DHS Responses to Public Comments Regarding Rule 253 Community and Employment Supports (CES) Agency Standards

Kathy Weatherl

Bost

Comment:

Bost - Comments on proposed CES waiver standards.

1) 302 Employee Qualifications:

   (3)(2 & 3) Still states employee must have high school diploma or GED or equivalent.
   We do not believe this is a necessary requirement and would like to see it removed. A high school diploma or GED does not qualify a person as a good support staff.

2) 313 Behavior Plans

   (2)(a)(III) Positive behavior support specialist – under consultation they expanded to say certified through Cetner of Excellence university of Arkansas Partners for Inclusive communities OR any other entity that offers a similar certification curriculum. **How can we find out what must be required in the certification curriculum if we choose not to use Partners? Will the state provide this information to us? Will the state have to approve a different certification curriculum?**

   (3)(A-G) Still lists the specifics of what must be in the PBSP**. It does not make sense that we as non-licensed providers, tell a licensed professional what they need to put in a PBSP. They are licensed professionals and know what should be addressed in a plan. We can share with them what you are requesting to be in the plan, but if they do not address all those items what will be the ramifications for the provider?**

3) 403 Transitions from 1 waiver provider to another

   1(f) requires signatures of both providers on the plan. **Not realistic as this will likely be done via technology or phone, especially if the individual is moving to a new area. Can we just document who was part of the meeting?**
   2((b) Requires current provider to be at transition conference. **What if the individual/guardian does not want the current provider at the transition meeting? That situation will occur because the individual/guardian is mad at the current provider and that's why they are transitioning. What is the expectation around this?**
   2€ States current provider remains responsible for delivery of services until such time as beneficiary's transition to the new provider is complete, which shall not exceed 90 days from the date of transition conference. **What will occur in a situation where a family fires the current provider but has not yet transitioned to a new provider. What will the expectation be**

for the current, but fired by the family, provider? If we are not allowed in their home and they refuse to work with us we cannot provide services during that transition period.

Response: Thank you for your comment

- The current CES Waiver application approved by CMS requires a high school diploma or GED for direct support staff, so this is unable to be changed until the requirement is changed within the CES Waiver.

- The state is not developing any additional curriculum or new certifications at this time.

- A certified as a CES Agency Consultation provider would be subject to the requirements of Section 313(3) for any positive behavior support plan they developed. If it was not compliance with Section 313(3), then it would not be an acceptable plan and they would not be able to be paid for performing a CES Agency Consulting service.

- The state will change Section 403(1)(f) to read "Documentation or other evidence that demonstrated both the current and new provider's consent to the transition plan (i.e. signatures on plan, email approval, etc.)" to expand the ways agreement can be demonstrated beyond signatures. DHS believes it should be required to show that all parties agreed to the transition plan and not just that they attended the meeting.

- Both the current and new provider must attend the transition meeting to ensure a safe transition from the current to the new provider. If a parent refuses to attend the transition meeting after reasonable attempts, that fact should be documented.

- A new Section 403(e)(3) will be added to the CES Agency which states, "If a current provider is denied access to deliver services by the beneficiary or the beneficiary's family/guardian before transition to the new provider is complete, then the current provider must specifically document its attempts and the family/guardian's denial of access to provide services."

Josh Wilson

ICM

Comment:

TO: Thomas Tarpley, Director, Division of Developmental Disability Services
FROM: Josh Wilson, PhD., CEO, ICM
DATE: 2-7-2024
SUBJ: Public Comment-Community and Employment Supports Agency Standards

- 403(d). We request that only the newly selected provider be required to participate in the transition conference and clarifying who is responsible for inviting other parties. There will be instances when all parties cannot attend the conference at the scheduled date and time.

- 403(e)(1). We request a timeframe be set for when a transition conference must be held following a new provider being notified of their selection. The addition of a timeframe will help avoid a delayed transition.

- 404(a)(1). We request that a provider be allowed to issue a refusal to serve when a conflict of interest arises that could hinder the provider from effectively supporting the beneficiary.

- 404(a)(2). We request clarity on how and who should be notified at DDS of a refusal to serve.

- 404(d). We request that a provider be allowed to immediately cease supports if there is a threat of immediate harm. For instance, a provider cannot enter a setting where a person is assaulting or threatening to assault the provider. Proposed language: "A provider may immediately cease serving an individual when a significant threat to provider's safety exists."

- 404(c). We request that a timeline be provided for when DDS will determine that a refusal to serve is based on legitimate health, safety, and welfare concerns.

- 404(d). We request that a provider only be required to continue serving a beneficiary for 30 days following the refusal to serve notice unless it is an immediate refusal due to the presence of a significant threat to the provider.

Response: Thank you for your comment.

- All parties currently listed in Section 403(d)(2) must attend the transition meeting to ensure a safe transition from the current to the new provider. If any party refuses to attend the transition meeting after reasonable attempts, that fact should be documented.

- Section 403(c) will be amended to read, "The new Provider must hold a transition conference to develop a transition plan for the beneficiary within fourteen (14) business days of issuing the notification required in subsection (b) above. If the new Provider is unable to hold the a transition conference within the required timeframe, reasonable justification for the delay must be documented."

- Section 404(d) will be amended to read, "If a Provider is currently serving a beneficiary when declaring a refusal to serve, the Provider shall remain responsible for the delivery of CES Waiver Services until the beneficiary transitions to their new Provider or other placement unless there is an immediate health or safety risk to Provider employees. A detailed description of any health and safety risk justifying the ceasing of service delivery prior to a completed transition of beneficiary to a new Provider must be documented."

Summit Compliance

Comment:

Summit would like to submit the below comments or questions for the proposed changes to the CES Agency Standards:

311. Restraints and Other Restrictive Interventions: There are some adaptive equipment items that providers view as mechanical restraints such as an enclosed bed, and buckle guards. Are items used for therapeutic or non-behavioral purposes still classified as mechanical restraints? If not, can more information be added for section 2?

(1) A Provider cannot use a restraint on a beneficiary unless the restraint is required as an emergency safety intervention.

(2) An emergency safety intervention is required when:

(A) An immediate response with a restraint is required to address an unanticipated beneficiary behavior; and

(B) The beneficiary's behavior places the beneficiary or others at serious threat of harm if no intervention occurs.

(3) The use of seclusion for a beneficiary is strictly prohibited.

(4) The use of the following types of restraints on a beneficiary are strictly prohibited:

(A) Mechanical restraint; and

(B) Chemical restraint.

402. Exits: Item (3) is very vague and might be up to interpretation. It would be helpful to have clear guidelines in this section.

