EXHIBIT L

DEPARTMENT OF HUMAN SERVICES, DEVELOPMENTAL DISABILITIES SERVICES

SUBJECT: DDS Community and Employment Supports (CES) Waiver and Medicaid Provider Manual #2-17

DESCRIPTION: The Department of Human Services Division of Medical Services (DMS) is proposing changes to the Medicaid Provider Manual, Division of Developmental Disabilities Services (DDS) Community and Employment Supports (CES) Waiver (formerly the Alternative Community Services Waiver) and the DDS CES Waiver AR 0188. The changes in the Waiver and the Manual are consistent.

The following is the summary of changes:

1. Changes name from Alternative Community Services to reflect the emphasis on integrating participants into the community and providing supported employment opportunities.

2. Adds 500 slots pursuant to Act 50 of 2017.

3. Details the independent assessment tool that will be used to evaluate all waiver participant's level of need and to develop their individualized person centered service plan, along with the functional assessments and application packet, by a third party vendor.

4. Modifies service definitions for Supportive Living and Respite to reflect the new two tier system used by the independent assessment.

5. Clarifies other portions of the waiver, including service definitions, so that the manual and the waiver mirror each other.

PUBLIC COMMENT: A public hearing was held on March 29, 2017. The public comment period expired on April 1, 2017. The department received the following comments:

Written comments received by Disability Rights Arkansas (DRA):

Regarding Waiver expansion, DDS continues to work to eliminate the waitlist for Waiver services. As you may be aware, under the new Provider Led Organized Care Act, Act 775 of the 2017 Regular Session, half of the revenue generated from the premium tax will be used to fund waiver slots for clients on the waitlist.

Regarding the suggestion that we conduct more stakeholder education for waiver participants and their families, you will be happy to hear that we have already begun that process. We have scheduled meetings specifically for participants' families during the

next few months to answer any questions they may have about the upcoming changes to the Waiver and to explain to them the changes that will be coming with the Provider Led Entity model being implemented. On March 29, 2017, Director Stone met with families at ICM; on April 5, 2017, she conducted a web conference with families from ASN; and on April 11, 2017, she met with families at Easter Seals. We are also encouraging all families to attend the provider meetings on Monday afternoons during the month of April. These meetings will be held at St. Vincent's Main Auditorium from 1:30 to 3:00 p.m. The meeting on April 10, 2017, was specifically geared toward DDS providers and clients.

Regarding access to Third Party Contractor Performance Assessments, Vendor Performance Reports are performed and available for all state contract vendors. Also, the RFP for the Independent Assessments requires the Vendor to perform a minimum of quarterly evaluations to ensure Beneficiaries are being properly assessed and assigned to the correct tier, that the IT platform is accurately capturing scores, and that the algorithms used are accurately measuring tiers. These evaluations must be submitted to DHS with the monthly reports. The RFP also requires that the Vendor have a system in place for participants to provide feedback and complaints and for complaints to be investigated. Regarding implementation of conflict free case management, we assure everyone that we are continuing to address this issue and to bring the CES Waiver into alignment with CMS regulations. The Independent Assessment is a first step to meeting the conflict free case management rule. In the next amendment to the Waiver, we will specifically add requirements that the PASSE must provide conflict free case management. For example, there will be a requirement that the PASSE cannot use a direct service provider to provide case management services to the same clients.

Regarding the suggestion that case managers be required to make monthly face-to-face contacts with their clients, we agree. This change will be made.

