EXHIBIT D

DEPARTMENT OF HUMAN SERVICES, DEVELOPMENTAL DISABILITIES SERVICES

SUBJECT: Community and Employment Support (CES) 1915(c) Waiver, CES Provider Manual and Certification Standards for CES Providers

DESCRIPTION: These amendments are being made to require all CES Waiver participants to join a PASSE. These amendments also change the existing case management service to care coordination, as defined in the PASSE Program. Care coordination is a broader service that will be provided to waiver beneficiaries who have not been attributed to a PASSE. Once the beneficiary is attributed to a PASSE, the PASSE will begin providing care coordination under the 1915(c) Waiver.

PUBLIC COMMENT: A public hearing was held on August 8, 2017. The public comment period expired on August 11, 2017. The Department provided the following public comment summary:

Comment: H – This does not match the CES Waiver for DD which says that "contact" must be made monthly, but "face-to-face" must be made at least quarterly. Please clarify if "face-to-face" can be telemedicine.
Response: Within the context of care coordination, we have clarified that the use of video conferencing for the purpose of required contacts is allowable after the initial face-to-face visit. Telemedicine is still allowable under the Medicaid State Plan in order to deliver a medical service.

Comment: We are not opposed to conflict-free case management – when properly interpreted and applied. We believe the draft rules are well-intentioned but have lost sight of the policy rationale underlying "conflict-free case management." "Case management" is a nebulous term that can mean all sorts of things. You cannot simply go into the manual and try to remove everything that you used to define as "case management." We believe the goal of "conflict free case management" should be to ensure that direct care providers do not control decisions of resource allocation that should be handled by an independent party. Beyond that, direct care providers are not only suitable but they are in the best position to effect better care coordination because they are the ones who see the clients on a regular basis and have the closest relationships with the clients and their families. We strongly recommend starting over, focusing on those tasks that pose actual conflicts, *i.e.*, resource allocation, by assigning them to a third party (the independent assessor, DDS, or the PASSE MCO), and then allow the direct care providers to provide the rest of the care by whatever name. This is not only easier to administer it is in the best interests of clients and what they have overwhelmingly demonstrated that they want when offered a choice.
Response: Based on public comment, DHS has clarified that it is the responsibility of the PASSE to comply with Conflict Free Case Management rules.

Comment: C – This section states: The care coordinator for attributed beneficiaries who are also CES Waiver participants cannot be affiliated with the direct service provider for that beneficiary." We strongly oppose this overly broad approach. See discussion above. A more nuanced approach is needed.
Response: Based on public comment, DHS has clarified that it is the responsibility of the PASSE to comply with Conflict Free Case Management rules.

Comment: PASSE APPLICANT seeks clarification on the requirement that "the care coordinator for attributed beneficiaries who are also CES Waiver participants cannot be affiliated with the direct service provider for that beneficiary." Can the State clarify how 'the direct service provider' is defined and identified for a beneficiary?
Response: Based on public comment, DHS has clarified that it is the responsibility of the PASSE to comply with Conflict Free Case Management rules.

Comment: Section 241 details the "Definition of Care Coordination"; however, it does not provide expectations on the separation of responsibilities of Care Coordinators at the PASSE level and those working for DD providers. Further clarification on the expectations/roles of these positions at the different entities should be provided.
Response: Based on public comment, DHS has clarified that it is the responsibility of the PASSE to comply with Conflict Free Case Management rules.

Questions: Regarding conflict free case management, who is the care coordinator? What is the role of the direct care supervisor? Are they care coordinators? What separates the current case manager from the future care coordinator?
Response: Under the PASSE care coordination model, all case management/care coordination activities will be done by the PASSE care coordinator. To ensure continuity of service and consistency, we have changed the definition of case management in the CES waiver and changed the name of it to care coordination. The current case managers will provide care coordination as it is defined in the CES waiver to their clients until such time as those clients are attributed to a PASSE. Then the PASSE will take over providing care coordination.

Question: How is the eligibility determination discussed in Section 241.000(C)(9) different from the independent assessment, and/or is this a prior authorization?
Response: Section 241.000(C) describes what functions a care coordinator will be required to perform for a DD Waiver client. One of those functions is assisting with the ICF/IID Level of care redetermination every year. A DD Waiver client will only have to undergo the Independent Assessment (IA) once every three (3) years unless there is a change in condition and another IA is requested. The IA will not be used to determine whether a client is eligible to receive waiver services that will be determined by DDS's intake and eligibility unit. The IA is a functional assessment that helps determine the individual client's service need.