402. Exits.

(a) A Provider may exit a beneficiary:

(1) If the beneficiary becomes ineligible for CES Waiver as provided in section 405;

(2) If the beneficiary chooses to use another Provider; or

(3) For any other lawful reason.

601: Supportive Living: The new health maintenance language found in the 1915(c) HCBS regarding Supportive Living services in the clinical setting is missing from this section.

601. Supportive Living.

(a) Supporting living services are individually tailored habilitative services and activities to enable a beneficiary to reside successfully in their own home, with family, or in an alternative living setting.

(b)

(1) Supportive living services must be provided in an integrated community setting.

(2) Supportive living services must directly relate to goals and objectives in the beneficiary's non-clinical treatment plan.

(3) Providers must ensure that a sufficient number of direct care staff are scheduled during the performance of supportive living services to guarantee the health, safety, and welfare of each beneficiary.

(4) Providers must have backup plans in place to address contingencies if direct care staff are unable, fail, or refuse to provide scheduled supportive living services.

(b) A Provider of supportive living services must maintain the following documentation in the

604. Supported Employment: Can service definitions be added to the below supported employment services?

(1) Supported employment services may include any combination of the following services:

(A) Job assessment and discovery;

(B) Person centered employment planning;

(C) Job placement;

(D) Job development;

(E) Job coaching;

(F) Benefits support;

(G) Training and planning:

Response: Thank you for your comment.

- The definition of a "Mechanical Restraint" is found in Section 103(p).

Lindsey Lauritzen

Disability Rights Arkansas

Comment:

Please see my attached comment on the new rule for community providers delivering services to beneficiaries enrolled in the CES Waiver.

Lauritzen comment on rule for 1915c pr

My name is Lindsey Lauritzen, and I am requesting that the Division of Developmental Services (DDS) make the following changes to increase the quality of services that individuals with disabilities receive who are enrolled in the Community and Employment Support (CES) Waiver.

1. Section 303a: All employees must receive training on specific topics. Items a. l thru a.6 are straightforward, but topics a.7, Verbal intervention and a.8 De-escalation techniques are vague. Providers could develop training materials for their employees that are not thorough and do not prepare them well for working with beneficiaries. If training in these topics is required, DDS should create the training materials for verbal intervention and de-escalation techniques and distribute to providers so that employees will be well-prepared and equipped with the right skills before having any beneficiary direct contact.

2. Section 601: The section on Supportive Living should be more detailed. B.1 Supportive living services must be provided in an integrated community setting, which is a necessity for providers on the CES Waiver so they are in compliance with the Home and Community-based Services (HCBS) Settings Rule. But the term "integrated community setting" is not defined in section 103 and there is no mention of the Settings Rule. Please define integrated community setting and incorporate the Settings Rule into this proposed rule for CES waiver providers.

a. The ways that beneficiaries experience their home and community help determine whether their home is an integrated community setting. Beneficiaries should feel they have independence, and feel they have a rich community life (CMS document 79 FR 2948).

b. It is important to mention in this rule that beneficiaries have a right to privacy, dignity, respect, and freedom as a recipient of CES waiver services, as this is specifically mentioned in the Settings Rule.

c. Mention that providers should prioritize autonomy and independence for beneficiaries.

Please consider these comments and others that you may receive from interested individuals in finalizing the proposed rules.

Response: Thank you for your comment.

- Providers are much more qualified to develop and utilize existing appropriate training materials on these topics than the State.

- Section 502(a) requires each Provider owned, leased, or controlled CES Waiver Service residential setting to meet the home and community-based services setting regulations as established by 42 CFR 441.301(c) (4)-(5).

Sherice Smith

Comment:

Sherice Smith
Public Comments.pc

As a person with a disability, I have personally experienced restraints and seclusion. It was not helpful, and it did not change my behavior. What it did do was leave me afraid of teachers in school and of tight spaces. Now, as a self-advocate and an advocate for others, I think the agency should be careful and clear when allowing use of restraints and seclusion so as not to traumatize another generation. The directives on restraints do not specify what should be done before resorting to restraints. Please consider the following.

1. How are "unanticipated" behaviors defined?
2. How will these rules be implemented and compliance monitored to ensure consistent application across all direct-service providers?
3. What exact forms of restraints can be used?
4. What is the maximum amount of time that a restraint can be used?

Many direct-service providers have worked in their jobs for a long time, and they are used to doing things the "old way," which we now know to be unsafe and ineffective.

I would also like to voice some concerns related to crisis response. How are providers supposed to develop crisis response plans? Are the plans required to be developed with guidance from someone who works in the mental health field? What if a provider does not have a clinical director on staff?

Please consider these concerns and others that you may get from concerned individuals.

Response: Thank you for your comment. Seclusion is strictly prohibited regardless of circumstances in Section 311(a)(3). Section 311 and Section 313 limit any restraints and restrictive interventions to an emergency safety intervention only. Section 311(a)(2) very specifically defines what constitutes an emergency safety intervention. Any time a restraint or restrictive intervention is administered (whether appropriate/permitted or not) is required to be specifically documented as provided in Section 311(c).

Derek Henderson

Disability Rights Arkansas

Comment:

Please see the attached comments regarding proposed CES Agency Standards.

Comments re CES Agency Standards.p

I wish to offer public comments concerning the proposed CES Agency Standards. I generally support the adoption of such standards to inform PASSEs and providers of their obligations, to inform beneficiaries of their rights and obligations, and to create a culture of accountability that implements waiver services with fidelity. I offer the following specific comments in their order of occurrence within the proposed rules.

• Section 103(h): Please clarify how the "pass-through" process will continue with certain requests for services, or what will replace it. Home modifications, for example, can only be completed by a contractor. The pass-through process requires a waiver provider to make the request and essentially serve as a middleman to the contractor.
• Section 103(i)(3): Please clarify whether "not a standard treatment" refers to not being standard for the condition or not being a regularly administered treatment to the particular beneficiary.
• Section 103(l): Please consider adding a requirement that the plan specifies who will provide the training and what their credentials are to be.
• Section 103(l)(5): Please clarify whether the plan is to be developed and approved by DDS or developed by another party and then approved by DDS.
• Section 103(m): Please clarify persons who are not to be considered employees. The current definition states that an independent contractor is not an employee if the contractor does not assist in day-to-day operations and has no beneficiary contact. The conjunctive here could mean that a contracted accountant, for example, is considered to be an employee.
• Section 103(o)(2)(E): Please clarify "informational gatherings." A provider could, for example, hold a recreational event open to all members of the community at which services are described. If any mention of services is only ancillary to the main purpose of the event, does that constitute marketing?
• Section 103(t): Clarify whether there may be CES waiver recipients who are not PASSE members. The PASSE manual still mentions Tier 1 beneficiaries as voluntary enrollees. The ARIA manual does not mention Tier 1 CES beneficiaries.
• Section 103(v)(3): Please clarify whether DDS is to develop and approve the plan or whether another party will develop the plan.
• Section 103(y)(1): Please clarify that the application of force means only the application of force with one's body. Mechanical and chemical restraints are prohibited, and objects presumably are prohibited as well.
• Section 103(z): Please clarify whether PASSEs are to develop risk mitigation plans for all beneficiaries. Please modify this definition to have a member's "care coordination team"

