DHS Responses to Public Comments Regarding CES Waiver Slot Increase

Shelley Kirk

Comment: My 18-year-old daughter has Rett Syndrome. This disease has left her 100% dependent upon others. The neurological disorder causes regression: she has lost the ability to walk, talk and feed herself (non-functional hand use) and incontinent. Every she does must be done with 100% assistance. As a single mom (with no family in the state of Arkansas), financially supporting her has become quite difficult due to Covid and staffing shortages. My daughter is approved for pervasive care (24 hours/7 days), but current staff consists of a weekend shift (12 hours Saturday and Sunday) and someone from 6pm-10pm Monday - Friday. This does not allow me much time to work. She was denied SNAP benefits because she is under 21 and it was based on my income. Although she receives some SSI, it almost half of the full benefits available. I am trying every avenue to be able to afford to keep my daughter in her home. This proposed change would make a tremendous difference in her life. Thank you for giving me the opportunity to address this issue.

Response: Thank you for sending in a public comment.

Dr. Josh Wilson, CEO, ICM

Comment: We urge DHS to continue allowing a General Education Diploma (GED) in lieu of a High School Diploma as a prerequisite for providing all services contained in Appendix C: Participant Services.

Response: It will be allowed in lieu of a HS diploma. The omission in the draft was in error. This was corrected in the amendment in the service definition, as appropriate.

Comment: What are the guidelines for creating and monitoring a Behavioral Prevention and Intervention Plan?

Response: The PASSE is responsible for developing a Risk Mitigation Plan for each client that outlines risk factors and action steps that must be taken to mitigate the risk. CES Waiver clients who are at risk of displaying behaviors that can lead to harm to self or community members must have a Behavioral Prevention and Intervention Plan that is overseen and implemented by the client's supportive living provider. The goal is to keep the member in his or her place of residence and avoid an acute placement. Supportive Living Staff developing, overseeing, and implementing Behavioral Prevention and Intervention Plans must receive training in verbal de-escalation, trauma informed care, and verbal intervention training.

Comment: Will supportive living providers be paid to create and monitor a Behavioral Prevention and Intervention Plan?

Response: Yes, this is billable under Consultation.

Comment: The current employment clearance registry website is addressed to long-term care facilities. How will the registry change to accommodate CES Waiver providers?

Response: This registry is only for long term care facilities and any mention will be removed from the Amendment. This was removed from the amendment as this registry is limited for use by LTC facilities.

Comment: How quickly will results from the employment clearance registry website produce results. The current waiting period of 48-72 hours for long-term care facilities slows the hiring process.

Response: This registry is only for long term care facilities and any mention will be removed from the Amendment. This was removed from the amendment as this registry is limited for LTC facilities.

Comment: When will the employment clearance registry website be operational?

Response: This registry is only for long term care facilities and any mention will be removed from the Amendment. This was removed from the amendment as this registry is limited to use by LTC facilities.

Comment: What are the requirements to become a "Qualified Developmental Disabled Professional" as listed on the consultation service definition?

Response: Qualified Developmental Disabilities Professional (QDDP means an individual possessing at least one (1) year of documented experience working directly with individuals who have related conditions, and is one of the following: a doctor of medicine or osteopathy, a registered nurse, or an individual holding at least a bachelor's degree in a human service field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology. No change was made to the amendment.

Comment: What are the requirements to become a "Positive Behavior Support Specialist" as listed on the consultation service definition?

Response: Minimum qualifications: Bachelor's degree preferred in job related area. Job related experience within specialized field is not required but is greatly preferred. Current CPR/First Aid, Background Registry are required.

Positive Behavior Support Specialist is responsible for providing training, support, and coordination of activities necessary for implementation of Positive Behavior Support inclusive of developing procedures and training materials for staff involved with individuals with challenging behaviors, assist in developing interventions, functional behavior assessments and behavior plans, provide data analysis, and understand applicable regulations governing use of behavioral supports. No change was made to the amendment.

Comment: Please define "CES Waiver services treatment plan" as listed on the consultation service definition.

Response: We recognize that each provider of service develops a treatment plan that outlines duration and scope for the service they are being paid to provide that are individualized in nature and developed to address identified needs. For example, if a member selects a particular Supportive Living provider, we expect that SL provider to have a treatment plan for that service they are providing. We also wanted to make it clear that developing a treatment plan is a billable service under consultation. No change was made to the amendment.

Tom Masseau, Executive Director,

Disability Rights Arkansas, Inc.