Comment: Please clarify 'current state,' 'future state,' and changes for 1) care coordination staffing including case managers, direct care supervisor (DCS), 2) related fees for the services, and 3) responsibility for plan of care between current providers such as DD waiver case management, DCSs, and PASSEs.

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Response: Under the PASSE care coordination model, all case management/care coordination activities will be done by the PASSE care coordinator. To ensure continuity of service and consistency, we have changed the definition of case management in the CES waiver and changed the name of it to care coordination. The current case managers will provide care coordination as it is defined in the CES waiver to their clients until such time as those clients are attributed to a PASSE. Then the PASSE will take over providing care coordination.

Question: Who will manage things like my child's pull-ups and meds? I manage them at present time and do not want someone else to take over. Will I be able to continue to manage these things?
Response: Yes, you will be able to continue to manage those things. The independent assessment will look at what is currently taking place to determine service needs. If you are currently meeting your child's needs the independent assessment will note that and that will be considered when forming the person centered service plan (PCSP).

Question: Can the assessment find someone who is pervasive not eligible for Waiver?
Response: No, the Independent Assessment is a functional needs assessment and is separate from the eligibility determination. So, the assessment will be used to determine the intensity of services a Waiver client needs, not to make them eligible or non-eligible for Waiver.

Question: Will the plan of care, with goals (outcomes) be the responsibility of the providers or the care coordinators? If it is done by the care coordinators, how does provider have input on the needs of the client if don't agree with goals set (or not) by care coordinator, we think the client needs?
Response: In Phase I, the development of the Person Centered Service Plan (PCSP) will stay the same as it has been in the past.

Question: The DDS Director said that case management and supportive living cannot be done by the same person. How are companies that have done away with case management handling health and safety issues? Including monthly visits? Specifically, for pervasive level of care clients?
Response: The language is clarified to reflect that the PASSE will comply with conflict free case management, which involves several components: assessment of an eligible individual (42 CFR 440.169(d)(1)), development of a specific care plan (42 CFR 440.169(d)(2)), referral to services (42 CFR 440.169(d)(3)), and monitoring activities (42 CFR 440.169(d)(4)). We have stated that the PASSE entity will comply with the overall federal regulation.

Question: If a consumer is pervasive level of care with inclusive opportunities for independence, how will that affect the change within the PASSE?
Response: Under the PASSE model, individuals currently classified as Pervasive level of care are until they are assessed being assigned Tier 2, which is the highest

level of need (24 hour paid services and supports). This does not negate the ability for services and supports being provided in inclusive settings that offer maximum opportunities for independence.

Question: Arkansas Medicaid is pushing supported employment. How is DDS proposing to actually provide licensing, training, and money to providers in order to serve our clients in this way? We're in a small town, have taken client with 20+ years dishwasher experience to apply several times for this job, last time, employer said had 200 people applying for 1 dishwasher job.
Response: DDS continues to promote supported employment options for individuals with disabilities. As part of our initiatives, DDS has worked with providers on a voluntary basis to provide assistance as providers transformed service delivery system in the employment arena. This assistance has included technical assistance through Consultants knowledgeable in the field who work directly with providers in their communities to develop provider/community specific planning; Inter/intra agency agreements to stabilize funding for Supported Employment and other activities. Through the implementation of the revised SE definition, greater flexibility in utilization of funding to better need employment support needs are being offered.

Question: Do you get another Plan of Care development fee of $90.00 for revisions?
Response: Yes, with an approved Prior Authorization.

Question: Who approves the plan of care?
Response: In Phase I, DDS will continue to approve.

Comment: Policy 602. B (in the Certification Standards for CES Waiver Services), which outlines requirements for Direct Care Staff, requires DSPs to have "One (1) year of relevant, supervised work experience with a public health, human services or other community service agency; OR Two (2) years' verifiable successful experience working with individuals with developmental disabilities."