complete the plan, as care coordinators generally will not have appropriate knowledge and resources to complete this alone.
• Section 103(aa): Please clarify situations that are considered to be seclusion and therefore are prohibited. Forcing a person into a closet is obviously seclusion. Physically preventing elopement from one's home may also be seclusion by this definition.
• Section 103(bb)(4)(C): Consider adding "acute psychiatric treatment facility" or similar language to account for the fact that a beneficiary can suffer serious psychological or emotional trauma.
• Section 103(cc)(2)(F): Clarify whether intent on the provider's part is necessary to constitute a violation.
• Section 201: Consider adding a requirement that providers must consent to having their credentials and records of any adverse actions available for a public electronic search feature.
• Section 202(b)(3): Consider adding a requirement that providers periodically update the list of employees it submitted. Ideally, there would be an electronic system in which providers would enter updates within days.
• Section 203(c): Consider adding expirations so that renewals will be required. Without renewal, there is no review cycle to ensure compliance.
• Section 302(b)(3): Consider requiring licensed professionals to periodically submit proof of good standing with their licensing agencies. Consider adding a requirement that licensed professionals report any actions against their licenses within 72 hours.
• Section 303: Consider providing additional guidance on specific training topics like trauma-informed care. DDS should consider creating a model training curriculum to serve as a minimum.
• Section 303(a)(8): Clarify the meaning of "de-escalation techniques. Since this term is used separately from "verbal intervention," it implies that de-escalation refers to a physical intervention. Non-physical de-escalation should be emphasized, but the current language muddles this.
• Section 303(b)(1): Consider adding a minimum amount of training in this area, and clarify whether activities like record review constitute training. Add a requirement that this training include information on the beneficiary's preferences. While not all clients are under guardianship, the Ward's Bill of Rights at Ark. Code Ann. § 28-65-106 offers some ideas about what preferences a caretaker might need to know about a client.
• Section 303(c): Consider placing minimum numbers on yearly refresher training.
• Section 303(e): Consider changing to "a licensed professional who has received substantially similar training as a condition of licensure." I believe it is extremely dangerous to bypass this requirement altogether.
• Section 305(a)(1): Clarify that service records must be available to a beneficiary or guardian at any time upon request.
• Section 305(b)(5): Consider adding a requirement that the service record include a list of the five nearest in-network emergency service providers and urgent care providers.
• Section 305(c)(1): Consider adding a requirement that the documentation of requesting the PCSP must be no older than 30 days. Providers must request this until they receive it.
• Section 305(d)(1)(A): Clarify that potential fill-in staff are "need to know."
• Section 305(d)(1)(B): Consider the effect of DHS Policy 1094 and whether this warrants clarifying this section regarding DRA's access to records.
• Section 305(d)(2)(B)(ii): Clarify that electronic records must employ sufficient security measures to safeguard personal information.

• Section 307(b): Clarify that providers assume responsibility for third-party compliance.
• Section 308(a)(1): Clarify that beneficiaries must be given reasonable opportunity to make use of their funds, namely intentional community integration and engagement.
• Section 308(b): Clarify that providers cannot disclaim criminal or civil liability under federal or state law.
• Section 308(d): Consider defining "account." Subsection (2) seems to indicate that a provider keeping clear records of deposits and withdrawals into an aggregate account is sufficient, but that does not comport with an ordinary understanding of what an account is. It would also be nearly impossible to calculate interest using the aggregate approach.
• Section 311(a)(2)(A): Consider removing this subsection. Subsection (B) is sufficient because it limits these interventions to serious safety threats. Subsection (A) is confusing because it seems to allow broad use of restrictive interventions for anything that is "unanticipated." If the section is read to require that subsections (A) and (B) both are met, it may not be clear whether a behavior should have been anticipated.
• Section 311(b)(1): Consider adding a requirement that a provider can only use a behavior de-escalation and management system if the system is approved by DHS (and situational requirements are met). At any rate, providers should not be creating their own interventions.
• Section 311(b)(2): Consider adding that the monitoring must include the client's physical and emotional conditions. Consider adding a requirement that providers debrief with staff concerning antecedents to the restraint and what steps will be taken to avoid the need for future restraints.
• Section 311(c)(1): Consider having DHS draft a reporting form to be used by all providers.
• Section 311(c)(2)(D): Consider requiring that all individuals involved compose independent narratives. It is very important that individuals not "get their stories straight" by composing one agreed narrative.
• Section 312(c)(2): Consider having DHS draft forms for medication plans and logs.
• Section 313(a)(3)(D): Consider adding a requirement that the plan include specific information about a beneficiary's history of restraint and seclusion and any anticipated adverse effects from continued application of restrictive interventions.
• Section 313(b)(1): Clarify who is to receive a risk mitigation plan and the form it should take. The risk mitigation plan is obviously very important. To use this section as an example, a consultation provider seems required for high-risk clients. If so, that would affect how services for such a beneficiary are to be considered and approved by the PASSE.
• Section 313(b)(2)(A): Clarify whether a psychiatrist can perform this task.
• Section 313(b)(3): Clarify how often the professional must review the plan.
• Section 401(a): Consider requiring providers to inform beneficiaries that enrollment with them is not a guarantee of coverage. Consider requiring providers to assume financial responsibility for any services they provide for which they did not follow normal procedures for requesting prior authorization.
• Section 402(a): Clarify what an "exit" is as opposed to "refusal to serve." Providers should inform PASSEs of exits.
• Section 402(b): Consider requiring steps to ensure that clients do not experience any gaps in services.
• Section 403(c): Consider placing a timeframe on when the new provider must hold the transition conference.