Comment: Disability Rights Arkansas, Inc. (DRA) is the federally authorized and funded nonprofit organization serving as the Protection & Advocacy System for individuals with disabilities in Arkansas. DRA is authorized to advocate for and protect human, civil, and legal rights of all Arkansans with disabilities consistent with federal and state law. I am writing on behalf of DRA to submit this letter with our comments to the State's proposed amendments to its 1915(c) Home and Community-Based Services Waiver. Some of the amendments, we appreciate, particularly the clarification of supervision and monitoring as a necessary and reasonable service that will permit individuals to live in community settings. However, we are very concerned about the expansion of group home settings from four bed to eight beds. Given that it is purportedly in response to pandemic-related needs, we question whether such a permanent solution is necessary or positive for individuals otherwise eligible to live in community settings.

We regret the lack of strict parameters to ensure such a move is justified and extremely limited and believe this could impair individuals from exercising a meaningful choice to live in community settings in its current form. The comments are organized into three parts. The first part concerns overall clarity of the amendments and possible formatting errors that could create confusion. The second part goes through the delineated modifications that are identified on page 1 of the amended application. The final part addresses areas not identified on page 1 but are modified by the proposed amendment. For ease of reference, when page numbers are identified in this document, it refers to the pagination of the waiver amendment document that shows tracked changes.

Comments overall regarding formatting and clarity:

The modifications to the waiver application in some places are formatted in a way that is unnecessarily confusing. One example is the Level of Care Criteria. Delineating the level of care criteria as it appears on page 38-39 of the amendment that each of numbers 1-12 apply to every individual in every case; however, that is inconsistent with how DDS regulation 1035, the federal regulations, or the state law define eligibility. Some of the elements apply only to individuals who have not been diagnosed with one of the categorically qualifying diagnoses but have been diagnosed with a condition that causes similar impairments to intellectual or adaptive functioning as an intellectual disability. As a result, it overcomplicates eligibility and level of care determinations in a way that governing laws and regulations do not permit. At various places throughout the application, the boxes do not display all of the text. This complicates the opportunity to review and comment on what text is being modified. An example of this is on page 53, Appendix B-7.a. In other locations, boxes have apparently been modified to display text that would otherwise disappear, such as on page 55, Appendix C, "Service Definition" for "Caregiver Respite." In the current state of the proposed amendment, we are unable to ascertain what else has been excised from sections, if anything. Public comment would be best served by permitting individuals to see the entire scope of proposed changes to the waiver application before modifications. Finally, perhaps simply an editing error, numbering throughout the application is inconsistent and confusing. An example of this is page 60, Appendix C, "Other Standard" for "Supported Employment." The proposed language as written reads:

> *"Must be: Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Support Needs.*
>
> *4) Permitted by the PASSE to perform these services.*
>
> *5) Cannot be on the National or State Excluded Provider List. Individuals who perform respite services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry check, and*
>
> *3) Have a high school diploma,*
>
> *4) Have at least one year of experience working with persons with developmental disabilities or behavioral health diagnoses; or complete a session on incident reporting, abuse and neglect identification and reporting, overall training on IDD diagnosis, as well as client specific training on diagnosis and behavioral support needs.*
>
> *3) Be certified to perform CPR and first aid"*

Clarity and transparency of modifications is extremely important to allow for adequate constructive notice. Further, clarity in the final application is not without regulatory effect. It is extremely important that individuals be afforded some measure of predictability in areas such as eligibility for both the waiver program and the individual services it authorizes. Please modify the application to ensure clarity and consistency where possible and extend the opportunity for public comment when those changes are made.

Response: Thank you for your comments.

Comment: Modifications identified by State's page 1:

The application indicates it is adding new services of both "HCBS Supervision and Monitoring" as well as "HCBS Enabling Technology"

HCBS Supervision and Monitoring:

We are grateful for clarification of the vital role that supportive living services can provide through supervision and monitoring. We have seen individuals experience a reduction in authorized supportive living due to a misunderstanding of whether supportive living may provide overnight assistance while a beneficiary is asleep. As a result, individuals were potentially exposed to dangerous circumstances. That said, we would appreciate clarification regarding this service. On page 88, the service is defined as permitting delivery within. a beneficiary's “own home," which is a home that is not licensed or operated by another entity. This is extremely unclear. How can a home not be operated by another entity? An entity other than what? Does this definition exclude delivery of this service to an individual who lives in an apartment owned by an HCBS provider?

Response: We agree that this is unclear, and it was our intention to exclude congregate settings larger than eight (8) only. We will clarify. This request was removed from the amendment per CMS guidance, to allow the state to further define the service with appropriate stakeholder involvement.

