DHS Responses to Public Comments Regarding Proposed Rule Change for HCBS and PASSE waivers (10/31/2021-11/29/2021)

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On Behalf of Easterseals Arkansas

Comment: In general, we wish to express concern over the lack of opportunity for provider involvement in the development of these proposed rule changes. CMS requires public input. This is how DHS responded to that question on the CMS template:

"Input was gathered and information will be shared with various stakeholders, including DD and BH provider associations. Among these are the Developmental Disabilities Provider Association, Arkansas Waiver Association and the DD CES Waiver Provider Network, Mental Health Council of Arkansas and the Private Providers Association. Information will be shared with PASSEs and other relevant stakeholders in addition to providing a period for public comment to garner more widespread public comment. (page 73)

This appears to be saying that DHS is seeking input from providers and others only after it developed the proposed rule. Provider partners are key to the success of Medicaid. We agree that changes are needed in the programs addressed in this rule, but the program could be more successful if providers were consulted before the rules were promulgated. It is very difficult to make substantive changes after the promulgation has already been issued unless we oppose them before legislative committees. This is not the ideal approach for anyone.

We understand that additional changes are planned in forthcoming amendments, and we ask to be included in those discussion before any rules are promulgated.

Response: DHS appreciates the feedback regarding stakeholder input and will take this into account as future amendments or changes are developed.

Comment: 1915(c) CES Waiver for IDD - Waiver Slots

The state is increasing the reserved slots for DCFS foster kids from 200 to 300 slots. We understand the need to add more slots for children in DCFS custody. There is also a reference that says: "Unduplicated Participants – increased from 4303 to 5483 in Year 1 (and each year thereafter of the 5 year renewal)." (Page 173) Please clarify how many slots are being added for those who have been on the waiting list for years or who are struggling with dual diagnoses.

Response: The increase was done in year 5 with the 12/20 amendment. No additional slots were requested with the renewal.

Comment: 1915(c) CES Waiver for IDD - Premium Tax Revenue

We have not seen data recently on how much has been collected from the premium tax the PASSEs pay and how it has been used in accordance with Act 775 of 2017. The Act states that the funds shall be:

Transferred in amounts not less than fifty percent (50%) … to the designated account created by § 20-48-1004 within the Arkansas Medicaid Program Trust Fund to solely provide funding for home and community-based services to individuals with intellectual and developmental disabilities until the Department of Human Services certifies to the Department of Finance and Administration that the waiting list for the Alternative Community Services Waiver Program, also known as the "Developmental Disabilities Waiver", is eliminated.

Can you explain how much has been collected to date; each expenditure of those funds; how many individuals have been moved off the wait list; and how many slots are being added in this proposed rule for wait-list individuals?

Response: Thank you for your comment; however, this was not addressed in the current amendment.

Comment: 1915(b) Managed Care Waiver - Tier 1

The state is removing references to Tier 1 (EIDT and ADDT and BH Counseling) as part of the PASSE, which the state originally said would be phased in to the PASSE program. Is the state no longer planning to move Tier 1 individuals into the PASSEs as was originally intended? What was the rationale for this decision?

Response: Thank you for your comment. As always, PASSE services include EIDT, ADDT and BH counseling services as well as higher level care. During Phase I, tier I services were described for clarity, but mandatory inclusion was never required.

Comment: 1915(b) Managed Care Waiver - Numbers of Beneficiaries

Different numbers have been reported on how many members are in the PASSEs. Can you please give an updated number broken down by DD and BH and tier levels?

Response: Thank you for your comment; however, this is not related to the current amendment.

Comment: 1915(b) Managed Care Waiver - PCCM

The proposed rule says the state is removing the requirement that participants use the Primary Care Case Management (PCCM) system. Was a PCCM fee being paid to PCPs for PASSE participants, and if so, how much will the state save through this change and how will the savings be used?

Response: Thank you for your comment; however, participation in the PCCM program has not been a part of this program since implementation/Phase I.

Comment: 1915(b) Managed Care Waiver - Tiers redefined

We reviewed the new definitions of the IDD Tiers staring on page 19. Can you explain what you believe will be the result of the changes in definitions, i.e., what is the intended result? What is the difference between Tier 2 and Tier 3?

Response: Thank you for your comment. Definitions are listed in Section A (Program Description), Part I (Program Overview), Section E (Populations Included in the Waiver) of the 1915 (b) amendment.