• Section 403(d)(2)(C): Consider adding “and other PASSE representatives necessary to ensure transition without a lapse in services.”
• Section 403(e)(1): Consider adding “complete as determined by the PASSE and recorded in a written notification sent to the client.”
• Section 404: This section and the concept of refusal to serve present challenges. If a provider is allowed to drop a beneficiary because the provider asserts it is unable to ensure health, safety, or welfare, this will undoubtedly have the greatest impact on clients with serious health needs. That could constitute discrimination on the basis of one’s perceived or actual disabilities. Since PASSEs receive capitated rates for members, one way to increase cost savings (and with it profits) is to pay for as few services as possible. If clients with the most serious needs are dropped due to those needs, they will likely be institutionalized. If this happens to clients who could live in their communities with proper supports, that could violate federal laws against discrimination on the basis of disability.
• Section 404(d): Clarify whether this is subject to a 90-day timeframe.
• Section 405: This section concerns me most. I think there is great potential for abuse and coercion. Stripping waiver eligibility is an extreme measure, and this section seems to allow it without due process for beneficiaries. My chief concern is who will decide whether a condition has been met and whether conditions overall are sufficient to warrant such a drastic penalty. Please clarify that a single event recorded by a provider will not be sufficient to strip waiver eligibility, and please clarify that beneficiaries will have normal due process protections of notice and opportunity to contest the action.
• Section 501: Emergency weather plans should be required and clearly defined. It is not sufficient for a provider to tell a client that he or she must rely on “natural supports.” Pursuant to federal regulations, natural supports must be voluntary, and they cannot supplant needed paid supports. Providers must have contingency plans in the event that weather prevents normal staffing. For example, a provider could have a contingency plan to rent sufficient space for temporary lodging for multiple individuals if staff cannot get to them in their homes and the clients have no natural supports. Clients who can temporarily stay with family can document that the temporary arrangement does not constitute a natural support as defined in regulations. I am not endorsing this option above any other, but I provide it to illustrate a range of approaches to weather planning.
• Section 502(g): Consider whether this complies with the International Residential Code. My understanding is that a bedroom must be at least 70 square feet with no dimension less than seven feet, and that at least half of the area of the room must have a minimum of seven foot ceiling clearance.
• Section 502(g)(2): Consider requiring a minimum of a twin bed, which is 38 inches wide.
• Section 502(g)(5)-(6): Clarify what constitutes “reasonable” furnishing. This could vary widely between providers without some guidance. Consider a comfortable chair among other minimum requirements, and consider whether a television or any other appliances is to be required.
• Section 503(b)(5): Consider requiring a minimum period of review, perhaps every three months. Also, DDS should have the final say (subject to client appeal rights) to approve or deny a variation.
• Section 601: Consider additional guidance on what is “sufficient.” Network adequacy guidelines on this are quite thin, only requiring that the service be “available” in all counties.
• Section 601(b): Consider requiring a minim period of review for goals, perhaps every

three months.
• Section 602(h)(3)(B): Define "mental health professional."
• Section 604: Consider explaining each of the services listed for supported employment.
• Section 608: Consider explaining how consultation can work in conjunction with other services, specifically how it can be used to provide better training for direct care staff. Nutrition training is especially pertinent, as I receive frequent reports from clients that they do not receive sufficient support from their providers in this area.
• Section 610: For supplemental support and other services, consider giving the PASSEs more direction on when these services should be approved. The DMS manual defines medical necessity, but PASSEs currently use criteria of their choosing for most medical necessity decisions. Please address this to ensure more consistent results across all the PASSEs.
• Section 702: Consider adding Disability Rights Arkansas as a recipient of reports pursuant to Rule 1094 and other sources of authority.
• Section 801: The PASSE manual requires PASSEs to proactively monitor implementation of services. Consider addressing the role of PASSEs in this section. Consider intervals at which DDS should monitor.
• Section 802: Consider addressing situations in which a PASSE knew or should have known of a violation and failed to report it or require corrective action.
• Section 803(a)(1)(B): Clarify that "public health" includes beneficiary health.
• Section 803(b)(3): Current policy presumes a provider's right to take on new clients. I think the presumption should be against taking on new clients. PASSEs are required to maintain sufficient provider networks. PASSEs should evaluate providers' current staffing and provision of services before providers are allowed to take on more clients.
• Section 806: Consider defining "violation." The definition seems to allow for a lot of subjective judgment, and that could lead to different interpretations that favor or punish specific providers. It is important to know how many events are being addressed, especially when monetary penalties are a possibility. Consider whether $500 per violation is a sufficient deterrent to achieve desired results.

Thank you for your consideration in this matter. Please contact my office with questions.

Response: Thank you for your comment.

- All beneficiaries in a CES Waiver slot are members of a PASSE.
- While certifications are not reissued, individual site visits are still performed as required.
- Providers are much more qualified to develop and utilize existing appropriate training materials on these topics than the State.
- Refreshers are required every other year pursuant to Section 303(c)
- Section 305(a)(3) will be added which states, "A beneficiary service record must be made immediately available to a beneficiary and their legal guardian upon request."
- Section 307(b) requires that Providers ensure third-party compliance.
- Section 403(c) will be amended to read, "The new Provider must hold a transition conference to develop a transition plan for the beneficiary within fourteen (14) business days of issuing the notification required in subsection (b) above. If the new Provider is unable to hold a transition

conference within the required timeframe, reasonable justification for the delay must be documented."

- Section 404(d) will be amended to read, "If a Provider is currently serving a beneficiary when declaring a refusal to serve, the Provider shall remain responsible for the delivery of CES Waiver Services until the beneficiary transitions to their new Provider or other placement unless there is an immediate health or safety risk to Provider employees. A detailed description of any health and safety risk justifying the ceasing of service delivery prior to a completed transition of beneficiary to a new Provider must be documented."
- Disenrollment of a beneficiary from CES Waiver only occurs as a last resort unless disenrollment is otherwise required by law.
- The definition of mental health professional can be found in Section 103(r).
- Providers must have a residential setting (if applicable) and staffing in place that meets these CES Agency Waiver standards prior to accepting a beneficiary.

Michelle Neece

Guardian to Paul Keller

Comment:

This letter is in response to the January 12, 2024 memo entitled "Community and Employment Supports (CES) Agency Standards. The following will outline the comments you requested from "Interested Persons and Providers".

As the Guardian for beneficiary, Paul Keller, of the Arkansas CES Waiver Program, I most certainly consider myself to be an "Interested Person". It was a disappointment to see that this memo was not distributed to all other Guardians, parents and Direct Care Staff who are impacted by the PASSE and Providers, as they have a very unique and vastly comprehensive understanding of how these standards directly affect the beneficiaries DDS is attempting to serve on a daily basis. I was fortunate enough to be able to have access to this memo, as I have witnessed not only the Waiver program in operation for the last 25 years, but I have been directly involved in the day-in and day-out issues that have plagued my beneficiary and many other beneficiaries since the PASSE program came into existence. These Agency Standards are desperately needed and have been a long time coming.