Comment: In the same box, the definition permits assistance with “evening and nightly routines." This service originally was proposed to offer overnight assistance; however, “overnight" is deleted in the final proposal. Is there a reason monitoring and supervision cannot assist with daily or morning routines if the service is not restricted to overnight?

Response: We agree that the service could be needed at any point during the day, not just overnight, and will make this change. This request was removed from the amendment per CMS guidance, to allow the state to further define the service with appropriate stakeholder involvement.

Comment: The definition also allows support to be provided either one-to-one or in a group. Is there any limit on how large the group should be? We are concerned that the effectiveness of the service could be drastically reduced if left with this ambiguous description. When reading this in conjunction with the following sentence authorizing the use of technology with this service, it would seem to permit a single support staff to provide this service to an entire apartment complex at one time through remote monitoring. Some limitation on how many individuals may be served would provide more clarity and predictability in the authorization of this service. There is also no distance requirement for the provision of technology supporting monitoring and supervision. Would this permit an individual to monitor a service recipient from a remote location or even from another state? We believe this would greatly reduce the positive impact of this service and create potentially unsafe conditions for individuals.

Response: We agree. See responses above on this topic. This request was removed from the amendment per CMS guidance, to allow the state to further define the service with appropriate stakeholder involvement.

Comment: Finally, the definition requires an "Assessment for Remote Support Services." The assessment is not defined or otherwise described in this document. Is this a standardized assessment to be uniformly used by the PASSEs when evaluating this service? Who administers this assessment? Why is there no other mention of it in the entire waiver application?

Response: Our intention is further defined as Enabling Technology and developing a tool for assessment to ensure the client, family, and staff are properly trained. We will be pulling together a workgroup. This request was removed from the amendment per CMS guidance, to allow the state to further define the service with appropriate stakeholder involvement.

Comment: HCBS Enabling Technology: This service has both good and bad potential. On one hand, it would be a valuable way to provide an individual with more opportunities for independence. We are aware of individuals who do not want staff in their home every hour of every day. If able to safely do so, this would permit some individuals with privacy they might not have previously experienced. However, the service would be improved with clarity regarding preference. There are two different sets of requirements that are similar. Does enabling technology differ from monitoring technology? Is monitoring technology a form of enabling technology? We appreciate the apparent opportunity for the member to veto the use of enabling technology; however, its importance is minimized by placing the member's preference in parentheses within another requirement. Is a guardian permitted to authorize the use of this technology over a member's objection? What if the individual is not able to express a preference?

Response: It is not our intention to force the use of technology on any client or member. It will need to be a requested service by the client, or their guardian or parent, if there is one legally. The assessment will need to show that the use of technology will further assist the goals and objectives in the Person Centered Service Plan that the client and guardian or parent can operate the technology and that they are all trained on the technology. This request was removed from the amendment per CMS guidance, to allow the state to further define the service with appropriate stakeholder involvement.

Comment: Meanwhile, if it is a different service, monitoring technology must be the least restrictive option and "the person's" preferred method to meet an assessed need. Logically, "person" should refer to the "member" or "someone who receives HCBS waiver services" or any other way a waiver participant is described in the application. Does this permit an individual's guardian to reject the use of enabling technology if it is not their preference? Would they be permitted to do so over the member's objection? Why does this section refer to "person" instead of something more descriptive?

Response: Similar to any other Medicaid service, if a client has a guardian, or legally responsible parent in the case of a child client, we will abide by the guardianship order or the parent’s wishes. This request was removed from the amendment per CMS guidance, to allow the state to further define the service with appropriate stakeholder involvement.

Comment: The service also requires providers to treat the data collected by technology consistent with HIPAA but does not otherwise restrict how much of this data may be collected by the PASSEs or providers. Further, what happens to data gathered, if any, by such monitoring?

Response: The provider providing any service has full access to any data. This is true of the member's assigned PASSE. This request was removed from the amendment per CMS guidance, to allow the state to further define the service with appropriate stakeholder involvement.

Comment: Finally, the addition of this service fails to address the recent study commissioned by the state which showed the state has about 110,000 underserved households when it comes to broadband, which translates to huge swaths of the rural areas of the state. While the governor has suggested addressing this in a special session in the next couple of months it will still take time for that infrastructure to be put in place, which will delay implementation of a lot of the enabling technology initiatives.

Response: Thank you for your comment. DDS is aware of broadband deserts across the State. This request was removed from the amendment per CMS guidance, to allow the state to further define the service with appropriate stakeholder involvement.