Comment: 1915(b) Managed Care Waiver - Care Coordination

On page 29, responsibilities for care coordinators appear to have been reduced and many of the social determinants of health removed. More specifically, the following requirements have been deleted:

1. Behavioral Health Treatment Plans;

2. Person Centered Service Plan for Waiver Clients;

3. Primary Care Physician Care Plan;

4. Individualized Education Program;

5. Individual Treatment Plans for developmental clients in day habilitation programs;

6. Nutrition Plan;

7. Housing Plan;

8. Any existing Work Plan;

9. Justice system-related plan;

10. Medication Management Plan;

11. Discharge Plan; and

12. Service needs identified as the results of the member's IA.

The proposed rule retains more general terms below the section that has been deleted. We support clarifying the roles of care coordinators. There seems to be no consistent understanding among care coordinators and PASSEs as to what exactly CCs are to do. Some view their position as merely filling out their PASSE's particular template for the PCSP, while others view it as truly coordinating services. But which services they are supposed to be coordinating is not clear. The description of care coordinators varies from one extreme to the other. Please consider providing more clear guidance on CCs.

Either way, the role of care coordinators under the PASSEs has become much more limited than what was originally promised by DHS and the PASSEs. It is far short of what IDD providers did for clients when paid to provide "case management" and "direct care supervision." This rule change will continue to exacerbate the gap for the IDD members. Outside of the few functions that must be "conflict-free" (eligibility determination, needs assessment, care plan development and monitoring), there are many services in this section of the 1915(b) waiver that providers or PASSEs CCs either one could provide. We

believe the members' care coordination needs could be more effectively addressed through providers who know the members and their families, and understand their needs first-hand, including their social determinants of health. We urge a close examination at who is better positioned to achieve the best results for members and then paying for true care coordination. Instead, in many cases no one is providing the needed coordination or providers are having to do it for free on an ad-hoc basis.

Response: Thank you for your comment. None of the Care Coordinator requirements were eliminated. All of the relevant treatment plans are covered under no. 18 in the amended waiver. The Care Coordinator is still required to gather all existing treatment plans for the member in order to create or update the PCSP.

Comment: 1915(b) Managed Care Waiver - Care Coordination 24/7

We support the clarification on page 31 that CC services are to be available 24 hours and 7 days a week.

Response: Thank you for your comment.

Comment: 1915(b) Managed Care Waiver - Equal Access

DHS has deleted the statement that it will seek public comment from time to time to identify areas of concern around timely access to care, including stakeholder input at least every 3 years. We strongly oppose this effort to further reduce input from stakeholders. This violates the spirit if not the letter of CMS' Equal Access rule, particularly for a vulnerable population with a severe workforce shortage.

Response: Thank you for your comment. Stakeholder input is a part of the process prior to any changes to the program. As noted previously, DHS deems stakeholder feedback essential.

Comment: 1915(b) Managed Care Waiver - Marketing

DHS has revised the marketing materials section to read as follows:

The State permits the PASSE to market to potential enrollees through a website or printed material distributed through DHS choice counselors Specifically, eEach PASSE has a may create and run a website for information regarding its PASSE, provider network, and care coordinator services. This website may be linked to the DHS PASSE webpage and is designed to provide information for clients beneficiaries when making a decision to enroll or change a PASSEs.

The PASSE may also produce written marketing materials to distribute to enrollees and potential enrollees. The written materials may must be distributed by DHS or its designated vendors. choice counselors.

While we understand the state's desire to prevent unethical marketing, this approach is so restrictive and cumbersome that members and their families have no realistic and understandable way to compare PASSEs and figure out which is the best fit for them. What they receive in the mail is not something that

helps them make a decision. We urge the state to come up with a better approach to helping individuals become better informed.

Response: Thank you for your comment.

Comment: 1915(b) Managed Care Waiver - Medicaid Expansion Population –On page 75 it says that those Medically Frail persons in the ARHome Medicaid Expansion with a high need for BH will be enrolled in a PASSE. But those with an Alternative Benefit Plan under FFS will be excluded form the PASSEs. Please explain exactly what is being changed by this rule? How many individuals are currently enrolled in an ABP?

Response: Thank you for your comment. ARHome Medicaid Expansion will now include the identified population of Medically Frail. If you are interested in specific data on Medicaid programs, that information is available upon request.

Comment: 1915(b) Managed Care Waiver - Appeals

This section is revised to read:

Each PASSE must have a process by which a member can file a complaint or grievance regarding, at a minimum, the type of services available to PASSE members, the denial of a specific service or provider, the quality of services provided, when their chosen provider refuses to serve them, or regarding any other concern related to a provider or care coordinator in the PASSE's Network.