The initial and most glaring concern after digesting this memorandum would be who SPECIFICALLY at DDS is responsible for enforcing these said standards? Although there is a **Subchapter 8. Enforcement**, that addresses the monitoring of Providers and enforcement of actions, etc., there MUST BE a specific department and specific personnel within the Division of DDS that is set up to be responsible for receiving, investigating, monitoring, enforcing and reporting on all complaints that come in from ANYONE, be it a Direct Care Staff of a Provider company, an employee of a PASSE organization, a Guardian, a Direct Care Staff, a parent, a legal representative, a social worker or any other individual with a personal interest, who believes that these standards are being violated.

This contact information needs to be distributed state-wide to ALL interested parties (i.e., Providers and their employees, PASSE and their employees, any subcontractors associated with DDS, Guardians, parents, family members, direct care staff, etc.). This contact information should include the direct phone number to this department, the individuals' names and titles to whom the calls should be directed, the email addresses to which complaints or concerns should be sent and a physical address to send follow-up and official correspondence. To take it one-step further, a 24-hour hotline should be established for individuals to leave information anonymously or for people to leave concerns during non-business hours.

To simply provide a set of guidelines without the appropriate infrastructure set up to receive and process these complaints and concerns, and without universally distributing the contact information to report infractions of these standards is absolutely ineffective and unreasonable.

So let us begin with page 1, **Subchapter 1. General, 102. Purpose**:

The purpose of these standards is to:

(1) Serve as the minimum standards for community Providers delivering services to…

Although we understand it is part and parcel of legal jargon, it is an insult to our disabilities community to use the word "minimum" when we are referring to the "purpose" of these standards. **These should simply be "standards" that Providers must adhere to, period**. Our beneficiaries deserve more than simply the "minimum". Perhaps if DDS expected more than simply the "minimum" from their Providers, the beneficiaries that the Providers and DDS are tasked with serving would have the opportunity to receive better services. And isn't that the purpose of this memo to begin with?

Continuing on under page 1, **Subchapter 1. General, 102. Purpose**:

(2) Ensure the health and safety of beneficiaries who are enrolled in the CES Waiver.

This is such a broad and wide net to cast when listing this as a purpose. It is the single MOST important thing CES Waiver has to ensure the Providers are handling, and yet it is one of the things that currently suffers the most.

HEALTH AND SAFETY comes in all forms, shapes and sizes when referring to our beneficiaries, as most all of them require so much more than simply having a meal and a roof over their head to be considered as healthy and safe.

A great deal of our beneficiaries have the mentality of a child and as we all know, keeping a child "healthy" and "safe" requires much more than what an able-bodied adult requires. Many of our beneficiaries have specific and serious health issues, emotional issues and physical issues, which require staff that are able to identify and comprehend their needs, address their needs and attend to their needs, not just a warm body showing up at their home to sit on a couch and scroll through their phone, while randomly jotting down fake notes to turn in and not even conversating with their client. Providers must be willing and be given the resources to attract, hire and retain competent, qualified, engaged and competitively paid staff in order to help correct the current shortcomings in HEALTH AND SAFETY that are putting our beneficiaries at risk.

This is an area that will require a tremendous amount of change and monitoring if it is to become a truly successful purpose of the CES standards.

Moving on to page 11, **Section 303. Employee Training and Certifications:**

(a) All employees must receive training on the following topics prior to having any beneficiary direct contact that is unsupervised by another employee…

First and foremost, Provider-lead standardized employee training materials should be approved and signed off by DDS. It has been brought to my attention recently that there are some very questionable training materials being presented to new-hire employees by a local provider that could (and is) ultimately jeopardizing the HEALTH AND SAFETY and safety of our beneficiaries. We would suggest that DHS seriously consider monitoring curriculum that is used for training purposes. **Verbiage in this section of the Standards should address this potentially dangerous issue.**

After reading through the list of eight items, we are struck by the fact that there is no curriculum that addresses broad-based training regarding working with adults who are developmentally disabled. The training in the standards memo addresses HIPAA, reporting, basic health and safety practices, verbal intervention, etc., but these employees need a comprehensive education on working with the intellectually, mentally and physically disabled, as there are many new hires who have never worked with our beneficiaries and they need to be educated on how to treat them with dignity and respect, while still accomplishing their individual goals.

We are also struck by something we have experienced countless times in our personal situation. Our beneficiary requires 24/7 pervasive care that includes meal preparation and housekeeping. We see that training is offered for basic health and safety practices, verbal interventions, de-escalation techniques, infection control practices, etc. However, you would be surprised at the number of Direct Care Staff that are sent to care for an individual who apparently have no knowledge of the simplest of food prep or of keeping a house (i.e., vacuuming, dusting, cleaning a bathroom, etc.), or perhaps they simply choose not to do it, even though it is listed as part of their duties. Employees need to be trained on the very basics of keeping a beneficiary's home clean, sanitary and comfortable for them, as well as how to prepare appropriate meals for them, including any special dietary needs.

On page 12, under this same section, the standards go on to state:

(b)

(1) All employees must receive beneficiary-specific training in the amount necessary to safely meet the individualized needs of those beneficiaries prior to having any direct contact that is unsupervised by another employee.

(2) Every employee's beneficiary-specific training must at a minimum include training on the beneficiary's…

It has been our experience that any training our staff has received has come from other staff members and has been limited to four hours or less. This is simply not enough time to train a person on all of the intricacies that are involved with our beneficiary (and we're assuming many others). Not only does our

staff need a bare minimum of eight hours of on-site training, they also need at least eight hours of job shadowing to ensure that they are handling things appropriately.

We are also confused as to why other Direct Care Staff are tasked with training the newly hired staff members. Should it not be the job of the Providers to employ a trainer whose job it is to make sure that Direct Care employees are properly trained to work with a beneficiary? Or, in the alternative, should it not be the care coordinator's job to make sure they have trained a new Direct Care Staff to meet the HEALTH AND SAFETY requirements of a beneficiary before he/she places them in their home?

We cannot express to you the number of times that as a Guardian and as family members, we, ourselves, have trained staff over and over and over again when adequate training had not been provided. We have developed and provided job descriptions where there were none. We have developed and provided lists of job duties during shifts where there were none. We have developed information regarding our beneficiary and put it in print to hand out to staff where there was none.

Although we truly want to be involved in engaged developing the plan of care, the goals and the staffing of our beneficiary, we are aging and in poor health. What happens when we are no longer here to essentially step-in and do the job of our Provider when it is not being done properly? What happens when we are not able to constantly monitor our Provider and case management to make sure our beneficiary is receiving the proper services and care the waiver program and DDS is tasked with providing him? I will tell you what happens. Our beneficiary's HEALTH AND SAFETY will suffer. He will receive substandard care at the hand of DDS, our Providers and the PASSE, and that is NOT ACCEPTABLE.

