Planned Respite; Emergency Respite; Mobile Crisis Intervention; Therapeutic Host Home; Recovery Support Partners (for Substance Abuse); Substance Abuse Detox (Observational). Beneficiaries are eligible for the 1915(i) services if they meet the following criteria:

  Dually diagnosed clients:

  1) must have a documented behavioral health diagnosis and a documented developmental disability. These diagnoses must be made a physician and be contained in the individual's existing medical record;
  2) Must meet the institutional level of care criteria set forth by the Division of Developmental Disabilities Services for admission into an ICF/IID or CES Waiver;
  3) Must have been deemed a Tier 2 or Tier 3 by the independent assessment of functional need related to diagnosis; and
  4) Must be determined appropriate for HCBS State Plan services by the DHS Dual Diagnosis Evaluation Committee. The DHS Dual Diagnosis Evaluation Committee will be made up of clinicians and programmatic experts that work for or contract with the Division of Developmental Disabilities Services, the Division of Aging, Adult, and Behavioral Health Services, and the Division of Medical Services within the Arkansas Department of Human Services. This committee will be responsible for reviewing any cases presented for consideration to place the individual into a dual-diagnosed rate cell within the PASSE program and deemed eligible for the 1915(i) HCBS services.

  Behavioral Health clients:

  1) Must have a documented behavioral health diagnosis, made by a physician and contained in the individual's medical record; and
  2) Must have been deemed a Tier 2 or Tier 3 by the independent assessment of functional need related to diagnosis.

  Developmentally disabled clients:

  1) Must have a documented developmental disability diagnosis, made by a physician and contained in the individual's medical record; and
  2) Must have been deemed a Tier 2, or Tier 3 by the independent assessment of functional need related to diagnosis.