ADMINISTRATIVE RULES & REGULATIONS SUBCOMMITTEE
OF THE
ARKANSAS LEGISLATIVE COUNCIL

Room A, MAC
Little Rock, Arkansas

Tuesday, September 12, 2017
1:00 p.m.

A. Call to Order.

B. Reports of the Executive Subcommittee.

C. Presentation on Dissolved Minerals in Third-Party Rulemaking Rule Filings with the Department of Environmental Quality. (Jim Malcolm, FTN Associates)

D. Rules Filed Pursuant to Ark. Code Ann. §10-3-309.

1. DEPARTMENT OF CAREER EDUCATION, CAREER AND TECHNICAL EDUCATION (Katherine Turner)

a. SUBJECT: Program Policies and Procedures for Career and Technical Education

DESCRIPTION: The Arkansas Department of Career Education made changes to the Policy and Procedures document to address the renaming of the Skilled and Technical Sciences office and update references to the department using the former logo or "ACE" terminology. Other changes consist of updating deadlines to form submissions and the relocation of educational programs from one career program area to another. The most significant changes are to the guidelines that instructors teaching Project Lead the Way (PLTW) courses follow, and it no longer requires those instructors to add an endorsement to their license.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on May 24, 2017. The Department received one comment:

Dave Fisher

Comment: Yes, in reviewing the new P & P I noticed that the Arts A/V was redlined in the S & T office (name possibly being changed back to Trade & Industrial, as it was called several years ago). The Arts A/V, is still listed under the Program List in the revised P & P. **RESPONSE:** Thanks Dave for the input. I was told that Arts A/V had been redlined in the Policy and Procedures that is out for public review. I have not checked it yet, but it should not have been, and I will correct it.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The authority and responsibility of the Department of Career Education and the Career Education and Workforce Development Board ("Board") shall include general control and supervision of all programs of vocational, technical, and occupational education in secondary institutions. *See* Ark. Code Ann. § 25-30-107(b)(1). *See also* Ark. Code Ann. § 25-30-102(b)(1) (providing that the Board shall have general supervision of all programs regarding vocational, technical, and occupational education). This authority applies to programs in state technical institutes, state postsecondary vocational schools, state area vocational high school centers, state public schools, and any other public educational facility or institution with the exception of technical colleges, community colleges, universities, and colleges. *See* Ark. Code Ann. § 25-30-107(b)(2). The responsibilities of the Board shall include all vocational, technical, and occupational education, including without limitation the following: establishing policies relating to plans and specifications for facilities and instructional equipment; prescribing standardized standards for programs and teachers; approving applied courses of related academic instruction; and other items relative to program quality and operation. *See* Ark. Code Ann. § 25-30-102(c)(1). The Board shall adopt rules to administer the Board and the programs developed by the Board. *See* Ark. Code Ann. § 25-30-102(c)(2)(B).

2. DEPARTMENT OF COMMUNITY CORRECTION (Dina Tyler)

a. SUBJECT: Weapons and Security Equipment AR 4.3

DESCRIPTION: The department is requesting that this rule be repealed.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on July 17, 2017. No public comments were submitted. The proposed effective date is September 30, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Board of Corrections shall promulgate policies, rules, and regulations relating to the operation of community correction facilities and programs and the supervision of eligible offenders participating therein. *See* Ark. Code Ann. § 16-93-1203; 16-93-1205.

b. SUBJECT: Use of Force AR 4.9

DESCRIPTION: The department is requesting to rescind the rule entitled "Weapons and Security Equipment," and to move relevant content from that rule into the proposed rule entitled "Use of Force." The department is providing detailed guidance to staff about reporting and investigating incidents in an agency policy, so that information is being removed from this rule.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on July 17, 2017. No public comments were submitted. The proposed effective date is September 30, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Board of Corrections shall promulgate policies, rules, and regulations relating to the operation of community correction facilities and programs and the supervision of eligible offenders participating therein. *See* Ark. Code Ann. § 16-93-1203; 16-93-1205.

c. SUBJECT: Safety, Security, and Sanitation at Residential Centers

DESCRIPTION: This amendment clarifies search procedures to help ensure the safety and security of residents and staff at community correction residential centers. Objectives were added to facilitate compliance with the "Prison Rape Elimination Act" standards and the Division of Behavioral Health (DBHS) licensure standards.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on August 8, 2017. No comments were submitted. The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The cost to the state is unknown. The department uses existing staff to conduct inspections and if problems are

found, to resolve them. In some situations, the department indicates that it may need to purchase something to ensure safety, security, and sanitation.