And lastly, when a substitution staff person is sent in to a beneficiary's home, it is incumbent upon the Provider that the sub staff have been given beneficiary-specific training to that person, regardless of the circumstances under which they have been dispatched to that beneficiary. In other words, Providers need to be developing substitution staff pools in which the staff is trained and understands the needs of the beneficiaries. Otherwise, they are walking in blind and they have no idea what to expect or how to care for their beneficiary in a HEALTHY AND SAFE manner. They are currently being sent to residences with no training about the beneficiary, no contact sheets, no medicine sheets, no phone numbers, no information about the beneficiary, etc. This is ABSOLUTELY UNACCEPTABLE. It would be like pulling a stranger in off of the street and expecting them to know how to care for our developmentally disabled adult. **Verbiage must be added to this section to address this issue.**

On page 16, **Section 307. Third-Party Service Agreement:**

(a) A Provider may contract in writing with third-party vendors to provide services or otherwise satisfy requirements under these standards

We, as well as many, many other families have been experiencing a shortage in staffing. It would be our suggestion that not only do we "allow" Providers to contract with third-party vendors to provide services, but we **change the verbiage** to "encourage" Providers to contract with third-party Providers when staffing becomes an issue, particularly in emergency situations such as bad weather. As families, we see this as an alternative to situations in which there are staffing shortages or emergencies that arise in which we are told they have no one to send and "emergency services" will have to be dispatched out to the

beneficiary, which would cause a great deal of harm and disruption to a beneficiary's mental health and well-being. Third-party Providers could include, but would not be limited to, other Providers than the one assigned to the beneficiary, nursing or health Provider services, and on-call elder / senior care services, etc.

On page 16, **Section 308. Financial Safeguards:**

Regarding this section, when a beneficiary's finances are handled by a Provider, who oversees and audits the finances and transactions made by the Providers on the beneficiaries behalf and how often are these audits conducted? **Verbiage should be added to this section** that addresses the oversight and compliance of a Provider to manage a beneficiary's finances, as well as the frequency of audits so that Providers will be on notice that DDS will be seeing to it that a beneficiary's money is being handled properly. To state as in section *(b) (4) A Provider may only use, manage, or access a beneficiary's funds or other assets to the extent permitted by law…* does not give the Provider any sense that they will be actively monitored, audited and reviewed by DDS and subject to fines and penalties by DDS if discrepancies or mishandling are identified, as well as subject to punishment to the fullest extent by law.

On page 19, **Section 311. Restraints and Other Restrictive Interventions:**

(a)

(3) The use of seclusion for a beneficiary is strictly prohibited.

Please note that we have experienced, Direct Care Staff using "seclusion", or choosing to not take our beneficiary out in public to participate in activities, as a way for them to not fully perform their job duties. (Unfortunately, once again, we are also aware of this happening with many other beneficiaries.) This is seclusion and quite frankly, a form of abuse. Waiver services are intended to be a form of "community-based" services and living. That means that if the beneficiary's PCSP and Guardian dictates that they are to be involved in community activities, a Direct Care Staff member's indifference or lack of motivation in performing these tasks is irrelevant and should be cause for discipline by a Provider.

On page 26, **Subchapter 4, Entries and Exits, 401. Entries:**

(a) A Provider may enroll and provide those CES Waiver Services it is certified to deliver pursuant to its CES Waiver Service certification(s) to an eligible beneficiary.

Considering the current state of staffing difficulties, does it seem prudent to allow Providers to continue to accept new beneficiaries when existing beneficiaries are not being staffed and served in a timely and consistent manner? If a Provider is unable to show that at least 90 to 95% of their beneficiaries are fully staffed, should they be allowed to continue to accept new beneficiaries and benefit from the monetary gains this provides them when they are unable to serve their current members?

This sets current beneficiaries up to have their HEALTH AND SAFETY compromised by untrained, ineffective and incompetent staffing and suffer with constant lapses in staffing. We know this because

we have experienced it and continue to experience it over and over again. Additionally, a Provider needs to show that they have an adequate "pool" of substitution staff that can be drawn on before being allowed to accept new beneficiaries. **This verbiage MUST be changed** in order to preserve the HEALTH AND SAFETY that DDS lists as their purpose.

On pages 28 and 29, **Section 404. Refusal to Serve:**

> *(b) If a Provider is unable to ensure a beneficiary's health, safety, or welfare because qualified personnel are unavailable to deliver a CES Waiver Service included on the beneficiary's PCSP, Provider must be able to demonstrate reasonable efforts to recruit and retain qualified personnel and the results of those efforts.*

DDS needs to **add verbiage that elaborates** on what is considered "reasonable efforts", as we believe beneficiaries could be dismissed with a refusal to serve without reasonable efforts being made to recruit and retain staff. In the past many, many months, as Guardian, I have been doing the majority, if not all, of the active staff recruitment, as I have been unable to get my Provider to consider other alternatives to recruit staff or to "think outside of the box", which is what is often required. We have been told they do the typical advertising on Indeed, etc, but that is not adequate or reasonable in today's labor market. We've been told that they have "no one to hire in the Fort Smith area", and yet we were advised that another Provider in our area just put 30 people through new-hire training in Fort Smith this week. The ball is being dropped somewhere, wouldn't you agree?

The most important and pressing issue we have with attracting, hiring and retaining staff competent, qualified staff is the inadequate salaries they are being offered. I have written to my PASSE Provider requesting additional funds for staffing, and was turned down. We have utilized a personal care company to allow for more money in our "budget" to pay staff more, and yet our Direct Care Staff still only makes $13.00 an hour.

Providers are expected to be able to hire staff and put our beneficiary's life in their hands, to care for him, to meet his dietary needs, to take him out in the community and make sure he doesn't fall while using an assistive device, to take him to doctors' appointments (of which he has several) to bathe him, to perform his physical therapy exercises, to shave him, to wipe him, to monitor him at night with sleep issues, to give him his medicine, to make sure he doesn't walk out in front of cars, to make sure he doesn't try to cook for himself, to change the sheets on his bed, to keep his house, to keep up with his groceries, etc., this list goes on and on. His entire life, well-being, HEALTH AND SAFETY is in their hands and we only want to pay them $13.00 an hour. They can go to Wal-mart or McDonald's and make more per hour with none of the responsibility. How can Providers *"demonstrate a reasonable effort to recruit and retain qualified personnel"* when that is what they are up against?

Do you suppose that not paying a decent, competitive wage in today's labor market could be an obstacle to the HEALTH AND SAFETY of our beneficiaries? And yet a PASSE company that has millions and millions of dollars at their discretion, won't see to it that a Provider can offer a beneficiary's Direct Care Staff enough money that they can afford to pay their rent when they have someone's life in their hands? The Providers may attempt to make reasonable efforts to hire staff, but they MUST have the monies available

from the PASSES to be able and willing to pay qualified, competent employees so that the HEALTH AND SAFETY of the beneficiaries is put first, as DDS claims it is.