Comment: Removed restrictive language on who can receive Respite and where.

We are not sure why the state removed restrictions on where respite services may be provided. Is there a particular place that was not previously authorized that is targeted by this modification? If so, could that have been achieved by adding those places to the list without removing all restrictions on locations?

Response: Respite is a service available to PASSE members if identified on the member's PCSP and approved. We are trying to remove restrictive language in several services with this Amendment and allow further flexibility to meet individual client needs. No additional changes were made based on this comment.

Comment: "Respite services are not to supplant the responsibility of the parent or guardian," is a sentence that should be modified. Natural supports must be voluntary pursuant to 42

C.F.R. § 441.540(b)(5). The suggestion that parents or guardians bear responsibility for support when staff are not available is equivalent to authorizing natural support under duress - that is not voluntary

Response: We will relook at this sentence and assess the need to amend. Thanks. No additional changes were made based on this comment.

Comment: Permanently adding training requirements for direct support professionals in lieu of one year experience

The alternative to one year of experience proposed by the state is unclear. Under the alternative, one must "complete a session on incident reporting, abuse and neglect identification and reporting, overall training on IDD diagnosis, as well as client specific training on diagnosis and behavioral support needs." What is a "session?" Who will provide this session? Is it an online module the state offers, or an in-person class taught by a service provider? Are there qualifications for who may conduct this session?

Response: This is currently in place in an Appendix K, that was filed with CMS in December of 2021, to attempt to utilize a larger pool of potential staff during a record high staffing shortage. The provider of supportive living develops and trains the staff member. No additional changes were made based on this comment.

Comment: Increased the Group Home bed capacity from 4 to 8 to address trends in institutionalization we are seeing due to pandemic and workforce shortage.

We have great concerns about the state's reliance on institutional settings to meet individuals' needs. The state should be moving toward smaller settings, and this reflects a commitment in the opposite direction. Further, compliance with the settings rule might not be possible with some four-bed group homes, making it even less likely when increased to eight beds. The modification appears to permit current four-bed facilities to simply add beds without increasing space. We are concerned that this will happen against individuals' wishes and without faithful observation of individual preferences unless the state firmly and clearly requires it.

As it stands, the workforce needed to remedy the dearth of supportive living services in the state are able to work in lower demand, higher wage positions. Until the state expresses a commitment to remedying the problem causing the void that currently exists, it is of no consequence that the waiting list is eliminated. The state must commit to ensuring waiver support staff positions are attractive. Increasing the size of group homes should not be the solution. Further, permitting this permanent shift in response to the pandemic should be supplied with appropriate guardrails or a sunset if it is sincerely intended to be temporary.

The state must consider applying limits to when or why providers would expand from four beds to eight. It should require some evidence of knowing consent by the individual to live in that environment, how their individual needs will be met, and some way to ensure more individual choice or autonomy if forced into that setting. In addition, some individuals will naturally do far worse with more roommates, so additional protections should be considered to prevent larger settings from increasing the risk of institutionalization. More effort should be focused on protecting smaller settings where needed to ensure availability of such settings.

Finally, why isn't the state similarly devoting resources to increase the physical availability of more independent individualized settings at the same time? Expanding group home sizes does nothing to address staff shortages, without which the likely scenario is that people will be funneled into the group homes or other institutions.

Further, eliminating the waiting list, while a worthy endeavor, will be meaningless if individuals are not provided the services, they need to live to live in community settings. The PASSEs have returned millions of dollars to the state that they have not spent on individual services. The state should consider how it is using the returned funds and whether it would better serve the community of waiver recipients to invest it into improving and increasing the workforce supplying these services.

With the state budget surplus expected to reach 1.47 billion dollars by the end of this fiscal year on June 30, now would be a great time to commit to things like funds to address the staffing shortage and broadband infrastructure to make use of enabling and other technology.

Response: We respectfully disagree. From our viewpoint, we are seeing high levels of IDD clients with significant behavioral health needs that no provider will serve. These clients are being arrested, dropped off at Emergency Rooms across the State, or both. When this occurs, the only placement that will assist are State operated facilities: the Arkansas State Hospital, which is our single state operated psychiatric facility, and our five Human Development Centers (state operated Intermediate Care Facilities). We believe our clients should have a true choice between living in an institution and remaining in a HCBS setting. Our option for providing this choice is limited at this time. We believe that their behavioral support needs can be met in a more structured, more staffed, waiver group home setting.