LEGAL AUTHORIZATION: The Board of Corrections shall promulgate policies, rules, and regulations relating to the operation of community correction facilities and programs and the supervision of eligible offenders participating therein. *See* Ark. Code Ann. § 16-93-1203; 16-93-1205.

3. DEPARTMENT OF ECONOMIC DEVELOPMENT, STRATEGIC PLANNING AND RESEARCH (Kurt Naumann)

a. SUBJECT: Replacement and Repair of Manufacturing Machinery and Equipment Sales and Use Tax Refund

DESCRIPTION: This rule implements changes required as a result of Act 465 of 2017 as follows:

1. Provides the new graduated refund and subsequent exemption of sales and use taxes levied under §§ 26-52-301, 26-52-302, 26-53-106, and 26-53-107 applicable to purchases of replacement and repair of manufacturing machinery and equipment:
    a. Beginning July 1, 2014, four and seven-eighths percent (4.875%);
    b. Beginning July 1, 2018, three and seven-eighths percent (3.875%);
    c. Beginning July 1, 2019, two and seven-eighths percent (2.875%);
    d. Beginning July 1, 2020, one and seven-eighths percent (1.875%);
    e. Beginning July 1, 2021, seven-eighths percent (0.875%); and
    f. Beginning July 1, 2022, sales qualifying for the tax refund under this option are fully exempt from taxes levied under §§ 26-52-301, 26-52-302, 26-53-106, and 26-53-107.

2. Establishes a sunset date of June 30, 2022, for the discretionary incentive program administered by the AEDC that provides for an increased refund of all sales and use taxes (5.875%) levied under §§ 26-52-301, 26-52-302, 26-53-106, and 26-53-107. Of note is that businesses can choose either option until June 30, 2022—there will be no need for the AEDC program since the full exemption will be in place as of June 30, 2022.

PUBLIC COMMENT: A public hearing was held on July 28, 2017. The public comment period expired that same day. The Commission received no public comments.

The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: These rules implement changes to the law concerning the sales and use tax refund for the repair and partial replacement of manufacturing machinery and equipment made by **Act 465 of 2017**. Pursuant to Arkansas Code Annotated § 15-4-3501(h), the Executive Director of the Arkansas Economic Development Commission ("Commission") and the Director of the Department of Finance and Administration may promulgate rules necessary to implement section 15-4-3501, which concerns an increased refund of sales and use taxes for major maintenance and improvement projects. Further authority for the rulemaking can be found in Ark. Code Ann. § 15-4-209(b)(5), which permits the Commission to promulgate rules necessary to implement the programs and services offered by the Commission.

b. SUBJECT: Consolidated Incentive Act of 2003

DESCRIPTION: This rule implements changes required as a result of Act 465 of 2017 and makes technical corrections as follows:

1. Changes wording regarding county tier change requests due to sudden and severe periods of economic distress from "a county official" to "the county judge."

2. Deletes language regarding incentive programs that were replaced by Consolidated Incentive Act programs (pre-2003 programs).

3. At the request of DFA, adds language that specifies that no Consolidated Incentive Act financial incentive agreements shall be transferrable or assignable without the written consent of the AEDC Executive Director.

4. Establishes a sunset date of July 1, 2017 for InvestArk projects. No new applications will be received after June 30, 2017.

5. Makes technical and grammatical changes to wording, punctuation, and acronyms.

PUBLIC COMMENT: A public hearing was held on July 28, 2017. The public comment period expired that same day. The Commission received no public comments.

The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: These rules implement changes made by **Act 465 of 2017** concerning investment tax credits under the Consolidated Incentive Act of 2003 ("CIA"), codified at Arkansas Code Annotated §§ 15-4-2701 through 15-4-2714. Pursuant to Ark. Code Ann. § 15-4-2710(1), the Arkansas Economic Development Commission shall administer the CIA and may promulgate rules and regulations necessary to carry out the CIA's provisions. Arkansas Code Annotated § 15-4-209(b)(5) further permits the Commission to promulgate rules necessary to implement the programs and services offered by the Commission.