On page 30, **Subchapter 5., Settings Requirements, 501. Emergency Plans and Drills:**

Although not addressed in this section, there needs to be emergency plans in place regarding staffing policies during bad / inclement weather. We recently experienced an issue with being unable to have staffing provided to us (and there were no natural supports available) during a weather event and were told our Provider simply had no alternative but to send in "emergency services", which would have caused tremendous mental turmoil to our beneficiary.

This situation can be avoided by care coordinators being proactive in addressing upcoming weather events and planning ahead, as well as there being an "inclement weather emergency plan" in place. In our situation, there were two full days to plan in advance and see to it that a plan for Direct Care Staff was in place to avoid a disruption in services, but our coordinator chose to just "wait and see what happens", which created a tremendous amount of unnecessary drama for the Guardian, the family, the Direct Care Staff and the beneficiary.

If a Direct Care Staff is on duty during inclement weather and has no staff to relieve them, are they required to stay on duty until another staff member can arrive to relieve them? We would like some clarification on this matter, as we were advised by our Provider that they could not "make" a Direct Care Staff stay because it was against labor laws.

Some type of **verbiage needs to be added** to the Emergency Plans section that addresses inclement weather and how a Provider should make advanced plans (as we all know that Arkansas has plenty of advanced warning on weather events) to handle staffing in these instances to ensure no disruption of services.

On page 37, **Subchapter 6, Programs and Services. 601, Supportive Living:**

(b)

(3) Providers must ensure that a sufficient number of direct care staff are scheduled during the performance of supportive living services to guarantee the health, safety and welfare of each beneficiary.

(4) Providers must have backup plans in place to address contingencies if direct care staff are unable, fail or refuse to provide scheduled supportive living services.

As we have mentioned numerous times in this correspondence, Direct Care staffing and the quality of that Direct Care staffing continues to be an issue. We believe that adequate staffing can be accomplished with aggressive, proactive ad campaigns, collaboration with other vendors and providers such as healthcare agencies and senior care agencies, community outreach through churches, outreach through college campus organizations, reaching out to the United Way, active participation in job fairs, contacting hospitals, child care agencies and daycares, etc, as well as an increase in the availability of higher salaries for the workers who are hired. A sub staff pool must also be developed for when Direct Care Staff is sick,

on vacation or otherwise unavailable. This gives Direct Care Staff the ability to work normal, set schedules, without being stressed and overworked.

Once they are hired, better training and a more hands-on, involved and collaborative approach among the Direct Care staff, the Guardians, the PASSE and the Provider can result in a positive experience for our beneficiaries. But unfortunately, these things are not presently being done. My Provider case manager (who had been with us for six months) was setting up our annual meeting and did not even know the name or contact information for my PASSE care coordinator. Does this sound like collaboration to you? **Perhaps verbiage needs to be added** somewhere under the Supportive Living section that addresses the need for the Provider AND THE PASSE to work collaboratively with the Guardian and Direct Care Staff to assure that the beneficiary's goals are being worked on in a timely and consistent manner and that Direct Care Staff's job performance is being monitored in such a way that it meets the expectation of the job description and goals.

We would also **like to see verbiage that states** that a Guardian be offered to receive a copy of the daily progress notes as listed in number (b) (5) on a monthly basis.

Providers also need to be educated on the legal definition and appropriate use of the phrase "natural supports". In our situation, due to the age and health issues of our beneficiary's immediate family, he does not have any "natural supports". We are constantly being pressured and coerced, for lack of a better word, by our Provider to find and identify natural supports to make up for their lack of staffing. Providers MUST BE EDUCATED on what federal regulations define as "natural supports" and the fact that they are VOLUNTARY. We simply do not have natural supports in our situation, as we have no other family in the area.

In the case of a dire emergency, as Guardian, I would see to it that I would be taken to wherever my beneficiary was and provide whatever was needed, but due to my own health issues, that cannot occur unless it is a true emergency. Not being able to find Direct Care Staff because of poor planning on the part of a Provider or case manager does not constitute an emergency. **Verbiage MUST be added** which complies with federal law and clarifies the use of "natural supports" and the fact that it is voluntary when dealing with Guardians and family members.

On page 54, **Subchapter 7., 702. Reporting Requirements:**

(b) A Provider must submit all reports to the beneficiary's assigned PASSE and to DDS.

Again, there needs to be specific entities, names, titles and contact information for these incidents to be reported. To simply say that this information should be reported to PASSE and DDS is not specific and clear enough. In the past, if an incident occurred which was reported to our PASSE care coordinator, nothing was generally done because they simply are not given the authority to handle any situation outside of the purview of developing plans of care and ordering supplies. To contact a PASSE 1-800 number was completely ineffective, as well as trying to deal with an "ombudsman". Providers, Guardians, families and Direct Care Staff MUST be provided with SPECIFIC and ACCURATE contact information for

both PASSE companies and DDS in the event that anything should occur that would impact the HEALTH AND SAFETY of a beneficiary as listed in Section 701.

Continuing on page 54, **Section 703, Notification to Legal Guardian:**

(a) If a beneficiary has a legal Guardian, then a Provider must notify the legal Guardian of any reportable incident involving the beneficiary.

Verbiage should be added to this section which states the Guardian should be notified within 1 hour of the reportable incident, no exceptions.

On page 55, **Subchapter 8., Enforcement., Section 801, Monitoring:**

(a) DDS shall monitor a Provider to ensure compliance with these standards.

And **Section 802, Written Notice of Enforcement Action,** goes on to state how a Provider will be notified of all enforcement actions taken against a Provider.

Verbiage should be added here that addresses that any enforcement actions taken against a Provider that directly involve a specific beneficiary should also involve immediate notification to the beneficiary's Guardian.

On page 57, **Section 804., Moratorium:**

We revisit the subject of prohibiting a Provider from accepting new beneficiaries, as discussed earlier in this correspondence. Although in this section of the memo, a Moratorium is being used as a penalty as a result of an enforcement action, we believe that a Moratorium should be used as a daily practice that prevents Providers from accepting new beneficiaries when they are unable to fully staff and provide sub staff to the current individuals they serve. (Please refer to my comments on page 6 of this document under "Entries and Exits".)

The Moratorium verbiage should be taken out of the Enforcement Actions section and used as a daily DDS policy to prevent Providers from jeopardizing the HEALTH AND SAFETY of the beneficiaries being served by allowing them to continue to accept new beneficiaries if they cannot effectively staff and serve at least 90 to 95% of their current beneficiaries.