Regarding shared direct care, the comment does not accurately reflect the Waiver language that was put out for public comment. In response to several comments from clients and their families, we deleted any requirements for shared staffing before putting the Waiver out for public comment. Instead, the CES Waiver requires the following:

> *The PCSP development team must utilize the results of the Independent Assessment in creating the PCSP. When developing the PCSP the development team must consider cost-efficient options that foster independence, such as shared staffing and other adaptations. When such options are not utilized in the PCSP for a Tier 3 participant, it must be documented that the participant's health and safety require one on one staffing, twenty-four hours a day. Appendix D-1(d).*

Regarding the appeals process, we agree that the beneficiary should have more than ten (10) days from receipt of the notice to respond. Therefore, we are extending this timeframe out to *fifteen business days*. The Waiver appeal

process was amended to reflect the appeal process used for all Medicaid programs and found in the Medicaid Provider Manual, Section 191.000. Any changes from the previous appeal process will be explained and due process of beneficiaries and providers will be protected.

Regarding the Independent Assessment tool, DDS assures everyone that it has provided as much information as it currently able to regarding the tool that will be used to assess Waiver participants. As soon as more information is available, this information will be shared with the providers, clients, and their families so that public input can be obtained.

Written comments received by David Ivers with David Ivers with Mitchell, Blackstock, Ivers & Sneddon, PLLC:

Regarding case management under the PASSE, we will be making amendments to the CES Waiver and writing a concurrent 1915(b) waiver that will address case management under the PASSE. Case management will no longer be a service under the Waiver, but will be coordinated by the PASSE and paid for as part of the overall global payment. Children receiving targeted case management through EPSDT and on the Waiver will begin receiving case management through the PASSE once that model is implemented and will still need to undergo a prior authorization process for services until the PASSE takes full risk in January 2019.

Regarding the new rates, DDS will use an existing contract with an actuarial company to begin a rate study in May-June 2017. The results of this rate study will be used to implement a new rate methodology in the next waiver amendment.

The Tier 2 daily rate did not increase. In the September 1, 2016 Waiver, the daily rate for limited services was $176.00 and the daily rate for extensive services was $184.80. In the CES Waiver, DDS combined limited and extensive and made them Tier 2, or less than 24/7 level of care. Because we have no basis to change the rates, the daily maximum for Tier 2 was left at the daily maximum for extensive services, $184.80.

The timeframes regarding enrolling individuals into the PASSE are all estimates based on timelines established by the Transformation efforts and the Provider Led Organized Care Act. These timeframes will be adjusted as we get more information on how these changes will be implemented.

Regarding changes to the Medicaid Provider Manual and Licensure standards, we agree that significant changes will have to be made to these documents to implement the PASSE model. However, if we do not change the manuals to reflect the current waiver changes, we cannot implement the Waiver amendments effectively. Therefore, we must change the documents along with the Waiver amendments.

Written comments received from Syard Evans, Ph.D., Deputy CEO, Arkansas Support Network:

Regarding the comment that we 24/7 requirement forcing individuals to utilize 24/7 services when they are not needed. We appreciate this comment and understand your concerns. We hope that the new cost methodology will address these concerns by more accurately reflecting a rate for less than 24/7 care. Until such time, clients who have a medically necessary need for more than Tier 2 level of services ($184.80 per day), may have their Person Centered Service Plan amended to utilize more services with appropriate documentation.

We agree that clients should have an option for self-directed services. We are looking at ways to implement this in future waiver amendments.
In regards to adaptive equipment, DDS expanded the definition to include "enabling technology," which is technology that:
empowers participants to gain independence through customizable technologies that allow them to safely perform activities of daily living without assistance while still providing monitoring and response for those participants, as needed. Enabling technology allows participants to be proactive about their daily schedule and integrates participant choice. Before any enabling technology may be approved, it must be shown to meet a goal of the PCSP, ensures the participant's health and safety, and provides for adequate monitoring and response. Each participant who receives enabling technology must have an assessment conducted and a plan created for how that technology will be used to meet a PCSP goal, ensure the participant's health and safety, and provide adequate monitoring and response.

Written comments received from Mark George:

In regards to the reserved waiver capacity, this was a scrivener's error. The 200 slots are still reserved for children in the custody of DCFS. The CES Waiver will be changed to reflect this.

The Waiver priority language was revised, as suggested, so that the sentence makes sense.