4. DEPARTMENT OF ARKANSAS HERITAGE (Stephanie Wade, item a; and Rebecca Burkes, items b and c)

a. SUBJECT: Historical Marker Program Guidelines

DESCRIPTION: This rule creates guidelines and processes for administering a historical marker program. The markers will commemorate and acknowledge historically significant people, places, and events in Arkansas. Markers must be sponsored by civic groups and organizations and not solely by individuals. Upon receipt of an approved application, the Department of Arkansas Heritage will provide funding for 50% of the marker. Markers cost approximately $2,000. All applications must be supported by primary sources and will be reviewed by the Program Review Committee which includes the Arkansas State Historian (or designee) and Arkansas history academics.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on July 17, 2017. One comment was received by Stacy Mince on July 5, 2017. She commented, as follows:

COMMENT:

It's so wonderful that you're implementing a Historical Marker Program for Arkansas. I have some questions about the guidelines, though. While the third bullet point under General Marker Criteria says a civic group or organization needs to be the sponsor, do they necessarily have to be an

Arkansas organization? Could it be a for-profit entity that helps fund the marker?

Also, the pricing information is quite helpful. However, are the prices listed the full price or the half the applicant is responsible for?

I'm interested in pursuing a marker and am so glad this information is available!

RESPONSE:

The Historical Marker Program Guidelines do not require that the civic group or organization be an Arkansas organization.

The organization may be a for-profit entity.

The pricing listed is the total cost of the marker. The applicant will pay half of that amount plus a one-time $200 maintenance fee (as outlined in the application).

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Act 1001 of 1975 created the Department of Arkansas Heritage to be responsive to the cultural needs of the people of the State and to encourage greater participation of the public in the cultural affairs of the State. *See* Ark. Code Ann. § 25-3-101. Pursuant to Act 234 of 2017, funds were appropriated to the department for grants/aid and other heritage programs, to be payable from the Arkansas Department of Heritage Fund Account and funded by the conservation tax levied by Amendment 75.

With respect to the $200 maintenance fee, the department is authorized to establish and impose reasonable fees to recover costs of services rendered. Ark. Code Ann. § 25-3-105.

b. SUBJECT: National History Day Travel Grant Program

DESCRIPTION: This rule creates guidelines and processes for administrating a grant program, which provides up to $600 per student to cover the cost of traveling to the annual National History Day Contest in Maryland. National History Day is a year-long academic program focused on historical research, interpretation, and creative expression for 6th- to 12th-grade students. The National Contest is the final stage of a series of contests at local and state affiliate levels. The contest begins at the local

level in classrooms, schools, and districts. Top entries are invited to the state level contest. The top two entries in every category at the state level are then invited to the National Contest. Approximately 60 Arkansas students in grades 6-12 win the state competition and are invited to participate in the National Contest.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on July 17, 2017. No public comments were submitted. The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Act 1001 of 1975 created the Department of Arkansas Heritage to be responsive to the cultural needs of the people of the State and to encourage greater participation of the public in the cultural affairs of the State. *See* Ark. Code Ann. § 25-3-101. Pursuant to Act 234 of 2017, funds were appropriated to the department for grants/aid and other heritage programs, to be payable from the Arkansas Department of Heritage Fund Account and funded by the conservation tax levied by Amendment 75.

c. SUBJECT: Small Museum Grant Program

DESCRIPTION: This rule establishes the guidelines and process for administering a grant program to provide operating support to small museums in Arkansas. The rules include items such as who is eligible to apply for the grant, how applications are evaluated, documentation required by the applicant, and the timeline for application and decision. The maximum award is $2,500.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on July 17, 2017. No public comments were submitted. The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Act 1001 of 1975 created the Department of Arkansas Heritage to be responsive to the cultural needs of the people of the State and to encourage greater participation of the public in the cultural affairs of the State. *See* Ark. Code Ann. § 25-3-101. Pursuant to Act 234 of 2017, funds were appropriated to the department for grants/aid and other heritage programs, to be payable from the Arkansas Department of Heritage Fund Account and funded by the conservation tax levied by Amendment 75.

5. DEPARTMENT OF HUMAN SERVICES, COUNTY OPERATIONS (Dave Mills)

a. SUBJECT: Medical Services Policy Manual Sections E-600 through E-670 and Appendix R

DESCRIPTION: E-600 through E-670 are new sections of policy that implement the Achieving a Better Life Experience (ABLE) Program in Arkansas. An ABLE account is a tax-advantaged account that an eligible individual can use to save funds for the disability-related expenses of the account's designated beneficiary. $100,000 of the balance of funds in an ABLE account can be excluded from the resources of the designated beneficiary when determining eligibility for Medicaid.

Appendix R has been revised to include the ABLE Account Annual Contribution/Exclusion Limit.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on August 11, 2017. The Department received no public comments.