Given the low rates of unemployment in many areas of the state and the workforce crisis in the field of direct services, coupled with low wage reimbursements, requiring applicants to have previous experience will be a significant hardship for providers who already experience notable challenges in maintaining an adequate workforce.
Response: The cited section has been changed to require that a DSP has either (1) a high school diploma or GED; (2) one year of relevant work experience with a public health, human services, or other community services agency; OR (3) two years of verifiable experience working with individuals with developmental disabilities. Therefore, experience is no longer a requirement.

Comment: 213.300 – The maximum of $90.00 per plan development is not enough money.
Response: Thank you for your comment.

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Comment: 220.000 – Define specialty providers. The entire paragraph is confusing regarding care coordination. The whole 14 month transition time is confusing. Will care coordinators be only employed by the PASSE?
Response: As clients are attributed to a PASSE (if they are DD clients receiving services through the 1915(c) Waiver) the client will only receive care coordination under the PASSE. It will take approximately 14 months to completely transition all DD and BH clients into the PASSE model.

Question: Will providers be allowed to subcontract with the PASSE with care coordinators?
Response: It will be the decision of each PASSE entity to determine the financial relationship with the care coordinators.

Question: 405 E – Why is lease supposed to be in the person centered file?
Response: The final rule for HCBS settings requires that individuals in residential settings have a lease, residency agreement, or other form of written agreement that documents protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. A copy of this document should be maintained in the individual's file for annual licensure review.

Question: Why is rent expected to be one set fee among all? Consumers receive different amounts; why should one that gets $750 a month have to have a rule that they will pay the same as the one that receives $1200 when they can't afford anything extra as it is now?
Response: DDS does not set rates for rent.

Question: 501 – Who issues the Interim Service Plan?
Response: DDS will continue to approve interim plans of care.

Comment: Seems like the PCSP Developer does a lot. Who employs the PCSP, how are they reimbursed with all the time and work for which they are completing? Looks like this person gets all the leg work completed and the care coordinator just comes by to collect the completed work or monitor the work. Providers will be doing as much as they are now and more with reimbursement reductions. How?
Response: We disagree and believe the role of the care coordinator under the PASSE model will work in coordination with the supportive living provider and PCSP developer.

Comment: This section of the CES Waiver Standards states that DDS Quality Assurance personnel will review provider compliance with the Certification Standards on an annual basis. Language was removed, which required this review to be part of an annual on-site visit. DRA requests that this language be added back into the standards, and that an on-site visit be required as an element of oversight of the providers in order to ensure the best care possible for waiver beneficiaries. State oversight, including on-site visits, is important to ensuring safety of beneficiaries.
Response: We have clarified the language.

Comment: This section deals with the requirements for a beneficiary's Person Centered Service Plan (PCSP). It states that "The beneficiary (or, if applicable, their legal guardian) must be an active participant in the PCSP planning and revision process." DRA would like this language revised to state "The beneficiary **(and,** if applicable, their legal guardian)." This will ensure that the beneficiary always is considered a participant, even if they have a guardian. The language as written suggests that a beneficiary with a guardian may not be an active participant. Even a beneficiary with a guardian should have the right and opportunity to be an active participant in this process, which the suggested amended language supports more clearly.

Comment: This section contains the language: "If the beneficiary or their legal guardian objects to the presence of any individual at the PCSP development meeting, then the individual is not permitted to attend." DRA recommends that language be included to address situations where the beneficiary and guardian's wishes are in conflict. For example, the following language could be included: "If the wishes of the beneficiary or guardian are in conflict as to persons attending the meeting, the preferences of the beneficiary will be given primary consideration and take precedence where there is no compelling health and safety reason."

Response: DDS asserts that items regarding guardians will depend on the specifics listed in the actual guardianship order. Because of this, no blanket response can be made.

Comment: This section states that Providers shall not refuse service to beneficiaries unless they cannot ensure the beneficiary's health, safety, or welfare. The stated intent of this policy is "to prevent and prohibit Providers from implementing a selective admission policy based on the perceived 'difficulty' of serving a beneficiary." Determining whether or not a Provider's refusal to serve is legitimate is left to the discretion of DDS. The section contains no mention of consequences for a Provider in the event that it is determined that they are refusing beneficiaries in violation of this policy. DRA requests that this section be amended to contain sanctions against Providers who violate this policy, and addressing what actions will be taken by DDS in the event that a Provider demonstrates a pattern of improperly refusing to serve beneficiaries.