Are providers now allowed to refuse service for any reason?

Response: Thank you for your comment. Providers are expected to comply with the regulations within the PASSE network with which they are affiliated, as it relates to service delivery.

Comment: 1915(b) Managed Care Waiver - Performance Improvement Plan (PIP)

The proposed rule fleshes out the Performance Improvement Plan (PIP) requirements for PASSEs. (Begins on page 109). We support the PIP process, which addresses such important issues as NCQA standards, coverage for high risk/high needs members, access, timeliness of services, quality of services, grievances and appeals, utilization review, critical incidents, and network adequacy. However, this information is not made available or distributed in a readily understandable and transparent format for stakeholders. How will the Department make this information more readily available and useful as you work to improve the PIP process?

Response: Thank you for the comment. Each PASSE has a Consumer Advisory Council where such issues may be discussed. The primary focus of the Council is to provide education and advocacy to members.

Summit Community Care

Comment: Good Afternoon –

Summit Community Care presents their comments as it relates to the proposed rule changes for HCBS and PASSE waivers.

Please see attached and advise should you have any questions/concerns.

Thank you,

Summit Compliance

1915(c) Home and Community-Based Services Waiver

Brief Waiver Description: All services must be delivered based on an individual person-centered service plan (PCSP), which is based on an Independent Assessment by a third-party vendor, the health questionnaire given by the PASSE care coordinator, and other psychological and functional assessments. The PCSP must have measurable goals and specific objectives, measure progress through data collection, be created by the member's PASSE care coordinator, in conjunction with the member, his or her caregivers, services providers, and other professionals.

Does this include or exclude family members that work as paid staff for the enrollee?

Response: A paid staff members would fall under service providers. Their input in the development of the PCSP may be solicited with the permission of the member who directs the planning process in accordance with 42 CFR 441.725.

Comment: Appendix A: Waiver Administration and Operation, Use of Contracted Entities: PASSEs provide care coordination to all enrolled members, arrange for the provision of all medically necessary services to enrolled members, certify HCBS providers, and set reimbursement rates for services provided to its enrolled members. The PASSE care coordinators will develop the PCSP for clients that determines the services the individual receives.

Being that the PCSP is not the final determinant for authorized services, the word “determines” implies such. Seeing as though, there is language establishing a firewall between care coordination and utilization management, we suggest the language not illude that the CC will “determine” the services rendered.

Response: Thank you for your comment.

Comment: Appendix D: Participant-Centered Planning and Service Delivery, Independent Assessments: Every applicant must undergo an Independent Assessment that will determine whether the individual is a Tier 2 (requires paid care or services less than 24 hours per day, seven days a week) or Tier 3 (requires paid care or services 24 hours a day, seven days a week). This Independent Assessment will also assess each applicants’ overall strengths, needs, and risks; and will be used to develop the PCSP. The Independent Assessment must be completed every three (3) years.

It needs to be noted that the IA does not determine the level of need for the member (i.e. scope & duration). We have worked with the State to ensure that a member's service needs align with their conditions and symptoms and not the IA exclusively. For example, there may be Tier 2 members who receive 24 hours care, and vice versa for Tier 3. We have agreed with the State that the Tier level is not the sole driver of services.

Response: Thank you for your comment.

Comment: Appendix D: Participant-Centered Planning and Service Delivery, Assessment Types, Needs, Preferences, Goals and Health Status: The PCSP must be developed within 60 days of enrollment into the PASSE. At a minimum, the PCSP must be updated annually.

There are complications with the 60-day PCSP requirement, including but not limited to:

Enrollment data feeds from the State are often late causing multiple retro eligibility situations that reduce the actual time available to engage with the member;

Inaccurate addresses on the 834 (due to Gainwell using social security information) that often prevents locating the member quickly.

Barriers such as member knowledge of the PASSE, pandemic barriers, working with minors, etc. limit engagement with the member.

Please clarify if the requirement is calendar days or business days. It is challenging to overcome some of the barriers above and if calendar days is the expectation, we suggest modifying the requirement to 75 days rather than 60 or using the 834 "load date" as the metric start date.

Response: Thank you for your comment. Unless otherwise stated, requirement is calendar days.