In addition to requesting the ability to place clients in group homes with a larger capacity limit, we continue to work on other HCBS under the PASSE model that will keep clients in the community if they so choose. Those services include but are not limited to, community reintegration for children, therapeutic communities for adults, intensive family services, expansion of acute crisis units, co-locating behavioral health therapist in pediatrician offices, developmental and mental health screening, and in home crisis supports.

The Supportive Living service definition was changed to allow an increase to no more than eight (8) unrelated individuals to receive the SL service in group setting.

Comment: Streamlined "crisis plans, safety plans, behavioral support plans", in order to use consistent language across the PASSE program/Using the terminology Behavioral Prevention and Intervention Plans and clarifying that they are the responsibility of the Supportive living providers

On page 77 the proposed modification adds:

"The PASSE is responsible for developing a Risk Mitigation Plan for each client that outlines risk factors and action steps that must be taken to mitigate the risk. CBS Waiver clients who are at risk of displaying behaviors that can lead to harm to self, and/or community members must have a Behavioral Prevention and Intervention Plan that is overseen and implemented by the client's supportive living provider. The goal is to keep the member in his or her place of residence and avoid an acute placement.

Supportive Living Staff developing, overseeing, and implementing Behavioral Prevention and Intervention Plans must receive training in verbal de-escalation, trauma informed care, verbal intervention training,"

It also says: "Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment and plan modification; allowable providers: psychologist, psychological examiner, Positive Behavior Support (PBS) specialist, and Board Certified Behavior Analyst (BCBA) within the scope of their practice area."

Now, on page 117, it says, "Supportive Living providers must develop and implement Behavioral Prevention and Intervention Plans to address behavioral risks identified in the client's Risk Mitigation Plan performed by the PASSE. The specific details of the Behavioral Prevention and Intervention Plan are outlined in the service description under the service Prevention, Intervention and Stabilization."

It would seem that these are two very different things. Are they exclusive of each other? Why are the supportive living providers not utilizing the professionals identified in the earlier section for developing behavior interventions?

Response: PASSEs will begin developing Risk Mitigation Plans for all of their members that will identify all risks. This could be risk of falling, risk of choking, risk of elopement, or other risk. If a low-level behavior risk is identified on the Risk Mitigation Plan that triggers the requirement for that member to have a Behavioral Prevention and Intervention Plan. We believe the Supportive Living provider, when trained in verbal de-escalation, trauma informed care, and verbal intervention training, can develop and implement this type of plan. In fact, the DSP performing supportive living should be the most trained and knowledgeable staff member to understand and implement this plan. Previously, there was no training requirement and no clear understanding on who developed it nor implemented it.

Any high-level behavioral risk will require a Positive Behavioral Support Plan. We believe a member with high behavioral support needs will benefit from clinical oversight. We are also adding more clinical staff who can develop, implement, and monitor based on additional feedback during public comment. We will add licensed clinical social worker and licensed professional counselor to the list.

Comment: Areas not identified on page 1:

We are concerned that modifications to the level of care criteria and significant reductions to provider obligations regarding the use of restraint and other interventions were not expressly identified as amendments to the waiver.

Level of Care Criteria

It is possible that the formatting of page 38-39, Appendix B-6.d. leads to a misunderstanding of this amendment; however, it its current form, it evidently modifies the level of care criteria from what it has consistently been in state and federal laws and regulations.

First, the amendment adds the requirement that an individual "would be institutionalized in an ICF/IID in the near future, but for the provision of CBS Waiver services." This is not apparent in any of the cited policies, regulations, or laws from which it purports to derive. This is an extremely ambiguous and subjective phrase that could be used to exclude individuals simply because they or their families are committed to living in a community setting. It is unnecessary, extraneous, and should be removed

Response: We respectfully disagree. The criteria for admission in an ICF and the criteria to be on the CES Waiver are the same medical eligibility criteria. No additional change was made based on this comment.

Comment: Second, as discussed previously in these comments, DDS regulation 1035, the federal regulations, and state law define eligibility differently. As currently written, eligibility would require every individual to consistently exhibit scores of intelligence two or more standard deviations below the mean.

If this is the intent, it does not rely upon criteria and standards for ICF/IID facilities admission. According to federal regulations applying to ICF/IID facilities, a developmental disability includes a related condition defined as "[a]ny other condition, other than mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of [individuals with intellectual disabilities], and requires treatment or services similar to those required for these persons." 42 C.F.R. § 435.1010 (emphasis added).