Response: Currently, Waiver Providers cannot refuse to continue to serve unless they cannot maintain health and safety.

Comment: Section 706(C):

This section discusses the required contact by a care coordinator with a beneficiary while their waiver status is in abeyance. We are concerned about the issue of in-person contact with the beneficiary. When a beneficiary is in the community, the standards require that a care coordinator make monthly contact with the beneficiary, with at least one in-person visit per quarter. However, under the standards, during the period of abeyance when a beneficiary is placed in a licensed or certified facility for up to 90 days (with possible renewal), the care coordinator is required to only "have a minimum of one (1) visit or contact each month." This section does not require any in-person contact as currently written. The language of the abeyance section should be changed to clearly state that even though the beneficiary is institutionalized, the care coordinator is still required to make quarterly in-person visits.

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Response: This was the intent and the policy has been clarified to reflect your statement above.

Comment: The language is overly broad, does not honor the central premise of a provider-led, risk-bearing model under Act 775, and flies in the face of years of work between providers and DHS, first on health homes and now with the Provider-Led Arkansas Shared Savings Entity (PASSE) model (Act 775). It further fragments an already disjointed service system, and treats individuals with developmental disabilities differently than those receiving treatment for mental health or substance abuse. There is nothing in federal law that requires DHS to take the approach contained in the draft rules.

As currently drafted the PASSE Manual states: "*The care coordinator for attributed beneficiaries who are also CES Waiver participants cannot be affiliated with the direct service provider for that beneficiary.*" (241.000.C.) The draft CES Manual also states: "*Care coordination services may not include the provision of direct services to the beneficiary that are typically or otherwise covered as a service under CES Waiver of State Plan.*" (220.000). Finally, the draft CES Waiver Certification Standards state: "*No beneficiary being paid to provide direct services to a beneficiary may serve as the beneficiary's care coordinator.*" (701).

DHS has indicated verbally that these provisions apply only to Phase I care coordination and will not apply once the PASSE enters Phase II, full risk. However, the promulgated manuals do not make this distinction. If this were the case, there would be no reason to put the conflict-free language into the provider Certification Manual. Moreover, what would be the point of disrupting the entire developmental disability (DD) service system for some 15 months of Phase I, only to revert back to the current system? This is unfair to beneficiaries and confusing to everyone involved.

Additionally, the proposed provisions apply only to DD services. This alone creates a strange anomaly in which behavioral health clients can receive both direct services and care coordination through their chosen provider, but individuals with developmental disabilities cannot. The DD approach is contrary to the whole concept of integrated care.

Practical problems with the proposed rules.

For at least seven years, providers have been working with DHS toward a *provider-led* model of care coordination. At first, we worked toward this model under the authority for DD and BH "health homes." Then, through Act 775, this concept took hold, with our support, under the idea of provider-led organized care. The idea consistently expressed by DHS and its various consultants has been to capitalize on the valuable, long-standing relationships and frequent contact that direct service providers have with their clients as a pathway to successful care coordination by those same providers. All of this is lost if instead of encouraging this approach you actually prohibit it. Indeed, one could wonder what the point would be of a provider-led model.

Under the draft language being promulgated, the PASSEs could contract with DD case managers at Pathfinder, but those case managers would not be able to coordinate care for Pathfinder clients. Instead, they would have to coordinate care for clients at Easter Seals, Friendship, or UCP, etc., with whom they have no relationship. Conversely, case managers from Easter Seals, Friendship, or UCP would have to coordinate care for Pathfinder clients, and vice versa. The same scenario plays out all over the state.

It has been suggested that the PASSE could actually employ all case managers and they could remain housed with their current employers and serve existing clients. This would disrupt many longstanding employer-employee relationships, benefit packages, and other terms incident to employment. It would also be asking a lot of people who have consciously sought out work in the non-profit world to go to work for an insurance company with a different mission and culture.

In our discussions over the years with DHS, the state explained that it wanted to build health homes or PASSEs to capitalize on the success Arkansas has achieved with the patient-centered medical homes (PCMH). Imagine telling PCPs that in order to be a PCMH they would have to allow other physicians' offices to come in and coordinate their patients' care. The whole model would collapse before it started.