Regarding the Level of Care criteria, the CFR referenced, 42 CFR § 440.150, defines an ICF/IID. But, we agree that this is not necessary to reference and the reference will be removed. We also agree that the near future language should be removed. This section will be changed to reflect that the individual would be at risk for institutionalization absent waiver services.

Comments on the renewal application were addressed during that public comment period.

Regarding administrative review and appeal, all beneficiaries and providers may still ask for reconsideration or appeal of an adverse decision or a denial of eligibility pursuant to the Medicaid Provider Manual § 191.000 and the Arkansas Administrative Procedures Act, as well as the Arkansas Medicaid Fairness Act. The Waiver language was amended to reflect this process, not to remove the right to administrative review of decisions. However, the state does not offer an alternative process, only the reconsideration and appeal process outlined in Appendix F-1.

Case Managers should discuss all approvals and denials with their client and as such, do have a responsibility to ensure the client receives those. However, you are correct that DDS has the legal responsibility to ensure notice is received by the client. This language does not negate that legal responsibility.

We agree that the language in the definition of adaptive equipment regarding the minimum purchase is confusing and will change it.

We agree that "vehicle modifications" should be added to conditions to make it clear that care and maintenance of vehicle modifications are the responsibility of the individual. This change will be made.

We agree that the language in Appendix F-1 regarding notice of appeal rights was confusing. We have reworded it to make it clearer. Regarding the responsibilities of the case manager, this language explains the case manager's role in providing choice counseling and assisting the beneficiary with appeals. Regarding reconsideration, it is a standard part of the due process rights provided to Medicaid beneficiaries and is not an alternative dispute resolution process.

Regarding continuation of service during an appeal, it is the provider who assumes liability for non-payment of services. We have added this language back in to clear up any confusion.

The appeal section was re-written to conform to the Arkansas Provider Manual regarding administrative appeals.

The Medicaid finance team assists with compiling Appendix J and we believe that the numbers contained in Appendix J are accurate. However, we will review these tables for accuracy before finalizing the Waiver application.

Mark George also made oral comments at the public hearing on March 29, 2017, that were similar to his written ones and have already been addressed.

Mike McCreight with Pathfinder made several oral comments at the public hearing on March 29, 2017. Most of his comments were addressed in the responses to the written comments above. However, he did comment that group homes should not be eliminated

as an option for respite. We agree. This was an oversight and group homes will be added back in as a setting for respite.

The proposed effective date is July 1, 2017.

FINANCIAL IMPACT: The cost to implement the rule is $27 million for the current fiscal year ($7,943,400 in general revenue and $19,056,600 in federal funds); and $27 million for the next fiscal year ($7,865,100 in general revenue and $19,134,900 in federal funds). The $7,943,400 represents the amount of money being redirected to the DDS Waiver from the Tobacco Settlement Funds. The total is the state share based on an estimated cost of $54,000 per recipient and the addition of 500 new recipients.

Since the new or increased cost or obligation is 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, the agency submitted the following information:

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

The waiver is being amended to add 700 slots pursuant to Act 50 of 2017, which redirected $8.7 million of tobacco settlement funds to DHS to reduce the number of people on the waiting list for Waiver services. The waiver is also being amended to require all participants undergo an independent assessment which will be used to assist in determining the appropriate level of services for the client and develop the person centered case plan.

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

There is currently a waitlist for waiver services that has approximately 3000 people on it. Some of these individuals have been waiting for ten years to receive services. The additional funding will help to reduce the number of people on the waitlist by approximately 500 people.

(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;

The new rule will help to reduce the waitlist by 3000 people; also by incorporating the independent assessment, DDS is hoping to ensure that all services provided to Waiver participants are appropriate for the level of need the person has. The purpose of the independent assessment is to have a third party assess the needs of the individual and to require that assessment be used to develop the Person Centered Case Plan, along with other testing.