In closing, I would like to comment on the role that the PASSE is playing in how we are able to effectively serve our beneficiaries. This memorandum developed specifically addressed the Providers and what is required of them. However, as we all know, the PASSE companies are contracted with the state and have a legal obligation to fulfill the rules and regulations of said contracts. When is DDS going to start holding the PASSE companies responsible for their contractual obligations and develop a set of Community Standards for PASSE organizations that must be followed?

There MUST BE a CLEARLY DEFINED set of roles and responsibilities among the PASSE companies, the Providers and DDS that has yet to be conveyed to those who are tasked with participating in this infrastructure. This set of roles and responsibilities needs to be set out in writing and distributed to all interested parties, including PASSE companies, Providers, Direct Care Staff, Guardians, families, beneficiaries, etc.

At the end of the day, the most important and vital thing that has to happen is that we diligently go above and beyond our very best to serve and protect these fragile individuals in our care that so desperately depend solely on us for their well-being. I take this task very seriously and I can only hope that those at DDS with the authority to initiate true policy and systemic change will, as well.

Response: Thank you for your comment.

- Providers are much more qualified to develop and utilize existing appropriate training materials on the required topics than the State.
- If there is any complaint or concern of a legal guardian relating to a CES Waiver provider's compliance with these standards, they should report it to their assigned PASSE care coordinator. If there is concern with how PASSE is handling the concern then there is the PASSE grievance process. The state is also in the process of setting up a citizens portal where a legal guardian (and the general public) would be able to submit complaints and concerns relating to CES Waiver services. Information regarding the citizen portal will be provided once it is established.
- Providers are required to maintain detailed emergency plans for each beneficiary which must specifically include weather related emergencies under Section 501(B).
- A beneficiary's legal guardian is entitle to receive a copy of the daily progress notes or any other documentation in a beneficiary's service record at any time. Section 305(a)(3) will be added to clarify this which states, "A beneficiary service record must be made immediately available to a beneficiary and their legal guardian upon request."
- Section 703(a) will be amended to read "If a beneficiary has a legal guardian, then a Provider must notify the legal guardian of any reportable incident involving the beneficiary within one (1) hour of discovery."

Sabrina Woodson

CEO

Focus, Inc.

Comment:

302 (2) Each individual eighteen (18) years of age or older residing in an alternative

living home that is not a family member of the beneficiary must successfully pass the checks, screens, and searches prescribed in subdivision (b)(1) of this part.
COMMENT: This remains an issue as providers cannot require non employees to do drug testing. Why would we do an excluded provider check on non-employees? That is not in statute. Is the expectation that a person receiving services will be expected to find a new home if someone living in the home can't pass an excluded provider check?

Suggestion: To be consistent with Ark. Code Ann. 20-38-101, Could we use the statutory language, see below, and then we work to get the statute amended next session on the issues being brought up here?

Each individual eighteen (18) years of age or older residing in an alternative living home who has unsupervised access to a beneficiary served by the provider must successfully pass the checks, screens, and searches prescribed in subdivision (b)(1) of this part. This provision does not apply if the individual living in the home with the beneficiary: (a) is a family member of the beneficiary; (b) is a volunteer; or (c) works in an administrative capacity and does not have unsupervised access to the beneficiary.

Lastly, can guardian be included too? Some people live with their guardians and we would not want to do checks on them?

Page 1, Definition Alternative Living Home
COMMENT: Referencing the above, the definition in the rules of," ' Alternative living home' means beneficiary residential setting that is not owned leased or controlled by the beneficiary, the beneficiary's legal guardian, or a family member of the beneficiary" needs to be removed from the rules. 302 (2) is the only reference of "alternative living home" in the rules and again providers cannot require non employees to drug tests, provider checks, and searches.

313 Behavioral Management Plans (1) The selected provider for supportive living services must develop a behavioral prevention and intervention plan for a beneficiary if the beneficiary's risk mitigation plan identifies the beneficiary as a risk to display behaviors that can lead to harm to self or others but below a risk level requiring a positive behavior support plan. (b) (1) The selected Consultation Provider must develop and implement a positive behavior support plan if a beneficiary's risk mitigation plan identifies the beneficiary as a high behavioral risk that can lead to harm to self or others, as defined in the risk assessment and mitigation plan tool.
COMMENT: The risk mitigation tool has yet to be developed, presented, or trained with providers to have a start date of these rules for April 1, 2025. Providers will not be prepared or equipped to carry out the rules.

313 (b)(3) A positive behavior support plan must at minimum include all items listed in subsection(a)(3) of this part in addition to the following:…..
COMMENT: Licensed professionals are not receptive on mandates on how to write the PBSP, along with the shortage of licensed staff who are willing to do them for the consultation fee.

Subchapter 4. Entries and Exits
COMMENT: PASSE Open Enrollment also should be addressed.

403 (b) A newly selected Provider must notify the current Provider of its selection within fourteen (14) business days of receiving notification of its selection from the PASSE

(c) The new Provider must hold a transition conference to develop a transition plan for the beneficiary.
COMMENT: These should be in the Care Coordinators manual, not the CES manual. The Care Coordinator should be organizing and coordinating these tasks of which they have first access to the information. As of now, providers do not get notified to be able to initiate (b) and the care coordinators will be included in the transition conference and should coordinate the transition. If providers are to be responsible to develop a transition plan, it should be a billable service.

404 (d) If a Provider is currently serving beneficiary when declaring a refusal to serve, the Provider shall remain responsible for the delivery of CES Waiver Services until the beneficiary transitions to their new Provider or other placement.
COMMENT: Providers ask to have a timeframe for services to end with provider after a refusal to serve has been submitted. There are examples where a provider has submitted a refusal to serve and still are serving a client several years after declaring they cannot meet health and safety of the client.

Response: Thank you for your comment**.**

- Section 302(b)(2) will be changed to read, "Each individual eighteen (18) years of age or older residing in an alternative living home that is not a family member of the beneficiary must successfully pass the checks and searches required by Ark. Code Ann. §20-48-812(c)(1-4)."
- Section 302(b)(3) will be amended to read:

    "(3) The checks, screens, and searches prescribed in subdivision (b)(1) of this part are not required for any:

    (A) Licensed professional; or

    (B) Legal guardian of a beneficiary."

- Section 404(d) will be amended to read, "If a Provider is currently serving a beneficiary when declaring a refusal to serve, the Provider shall remain responsible for the delivery of CES Waiver Services until the beneficiary transitions to their new Provider or other placement unless there is an immediate health or safety risk to Provider employees. A detailed description of any health and safety risk justifying the ceasing of service delivery prior to a completed transition of beneficiary to a new Provider must be documented."