We cannot imagine that the state is serious about implementing the conflict-free case management rules as worded in this promulgation, to be effective in less than two months. That type of service disruption and chaos would take many months to address, not mere weeks. We strongly urge the state to modify this extreme version into a more workable, integrated approach discussed in this letter.

The conflict free case management rules do not apply to a 1915(b) PCCM waiver.

The conflict free case management rules apply only to case management offered through 1915(c) waiver, Community First Choice, and 1915(i) state plan services. (Refer to CMS Home and Community-Based Services Final Rule, 79 Fed. Reg. 2948-3039 (January 16, 2014), codified at 42 C.F.R. §§ 441.301, 441.555, and 441.730.) The proposed rules remove case management from the Community and Employment Supports (CES) DD 1915(c) waiver in favor of care coordination provided under a 1915(b) waiver. The CMS rule does not apply to 1915(b) waivers for managed care, including "primary care case management" (PCCM), which is the authority being used by Arkansas for Phase I care coordination.

For a number of years now, some states have placed requirements on managed care organizations to deliver case management services without conflict in their state MCO contracts for managed long term services and supports (LTSS). We are not opposed to this type of arrangement; however, it should not be the overly broad approach laid out in these proposed rules. We believe the approach we have designed for our PASSE more than meets the requirements of the law while remaining true to the provider-led nature of Act 775.

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Moreover, for purposes of resolving the problem the proposed Arkansas rules create, one need not agree that the conflict-free rule does not apply to 1915(b), whether PCCM or full risk. The state can resolve the issue by addressing the supposed "conflicts" in a more logical manner that preserves the integrated approach we have been working on all these years. (See "Solution" section below.)

Regardless of whether the conflict-free rules apply or not, the proposed language is not in compliance. One can review the federal regulations at some length and still not be clear exactly what CMS considers the "conflicts" to be when a direct service provider provides case management. "Case management" is a generic term that means many things to many different people. CMS was not consistent in the way it addressed the issue in 1915(c) vs. Community First Choice and 1915(i). Logically, if one parses out the various functions under CMS' historic definition of case management, conflicts arise in **resource allocation**, *i.e.*, **eligibility evaluations**, **needs assessments,** and **care planning**.

Under the proposed Arkansas rules, DHS has resolved the first two "conflicts": It has maintained control of eligibility, and it has contracted with Optum to conduct needs assessments. However, for reasons that are not clear to us, DHS has placed service plan development under Supported Living with the direct care provider, using a newly created title called "Person-Centered Service Plan Developer." If the conflict-free rules were to apply to care coordination under 1915(b), this would be a violation of the 1915(c) rule, which states: "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management *or develop the person-centered service plan*." (42 CFR 441.301(c)(vi)). **Response: We agree. The language is clarified to reflect that the PASSE will comply with conflict free case management, which involves several components: assessment of an eligible individual (42 CFR 440.169(d)(1)), development of a specific care plan (42 CFR 440.169(d)(2)), referral to services (42 CFR 440.169(d)(3)), and monitoring activities (42 CFR 440.169(d)(4)). We have stated that the PASSE entity will comply with the overall federal regulation.**

We have recommended in the past that the Independent Assessment tool, in this case MnCHOICES, be used to provide a basic plan to fulfill this function, and then the direct service provider would use this tool to provide a more detailed care plan with services, staff, and schedules within the budget approved by DHS. (This appears similar to the approach taken in Minnesota.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_172354. We still believe this is a good approach that will bring the state into compliance. Alternatively, the CMS final Managed Care Rule does not prohibit the MCO/PASSE from performing this function.

On a related note, the draft CES Manual prohibits care coordination by case direct care providers, and it also says that providers may do so as long as they implement certain firewalls, which is the process used today. It is not clear if this language was intended or not, but the firewalls are similar to what we propose under "Solutions."

The draft CES Manual fails to provide a clear distinction between the direct care and care provider and the care coordinator, creating overlapping and confusing responsibilities.

The draft CES Manual reflects the difficulty in trying to separate functions that should not be separated. One glaring example is that it states that the direct care provider is to provide a "PCSP Developer" to develop and implement the person-centered service plan (PCSP), but the Care Coordination section says the person-centered service plan is the responsibility of the care coordinator.