Arkansas Code Annotated, § 20-48-101, which is cited in the Request, is consistent with these federal regulations. This statutory section includes a definition of developmental disabilities that includes not only the five categorically eligible diagnoses but also includes an “other" category for a condition that is closely related to an intellectual disability that results in" an impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability or requires treatment and services similar to that required for a person with an intellectual and developmental disability." (emphasis added).

Like Federal law, Arkansas state law does not require that an individual have both a categorically qualifying diagnoses and significant adaptive behavior deficits. DDS Policy also does not define eligibility criteria as narrowly as what is described and proposed in this amendment. DDS Policy 1035 provides that an individual with an impairment in intellectual functioning or adaptive behavior can be eligible.

What appears to be missing from this section is the clarification that exists in DDS Policy 1035, which states:

"In the case of individuals being evaluated for service, eligibility determination shall be based upon establishment of intelligence scores which fall two or more standard deviations below the mean of a standardized test of intelligence OR, is attributable to any other condition found to be closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability, or requires treatment and services similar to those required for such persons."

We would appreciate consistency in this description, as it could greatly impact access to services for children with traumatic brain injuries or other conditions that might result in significant deficits in adaptive behavior, but who might have borderline intelligence scores. The state should modify this section to reflect DDS Policy 1035, Arkansas Code Annotated, § 20-48-101, and 42 C.F.R. § 435.1010.

Response: It is not our intent to alter our current eligibility criteria in any way. No additional change was made based on the comment.

Comment: Use of restrictive interventions and restraint

We are particularly concerned about the quiet removal of the following language from pages 145 and 148:

"DDS requires that, before a provider may use any restrictive intervention, they must have developed alternative strategies to avoid the use of those interventions by developing a behavior management plan which incorporates the use of positive behavior support strategies as an integral part of the plan. The plan must:

1. Be designed so that the rights of the individual are protected,
2. Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or puts the individual at medical risk,
3. Identify the behavior to be decreased,
4. Identify the behavior to be increased,
5. Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior,
6. Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person,
7. Identify the event that likely occurs right before a behavior of concern,
8. Identify what staff should do if the event occurs,
9. Identify what staff should do if the behavior to be increased or decreased occurs, and
10. Involve the fewest interventions or strategies possible."

As on page 148; on page 145, "restrictive intervention" is replaced by "physical restraint." The removal of this is not clearly identified on page 1, unless it is an intended part of streamlining 'crisis plans, safety plans, behavioral support plans' or clarifying that behavior plans are the responsibility of supportive living providers. While we understand the need to clarify or assign responsibility for such plans, we do not understand why the state would eliminate the specific elements that must exist in such plans. Further, the elimination of specific plan requirements does not require the state to eliminate the obligation to develop a plan before using restrictive interventions or physical restraint. We would greatly appreciate the state maintaining these or similar requirements of providers.

Response: Thank you for your comment. We have reinserted one through ten (1-10) above back under Positive Behavioral Support Plans. This change was made, and language as indicated above was put back in place with the amendment.

Comment: Conclusion

Strengthening and improving access to HCBS services must be a priority in Arkansas to ensure that the State is not only serving but adequately serving individuals with developmental disabilities who desire to live in the community as opposed to institutions.

Response: Thank you for working with us on this Amendment and all other projects. We appreciate you.

Larry Stang, DDPA Executive Director

Comment: Since Crisis Intervention is a service available under the PASSE program to all members, it is important that CSSP is included in the list of providers eligible to provide this service.

Clarification of "certification" and "credentialing" is needed.

Response: CSSP is an optional provider on all CES Wavier services. We will doublecheck that they are included accordingly. Certification falls under the purview of the State (DHS); credentialing is a term of art under managed care regulations that is very similar to Medicaid provider enrollment. No additional change was made based on this comment.

Comment: DDPA is excited the administration has addressed the waiting list by increasing CES Waiver slots by 3,204 over the next three (3) years. We support the efforts of the Governor and want this effort to be successful. However, without competitive entry level wages, it is unlikely that service provider agencies will be able to attract the number of direct support professionals and supervisors to deliver services and support to this expanding population of recipients.

DD providers are often asked to provide care coordination functions without reimbursement. Allowing DD providers to get paid for certain allowable care coordination functions should be an option.

We are glad to see that the one-year experience requirement has been removed in lieu of training. Hopefully this will be an initial step in creating a career ladder for direct support professionals by creating mentoring opportunities for excellent DSP's.

Priority status for recipients residing in supported living arrangement group homes and apartments should not be removed. Removal of priority status will result in empty group home beds and apartments throughout the state. This is not a good use of scarce housing resources for the people we serve.