(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;

N/A

(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;

Unknown at this time.

(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

N/A

(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.

The waiver must be renewed every five years, so DDS and DMS reviews the waiver and Provider Manual during that time to ensure that services are being provided to participants in the most cost efficient manner available while still ensuring participant's health and safety.

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

EXHIBIT L

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

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Developmental Disabilities Services

DIVISION DIRECTOR Melissa Stone

CONTACT PERSON Elizabeth Pitman

ADDRESS P.O. Box 1437, Slot N501

PHONE NO. (501) 682-4936 **FAX NO.** (501) 682-8380 **E-MAIL** Elizabeth.pitman@dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Melissa Stone

PRESENTER E-MAIL Melissa.stone@arkansas.gov

INSTRUCTIONS

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

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

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1. What is the short title of this rule? DDS Community and Employment Supports (CES) Waiver & Medicaid Provider Manual #2-17

2. What is the subject of the proposed rule? Amendments to the existing Waiver to add 500 new slots and begin independent assessments on all Waiver participants; along with amendments to the Medicaid Provider Manual to reflect these changes.

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

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

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

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

When does the emergency rule expire?

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

Yes ☐ No ☐

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

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

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

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

7. What is the purpose of this proposed rule? Why is it necessary? The Waiver is being amended to add an additional 500 slots to the waiver due to the redirection of $8.7 million in Tobacco Settlement Funds pursuant to Act 50. The waiver amendments also incorporate independent assessments, which is the first step toward conflict free case management and Transformation of the Medicaid program. The Medicaid Provider Manual will be updated to reflect these changes.

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

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

Date: March 29, 2017
Time: 4:30 p.m.
Place: Darragh Center, Main Library, 100 S. Rock Street Little Rock, AR

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
April 1, 2017

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

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. See 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). See 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. Providers, specifically Arkansas Waiver Association – Keith Vire and Cindy Alberding (for); Developmental Disabilities Provider Association – Judy Watson, President (for)

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Developmental Disabilities Services

PERSON COMPLETING THIS STATEMENT Elizabeth Pitman

TELEPHONE (501) 682-4936 **FAX** (501) 682-8380 **EMAIL:** Elizabeth.pitman@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 DDS Community and Employment Supports (CES) Waiver and Medicaid Provider Manual #2-17

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		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total _____ Total _____

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

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

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

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

Current Fiscal Year
$ 7,943,400

Next Fiscal Year
$ 7,865,400

These numbers represent the amount of money being redirected to the DDS Waiver from the Tobacco Settlement Funds. The total is the state share based on an estimated cost of $54,000 per recipient and the addition of 500 new recipients. We will receive a federal match in the amount of $19,056,600 in this current fiscal year; and $19,134,900 in the next fiscal year.

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;

The waiver is being amended to add 500 slots pursuant to Act 50 of 2017, which redirected $8.7 million of tobacco settlement funds to DHS to reduce the number of people on the waiting list for Waiver services. The waiver is also being amended to require all participants undergo an independent assessment which will be used to assist in determining the appropriate level of services for the client and develop the person centered case plan.

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

There is currently a waitlist for waiver services that has approximately 3000 people on it. Some of these individuals have been waiting for ten years to receive services. The additional funding will help to reduce the number of people on the waitlist by approximately 500 people.

(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;

The new rule will help to reduce the waitlist by 500 people; also by incorporating the independent assessment, DDS is hoping to ensure that all services provided to Waiver participants are appropriate for the level of need the person has. The purpose of the independent assessment is to have a third party assess the needs of the individual and to require that assessment be used to develop the Person Centered Case Plan, along with other testing.

(3) 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;

N/A

(4) 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;

Unknown at this time.

(5) 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

N/A.

(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.

The waiver must be renewed every five years, so DDS and DMS reviews the waiver and Provider Manual during that time to ensure that services are being provided to participants in the most cost efficient manner available while still ensuring participant's health and safety.