Rebecca Miller-Rice, an attorney with the Bureau of Legislative Research, asked the following questions to which Mr. Mills, DHS/DCO Program Administrator, responded:

(1) Are these the only rules that will be promulgated for the ABLE program? **RESPONSE:** I believe there will be other rule changes promulgated by the State Treasurer's Office regarding implementing and maintaining the actual ABLE accounts. Emma Willis of the State Treasurer's Office can provide clarification on this issue.
RESPONSE FROM MS. WILLIS: At the present time, there are no plans to promulgate any rules specific to the ABLE accounts by the State Treasurer's Office; because the accounts are accounts similar in nature to 529 accounts, they will operate under the current 529 regulations of the Office.

(2) Under Arkansas Code Annotated § 20-3-105(c), the ABLE Program Committee is charged with adopting the necessary rules, with the Committee being made up of DHS, the State Treasurer, and Arkansas Rehabilitation Services. Was the Committee consulted on these rules?
RESPONSE: As previously stated, I am a member of the ABLE Program Committee and the Committee was consulted and is aware of these rules.

(3) Is DHS pursuing promulgation on the Committee's behalf?
RESPONSE: DHS is pursuing promulgation of the Medicaid policy portion of the ABLE account rules on the Committee's behalf.

The agency states that CMS approval is not required for this rule. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: For the current fiscal year 2018, the cost to implement the rule is $2,052,493 ($603,843 in general revenue and $1,448,650 in federal funds); and $2,816,128 for the next fiscal year 2019 ($820,338 in general revenue and $1,995,790 in federal funds).

Since there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined, the Department provided the following information:

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

The proposed rule change will establish the Achieving a Better Life Experience (ABLE) program in Arkansas. The ABLE account is a tax-advantaged account that an eligible individual can use to save funds for the disability-related expenses of the account's designated beneficiary. ABLE account funds up to a $100,000 limit will be disregarded as a resource when determining Medicaid eligibility.

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

The ABLE account is a tax-advantaged account that an eligible individual can use to save funds for the disability-related expenses without losing their Medicaid eligibility. The proposed rule is required by federal statutes Public Law 113-295(529A) and SI 01130.740, as well as, Arkansas Code 20-3-105(b).

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule:

The proposed rule is required by federal statutes Public Law 113-295(529A) and SI 01130.740, as well as, Arkansas Code 20-3-105(b).

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs:

Implementation of an ABLE account will allow an eligible individual to save funds for disability-related expenses without losing their Medicaid eligibility and will allow the state to comply with federal statutes Public Law 113-295(529A) and SI 01130.740, as well as, Arkansas Code 20-3-105(b).

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule:

N/A

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule:

There were no alternatives proposed.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response: and

N/A

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

The Agency in compliance with ACA 25-15-204 will review the rule every 10 years.

LEGAL AUTHORIZATION: The instant rules establish the Achieving a Better Life Experience ("ABLE") program in Arkansas as required to comply with **Act 1238 of 2015**, Pub. L. No. 113-295(529A), and SI 01130.740. Arkansas Code Annotated § 20-3-105(c) provides that the ABLE Program Committee shall adopt rules necessary to administer the ABLE Program Act ("Act"), codified at Ark. Code Ann. §§ 20-3-101 through 20-3-113, and to ensure compliance with the ABLE Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295 and federal regulations under the act. *See also* Ark. Code Ann. § 20-

3-105(a) (providing that the Act shall be administered by the ABLE Program Committee, composed of the director of the Department of Human Services, the director of Arkansas Rehabilitation Services of the Department of Career Education and Workforce Development, and the Treasurer of State, or their respective designees); Ark. Code Ann. § 20-3-105(d)(2) (also providing that the Committee shall adopt rules for the general administration of the program). Rules under the Act shall ensure that: (a) a rollover from an ABLE account does not apply to an amount paid or distributed from the ABLE account to the extent that, not later than the sixtieth day after the date of the payment or distribution, the amount received is paid into another ABLE account for the benefit of the same designated beneficiary or an eligible individual who is a member of the family of the designated beneficiary, but this limitation does not apply to a transfer if the transfer occurs within twelve (12) months after the date of a previous transfer under this subchapter for the benefit of the designated beneficiary; (b) a person may make contributions for a taxable year for the benefit of an individual who is an eligible individual for the taxable year to an ABLE account that is established to meet the qualified disability expenses of the designated beneficiary of the account; (c) a designated beneficiary is limited to one (1) ABLE account; (d) an ABLE account may be established only for a designated beneficiary who is a resident of Arkansas or a resident of a contracting state; and (e) other requirements of this chapter shall be met. *See* Ark. Code Ann. § 20-3-106.