Other examples:

Under 213.000 Supported Living (which is delivered by the direct service provider), the draft Manual charges the direct care provider with the following responsibilities:

C.2 "Serving as liaison between the beneficiary, parents, legal representatives, care coordinator entity and DDS officials." – Isn't this care coordination?
Response: We respectfully disagree.

C.3. "Coordinating schedules for both waiver and generic service categories." – Yet Care Coordination Services Section 220.000 says the care coordinator is responsible for "coordinating and arranging all CES waiver services and other state plan services." It also says the care coordinator is responsible for "generic needs."

C.9. "determine whether the person is receiving appropriate support in the management of medication." – Yet, the Care Coordination section lists "Medication management plan" as a care coordinator responsibility. (It also says the care coordinator is responsible for coordination of medication management. Does this have some meaning different than the direct care providers' "support in the management of medication"?)
Response: The role of the care coordinator will be to work closely with all service providers, including the supportive living provider if applicable to ensure appropriate services and supports are being provided to the beneficiary.

C.9.f. Both the direct care provider and the care coordinator are monitoring the medication management plan.

C.9.g. Both the direct care provider and the care coordinator "are responsible to assure appropriate positive behavior programming is present and in use with programming reviews at least monthly."

C.9.i. Toxicology screenings are the responsibility of the direct care provider "with care coordinator oversight."

C.9.j. Medication administration is monitored by both the direct care supervisor and the care coordinator at least monthly.

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The bottom line is that this type of separation of functions is at odds with the whole concept of integrated care. Healthcare is fragmented enough without deliberately creating more fragmentation. What will happen when a direct care provider doesn't "cooperate" or provide information in a timely manner – will the care coordinator still be able to get paid? What will happen when a client experiences an adverse event and the direct care provider wants to immediately respond but can't do anything until the care coordinator signs off? As written, no one understands who is in charge of what. It could result in people working at cross-purposes and finger-pointing when something does not get done or something goes wrong.

This is exactly what happened when Arkansas tried the "conflict-free" approach in 1989 with the initiation of its 1915(c) waiver program for individuals with DD services. The majority of provider organizations chose to be direct care providers, leaving too few case managers in many parts of the state. Some case managers had little or no knowledge of the operational realities of direct care, which led to the creation of unrealistic expectations for clients. Conversely, some direct care providers did not understand the duties of case managers. Also, the state found that some case management functions fit within a third-party approach; but others, particularly day-to-day care coordination, needed the presence of on-site staff. The end result was significant confusion regarding which entity should perform a wide variety of functions and a great deal of frustration for clients. Consequently, Arkansas abandoned this approach around 1995. Consumers are now offered a choice. Tellingly, the vast majority choose the same provider for direct care and case management.

Solution – Assuring Conflict-Free Case Management, Supporting Existing Relationships

We have been working diligently to define roles and relationships to make sure the members of our PASSE receive complete, conflict-free case management and service coordination. Amerigroup will contract with the PASSE to provide care coordination. Amerigroup, in turn, will contract with direct care providers for collaborative activities to enhance overall care management; but Amerigroup and the PASSE, not the direct care provider, will remain ultimately responsible for service coordination.

Amerigroup's Service Coordinators will verify compliance with conflict-free case management standards by providing service coordination with no direct service responsibilities. Amerigroup will contract with local DD and BH direct service providers for the type of case management activities that have been traditionally offered through the DD waiver. We believe the direct care provider is in the best position to develop a detailed care plan, and that Amerigroup's Service Coordinators should retain full accountability for development and implementation of all person-centered service plans and other service coordination functions.

Direct care providers have valuable, longstanding, in-person relationships with PASSE participants. These relationships are key to identifying individual goals, preferences, service barriers, and creating person-centered strategies that support members in leading meaningful lives. Our approach reduces redundant touch points and simplifies processes for PASSE members, while appropriately placing the responsibility for integration and coordination with the Amerigroup Service Coordinator, which fosters conflict-free case management.