Comment: Appendix G: Participant Safeguards, Medication Management and Follow-Up:

The Care Coordinator must develop and implement a Medication Management Plan for all members receiving prescription medications. The plan must describe:

How direct service staff will, at all times, remain aware of the medications being used by the member,

How direct service staff will be made aware of the potential side effect effects of the medications being used by the member,

How the care coordinator and service providers will ensure that the member or their guardian will be made aware of the nature and the effect of the medication,

How the care coordinator and service providers will ensure that the member or their guardian gives their consent prior to the use of the medication, and

How the service providers will ensure that administration of the medication will be performed in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

We have concerns' that CCs would be responsible for direct service staff education/knowledge of medications. While we will work closely with DSP staff, the language implies that non-licensed Care Coordinators are supposed ensure that DSP providers are trained and "supervised" by the CC.

We have concerns that the language states that non-licensed care coordinators are responsible for side-effect education, consents for medications, and the administration of the medication.

Response: Thank you for your comment. Please note that service providers are also included as responsible for ensuring education to member/guardian/direct service staff regarding nature and effects of medication.

Comment: While CCs will be directly involved in coordinating medication adherence/ compliance with members, the clinical responsibility for administration, education on side effects, and obtaining consents rest with a licensed provider. We strongly recommend adjusting this section to align with the actual role of the care coordinator who is not a licensed provider.

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

1915(b) Waiver

Section A: Program Description, Part I: Program Overview, Services: The PASSE is responsible for providing all services to its members, including services contained in:

Please review the term providing, as the PASSEs do not provide services. This language has led to some confusion amongst the PASSE community, and we recommend modifying the term to align with what the PASSEs are doing (assisting, approving/authorizing).

Response: Thank you for your comment

Comment: Section A: Program Description, Part I: Program Overview, Services: These services are EXCLUDED and the PASSE will not be responsible for providing them:

Non-emergency medical transportation (NET)

Dental benefits in a capitated program

School-based services provided by school employees

Skilled nursing facility services

Assisted living facility services

Human Development Center Services

Waiver services provided to the elderly and adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices Program.

Transplant and Associated Services

The language referencing excluded services state the PASSE will not be responsible for providing them; however, we have been asked to assist with enrollees in a SNF facility; we would like to get clarity around some inclusive language, and we would also like clarification around associated transplant services.

Response: Thank you for your comment.

Comment: Coordination and Continuity of Care Standards: Each member will be assigned a Care Coordinator who must make contact with that member within 15 business days of enrollment. The PASSE Care Coordinator will then have 60 days from the date of enrollment to conduct a health questionnaire and coordinate a Person-Centered Service Plan (PCSP) Development meeting. The PCSP must address any needs noted in the Independent Assessment, the health questionnaire, and any other assessment or evaluation used at the time of PCSP development.

1. We have concern's that CCs would be responsible for direct service staff education/knowledge of medications. While we will work closely with DSP staff, the language implies that non-licensed Care Coordinators are supposed ensure that DSP providers are trained and "supervised" by the CC.

2. We have concerns that the language states that non-licensed care coordinators are responsible for side-effect education, consents for medications, and the administration of the medication.

While CCs will be directly involved in coordinating medication adherence/ compliance with members, the clinical responsibility for administration, education on side effects, and obtaining consents rest with a licensed provider. We strongly recommend adjusting this section to align with the actual role of the care coordinator who is not a licensed provider.

Response: Thank you for your comment. Please see previous response.

Comment: Section A: Program Description, Part III: Quality: As required by 42 CFR § 447.203, DHS monitors each PASSE organization's network providers to ensure members have adequate and timely access to care. DHS has established access standards which the PASSE is required to meet. DHS requires that the PASSE and contract provider networks cooperate with DHS's analysis for access and provide any requested data required to carry out DHS's process for monitoring access to care.

We would like to see this language modified to the following:

Response: Thank you for your comment. No information on how language might be modified is included.

Comment: As required by 42 CFR § 447.203, DHS monitors each PASSE organization's network providers to ensure members have adequate and timely access to care, as defined in the PASSE Provider Agreement or the PASSE Provider manual. We would also like DHS to consider revising standards and a mechanism as to how standards would change if they were modified again.

Part IV: Program Description, A. Marketing: All allowable, written marketing materials will be translated into Spanish and Marshallese. All PASSEs must be able to provide written materials in any language requested by the member.

Please clarify if this requirement is for member materials only.

Response: Thank you for your comment. This is for member materials.

Comment: Part IV: Program Operations, C. Enrollment and Disenrollment: The proportional assignment methodology will be utilized to assign members to the PASSE, unless at lest one of the following conditions exist:

the PASSE has fifty-three percent (53%) or more of the market share of existing mandatorily assigned members;

The PASSE fails to meet specified quality metrics as defined in the PASSE Provider Agreement; or

The PASSE is subject to a sanction, including a moratorium on having members assigned to it.