The adding of HCBS Monitoring and Supervision tries to address those individuals, that due to limitations, have staff that are available "in case" something happens and they are needed. It appears there would be a lower rate for this service, as compared to Supportive Living. However, it would be a billing nightmare if, when the DSP is needed to perform a "Supportive Living" function, they would then shift from "Monitoring" rate to "Supportive Living" rate.

DDPA wants to thank DDS staff for their continued hard work on behalf of individuals with developmental disabilities and their families. We value the positive working relationship we have with DDS and appreciate the willingness of everyone at DDS to help resolve issues and specific challenges faced by DDPA members.

Response: While we completely understand your comment around care coordination functions, we hope that by adding additional flexibility to Consultation and allowing treatment plans to be billed will

alleviate some of your financial burden. We are asking to raise group homes from four (4) to eight (8) because we need more immediate HCBS placements. We do not believe group homes will be empty. Clients should always have a choice in where they live and should choose whether they want to live in a group home or alone.

As for Supervision and Monitoring, the service is intended to be used, just like all other PASSE services if on the member's PCSP and approved. Clients should be receiving multiple different services based upon their functional need throughout the day. This should be no different.

We appreciate working with DDPA to resolve issues as well. We appreciate our cooperative relationship. The Change was addressed in the Supportive Living definition in the amendment.

<u>David Ivers, J.D., VP for External Affairs & General Counsel</u>

<u>Easterseals Arkansas</u>

Comment: We are concerned that the changes do not go far enough to resolve the very real crisis in the home and community-based service system. There are a number of elements in IDD system design that are broken, but the shortage of Direct Support Professionals (DSPs) who provide the direct care continues to plague the whole process. We believe the best way to deal with the workforce shortage is to increase reimbursement rates to providers to a level that enables them to pay DSPs a competitive wage. Nothing short of that will fix the problem. Also, we desperately need funding for training and ongoing workforce development with a career ladder for DSPs. Until these things are done, we will not be able to adequately serve the existing population or those coming off the wait list. The measures in here are mostly welcome, but they are not a substitute for adequate rates. The PASSEs claim an inability to pay more due to the global PMPM fee they are paid by DHS. We are not attempting to be the arbiter of this argument, but something must be done to improve rates. We noticed in some places CSSP is added to the provider type that can provide a service listed, but other times it was not. What is the rationale for this? For instance, why is CSSP not included for Respite, Supported Employment, Supportive Living, Community Transition Services, Consultation, Environmental Modifications, Supplemental Supports, HCBS Supervision and Monitoring, HCBS Enabling Technology. Also, sometimes CSSP is not listed in the "Provider Type" box, but it is listed below that under "Certificate" required. If these licensure types are not aligned, it requires providers to try to adhere to two different regulatory tracks if they want to provide both IDD and behavioral services under CSSP. Why is DDS removing the requirement for PASSEs to offer an Interim Service Plan? We understand a mechanism will be put in place to require prompt service, but shouldn't that requirement be in place before this provision is removed? Also, a requirement on the PASSEs for prompt service should also apply for those individuals whose former provider was unable to serve them due to health and safety concerns, or the individual could be left in limbo for long periods.

Response: Thank you for your comments. DDS will continue to support providers in any way we can while providers negotiate rates with the PASSEs. CSSP will be added as a provider for Respite, Supported Employment, Supportive Living, Community Transition Services, Consultation, Environmental

Modifications, Supplemental Supports, HCBS Supervision and Monitoring, and Enabling Technology. It was an oversight.

We are currently working with the PASSEs on the other issues you mentioned: Interim Service Plans and prompt delivery of service through Agreement negotiations.

Comment: *Clarification that certification is the responsibility of DHS and MCO credentialing is the responsibility of the PASSEs. Clarified the role of DDS, DMS and DCO in the approval process.*

Response: No additional change was made based on the comment.

Comment: We agree on need for clarifications, but did not see the roles defined. What are the functions of “certification” versus “credentialing”? Do they differ and if so, how, and who does each part?

Response: Please see a response above in the document regarding this distinction. No additional change was made based on this comment.

Comment: *Removed Crisis Intervention because it is a service available under the PASSE program to all members and was duplicative in this waiver. Streamlined “crisis plans, safety plans, behavioral support plans”, in order to use consistent language across the PASSE program.*

Agree. Thanks.

Response: Thank you.

Comment: *Using the terminology Behavioral Prevention and Intervention Plans and clarifying that they are the responsibility of the Supportive Living providers.*

Good change. Thank you.