We urge the Department to remove the current language in the proposed rules and modify it to require each PASSE to implement conflict-free provisions that address resource allocation, but allow direct care providers to coordinate day-to-day care of their clients. **Response: We agree. The language is clarified to reflect that the PASSE will comply with conflict free case management, which involves several components: assessment of an eligible individual (42 CFR 440.169(d)(1)), development of a specific care plan (42 CFR 440.169(d)(2)), referral to services (42 CFR 440.169(d)(3)), and monitoring activities (42 CFR 440.169(d)(4)). We have stated that the PASSE entity will comply with the overall federal regulation.**

The agency states that the waiver will require CMS approval; as of August 23, 2017, that approval is pending. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: The agency estimates a savings of $2,297,899 for the current fiscal year ($669,378 in general revenue and $1,628,521 in federal funds) and $479,830 in the next fiscal year ($139,774 in general revenue and $340,056 in federal funds).

Because the PASSE will begin performing care coordination services for all waiver participants once they are attributed, the Department expects to see a savings on each participant once they become attributed. This savings will be a total of $217 per month per attributed participant. The $217 is derived from stopping care coordination under the waiver ($117/month) and from taking the care coordination fee out of the supportive living payment ($100/month). There will be a new fee of $90 per year for the development of the PCSP by the supportive living provider. All care coordination services will be provided by the PASSE once a participant becomes attributed.

LEGAL AUTHORIZATION: The proposed rule changes incorporate revisions brought about by **Act 775 of 2017**, which created the Medicaid Provider-Led Organized Care Act, to be codified at Arkansas Code Annotated §§ 20-77-2701 through 20-77-2708. Pursuant to Ark. Code Ann. § 20-77-2708, as amended by Act 775, § 1, the Department of Human Services shall submit an application for any federal waivers, federal authority, or state plan amendments necessary to implement the Medicaid Provider-Led Organized Care Act, and it may promulgate rules as necessary to implement the Act. The Department is further required to 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, and it shall 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(1), (12).

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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

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NAME OF PRESENTER AT COMMITTEE MEETING Melissa Stone

PRESENTER E-MAIL Melissa.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

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1. What is the short title of this rule? Amendment to the Community and Employment Support (CES) 1915(c) Waiver; the CES Provider Manual; and the CES Certification Standards

2. What is the subject of the proposed rule? These Amendments are being made to require all CES Waiver participants to join a PASSE. These amendments also change the existing case management service to care coordination, as defined in the PASSE program. Care coordination is a broader service that will be provided to Waiver beneficiaries who have not been attributed to a PASSE. Once the beneficiary is attributed to a PASSE, the PASSE will begin providing care coordination under the 1915(b) Waiver.

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. Act 775 of 2017, Ark. Code Ann. § 20-77-2701 et seq.; and Ark. Code Ann. § 20-76-201 et seq.

7. What is the purpose of this proposed rule? Why is it necessary? The existing 1915(c) Waiver and the accompanying Manual and Certification Standards must be changed to incorporate the 1915(c) waiver population into the mandatory population being attributed to a PASSE pursuant to Act 775 of 2017.

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). http://humanservices.arkansas.gov/ddds/Pages/default.aspx

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

   Date: August 8, 2017

   Time: 4:30 p.m.

   Place: Arkansas Enterprises for the Developmentally Disabled
   105 East Roosevelt Road
   Little Rock, AR 72206

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
   August 11, 2017

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
   October 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. 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. Recipients of CES Waiver services, their parents/guardians, Community Programs, Service Providers, Care Coordinators, and other interested parties.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Arkansas 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 Amendment to the Community and Employment Support (CES) 1915(c) Waiver; the CES Provider Manual; and the CES Certification Standards

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	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0

Total	0	Total	0

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	($669,378)	General Revenue	($139,774)
Federal Funds	($1,628,521)	Federal Funds	($340,056)
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	($2,297,899)	Total	($479,830)

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**
$ 0	$ 0

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	**Next Fiscal Year**
$ (2,297,899)	$ (479,830)

Because the PASSE will begin performing care coordination services for all Waiver participants once they are attributed, we expect to see a savings on each participant once they become attributed. This savings will be a total of $217.00 per month, per attributed participant. The $217.00 is derived from stopping care coordination under the waiver ($117.00/month) and from taking the care coordination fee out of the supportive living payment ($100.00/month). There will be a new fee of $90.00 per year for the development of the PCSP by the supportive living provider. All care coordination services will be provided by the PASSE once a participant becomes attributed.

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.