Comment: We would like to State specifically define:

What quality metrics are subject to this algorithm

Define how failures are met (single quality metric or a percentage of the metrics)

Define the measurement period

Advise how long a PASSE would be removed from the algorithm

Response: Thank you for your comment.

Comment: Typo: lest, should be least

Response: Thank you for your comment.

Comment: Part IV: Program Operations, E. Grievance System: Each PASSE must have a process by which a member can file a complaint or grievance regarding, at a minimum, the type of services available to PASSE members, the denial of a specific service or provider, the quality of services provided, when their chosen provider refuses to serve them, or any other concern related to a provider or care coordinator in the PASSE's network.

What's the intended resolution of a grievance when a provider refuses to serve an enrollee? We need clarification on the expected resolution regarding this type of grievance, as our authority to enforce or require a provider to serve a member is limited.

Response: Thank you for your comment. The grievance resolution process is outlined in the PASSE Agreement.

Comment: Section C: Monitoring Results, Consumer Report Data: DHS collected information from NCI surveys and CAPHS surveys. NCI was conducted annually. Some issues with the surveys were the manner in which the individual conducting the entered information. This was mainly related to the presurvey that PASSEs were completing. Additional information and training was done with the PASSEs to explain the survey purpose in greater detail. Other actions based on respondent feedback were to verify questions were answered accurately. To do this, DHS follow-up directly with the respondents (PASSE members) and verified answers. DHS will offer additional training to PASSEs in the coming year. DHS received CAPHS surveys from the MCOs in 2019 and 2020. The surveys were used to monitor member satisfaction and ensure adequate services were being provided. CAPHS surveys were submitted with the exception of two of the PASSEs who did not submit in 2019. The PASSEs submitted in the subsequent year. CAPHS survey scores revealed that the PASSEs overall were surpassing NCQA standards but for several questions the MCOs reported below the standards. DHS will continue to monitor the surveys for improvement as the PASSE program develops. Additionally, the PASSE unit collected information on PASSE member surveys (quarterly) and PASSE provider surveys (annually) to monitor the quality of services provided to members. Surveys showed general satisfaction with PASSE services and care coordination. DHS is working with the EQR to standardize the surveys so that each PASSE is using the same one.

We currently use NCQA nationally recognized surveys that allow for comparison across all markets. We would like clarity on the need to consolidate under a new EQR designed survey, as opposed to the current nationally recognized survey.

Response: Thank you for your comment. This can be addressed when undergoing the EQR protocol related to member and provider surveys.

Comment: The ending of the first sentence appears to be incomplete.

Response: Thank you for your comment.

Comment: Section C: Monitoring Results, Geographic Mapping and Network Adequacy: Geographic mapping was conducted at the onset of the PASSE program and PASSEs have provided geo maps with network adequacy submissions. DHS is working with a contracted vendor to do geographic mapping with all network adequacy reports as of July 2021. The DHS PASSE Unit monitors network adequacy biannually through reports submitted by the PASSEs. Any areas lacking in the network addressed with the plans they are expected to improve access within a six-month period or they will have a corrective action plan around any deficiencies. The plans had to address any AONs related to network adequacy as found by the EQR.

We would like clarification on how DHS will reconcile this 6-month improvement requirement with a Network Variance Report that's already been approved; there are situations where we may not be able to find certain provider coverages in some rural areas.

Response: Thank you for your comment. DHS is currently working to provide guidance to the PASSEs around this.

Comment: Process for Making Person-Centered Service Plan Subject to Approval of the Medicaid Agency: PCSP/Treatment plans will be signed by all individuals involved in the creation of the treatment plan, the client (or signature of parent/guardian/custodian if under age of 18), and the physician responsible for treating the mental health issue. Plans should be updated annually, when a significant change in circumstances or need occurs, and/or when the client requests, whichever is most frequent.

Since the start of the PASSE, DHS indicated that physician signatures wouldn't be required, due to the many factors that make it complicated to do so and because the physician already signs treatment plans, waiver eligibility documents, etc. As such, we recommend removing this language from the waiver.

Response: Thank you for your comment.

Comment: System Improvement, Frequency: On-going monitoring will occur. Quarterly and annual reports will be analyzed and reviewed by the DMS Waiver Compliance Unit. Data will be analyzed quarterly by the Behavioral Health Agencies or Community Support System Provider Providers and annually by the EQRO. Network adequacy will be monitored quarterly.

We're currently providing bi-annual network adequacy reporting and monthly change reports with updates to any changes in the network.

Response: Thank you for your comment.