Response: Thank you.

Comment: *Clean up on Consultation service to clarify what type of clinician can provide what task.*

Agree this is an improvement.

Response: Thank you.

Comment: *Adding two new services: HCBS Monitoring and Supervision and HCBS Enabling Technology.*

We strongly support the addition of Enabling Technology. However, we believe the following may be too limiting, especially with technology advancing so rapidly: “Allow a direct care staff, guardian or legally responsible person to see, hear or locate a person.” We would suggest that the other criteria address the appropriateness of the service without adding this one, which seems like it narrows the technology down to surveillance. Also, as it is written, Enabling Technology cannot be accessed and utilized by individuals in providerowned settings. That should be an option so that individuals in more restrictive settings can learn to utilize technology as a support for transitioning to a less-restrictive environment. For Monitoring and Supervision, does this mean that if a provider provides supervision and monitoring during Supportive Living that they cannot bill for that service, or they have to bill for it as Monitoring and Supervision (which presumably will be at a lesser rate)? Conversely, the definition of Monitoring and Supervision says that it can include carrying out the Behavior Plan, reinforcing other skill development supports, and assisting with IADLs. That is much more than “monitoring and supervision.” The documentation and billing for this could become extremely problematic. Also, it is not clear about the limitation to “own home” not “licensed or operated” by another entity – What about an apartment owned by the provider -- they are not “licensed” by a provider – they are the actual homes of the individual and should not be caught in the exclusion. We would encourage more thought to this entire section.

Response: Please see a response above in the document regarding this. Request for approval of this new service was withdrawn in consultation with CMS, to allow the state to further develop the service with appropriate stakeholder involvement.

Comment: *Removed restrictive language on who can receive Respite and where.*

Agree this is an improvement.

Response: Thank you.

Comment: *Removed prescriptive language under Supported Employment and replaced with examples.*

Agree. Thank you.

Response: Thank you.

Comment: *Clarified who can be paid staff under the waiver.*

Response: Thank you.

Comment: *Increased the Group Home bed capacity from 4 to 8 to address trends in institutionalization we are seeing due to pandemic and workforce shortage.*

We have concerns about this one. We share concerns about increased institutionalization, but do not believe increasing the size of group homes is the right cure. This is taking Arkansas in the opposite direction of best practices around IDD services and the expressed desires of individuals with disabilities. We believe the best way to deal with the workforce shortage is to increase reimbursement rates to a level that providers can pay DSPs a competitive wage. Once that is done, there will not be a need for this change.

Response: See response to this topic above in the document. This change was made during the amendment to the Supportive Living definition.

Comment: *Significantly increased the number of waiver slots over the next 3 (three) years to serve an additional 3,204 people.*

We applaud the Governor for the commitment to do this. However, unless the PASSEs increase reimbursement to providers to a level that we can pay DSPs a competitive wage, there will not be enough workers to serve the individuals coming off the wait list. There are not enough to serve even the current list. Moving individuals into larger group homes is not the answer. Adequate rates are.

Response: See response to this topic above in the document about providers negotiating rates with the PASSEs. No additional change was made to the amendment based on this comment.

Comment: *Added 200 more slots for children in foster care.*

Support.

Response: Thank you.

Comment: *Clarified that assisting clients with some medications is not "administration."*

Support. This is a helpful clarification.

Response: Thank you.

Comment: *Corrected requirements for Care Coordinator qualifications.*

We have no issue with this, but do point out that this care coordination model has not worked well in the IDD space for reasons that have been articulated in many forums many times. Please clarify that PASSES can pay providers to perform any of the functions that are not in the "conflict-free" regulation. Many functions have been pushed back or left for providers to do with no compensation.

Response: Thank you.

Comment: *Permanently adding training requirements for direct support professionals in lieu of one year experience that is currently in place in an Appendix K.*

Support, at least temporarily.

Response: Thank you.

Reba Shipley, member of Arkansas' Medicaid Voice Council

CES Waiver amendments were presented to the Council on May 16, 2022

Comment: After the meeting I had a few questions that came to mind.

When will the new proposed changes take affect?

Response: Upon CMS and the Arkansas General Assembly's approval. No additional change was made based on this comment.

Comment: Will the children be included in the paid family helper?

Response: Yes. No additional change was made based on this comment.

Comment: Thank you for your time. You did a wonderful job today. It was so exciting to see all the positive changes. You guys have so many different things to deal with and we appreciate all you do.

Response: Thank you.