6. <u>DEPARTMENT OF HUMAN SERVICES, DEVELOPMENT DISABILITIES SERVICES</u> (Melissa Stone)

a. <u>SUBJECT</u>: CHMS Medicaid Provider Manual, DDTCS Medicaid Provider Manual, CHMS State Plan Amendments, DDTCS State Plan Amendments, DDS Standards for Certification, Investigation, and Monitoring

<u>DESCRIPTION</u>: DDS is the lead agency for CHMS and DDTCS programs in Arkansas. As such, DDS is responsible for overseeing the programs and certifying and monitoring DDS center-based services. These changes modify the CHMS Medicaid Provider Manual, the DDTCS Medicaid Provider Manual, the State Plan for CHMS and DDTCS programs, and the DDS Standards for Certification, Investigation and Monitoring. DDS proposes the following changes to all of the documents:

1. Incorporating the annual Independent Assessment for beneficiaries receiving DDTCS or CHMS.

2. Changing eligibility requirements for DDTCS and CHMS services to require the Independent Assessment.

In addition to the above changes, DDS proposes the following changes to the CHMS and DDTCS Medicaid Provider Manual:

1. Revise information regarding Part C of the Individuals with Disabilities Education Act (IDEA).

2. Revise information regarding Part B of the Individuals with Disabilities Education Act (IDEA), including election to opt-in or opt-out to provide or not provide special education related services in accordance with Part B to all children with disabilities it is serving aged three (3) until entry into kindergarten.

3. Heighten staff to beneficiary ratios in the classroom setting.

The DDS Standards for Certification, Investigation and Monitoring were also updated to incorporate the requirement for weekly progress notes, at a minimum.

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

Question: Please talk about the new DDTCS plan. Ratio staff to consumer, etc.
Response: The DDTCS Manual details the changes, as does the summary.

Question: We have heard a rumor that special education classes will no longer exist under new plans.
Response: Special Education continues to be the responsibility of the Department of Education.

I am writing in regard to changes in the DDTCS/CHMS manual, specifically DDS-Stnds-Redline.doc, CHMS-2-17up.doc, and DDTCS-2-17.doc.
Comment: Let me begin by stating that I have two vested interests in these changes. I have a great-niece and great-nephew who have received services at the Community School of Cleburne County (CSOCC). I know firsthand the critical work that is done in the lives of small children to ensure that they have the best possible opportunity to develop necessary skills for a successful transition to public school kindergarten.

As a former kindergarten teacher in the Russellville Public Schools, I am fully aware of how imperative it is that proper and thorough evaluations be conducted in order to assure each child of a correct assessment of skills

and needs, so that these can be adequately addressed throughout the school year. In my particular case, we conducted a "screening" process for each child entering kindergarten that lasted approximately 90 minutes and included assessments by no less than five certified personnel and a Registered Nurse.

Additionally, the parents were interviewed so that a fair assessment of home life, background information (such as childhood illnesses, allergies and special physical needs) and more could be conducted. We compiled all of this information and met as a group to discuss our findings and create a written report on the children that was then given to our principal, so that a fair match could be made between these students and the teachers who would guide them through their kindergarten year.

Not only was this in-depth assessment conducted for every child entering kindergarten, but each person who was involved in this evaluation process received approximately 20 hours of training specifically for this setting. Many of us already possessed Master of Education degrees in Early Childhood Education and/or Educational Administration. But we still sat through extensive training just for this specific exercise.

Here are my concerns with regard to the changes I am seeing in these documents:

1. I am not certain WHO will be conducting this "screening"; however, it appears that it likely will be a "third party." Will these persons be properly trained to make such an assessment? Will they be certified educators who have received additional training in how to evaluate the needs of children – especially those who may have specific physical, mental, verbal and developmental challenges – both readily observable and covert?
Response: The contract requires the Assessment vendor to hire assessors that meet the following qualifications: (1) two years of experience with the DD/ID population, and (2) meet the requirements of a Qualified Developmental Disability Professional (QDDP). The vendor will be conducting training of each hired assessor. This vendor, Optum, has conducted assessments in many other states and is familiar with the assessment process and how to train assessors.

Will this "screening" be thorough and given the proper time necessary to fully evaluate the child's needs? Will someone visit with the parents and assess background information, such as housing situations, family dynamics, history of possible abuse and neglect, etc.
Response: The screen will be the Batelle Developmental Inventory-2, and will be used to determine if the child needs to receive a full evaluation at the CHMS/DDTCS facility. Parents may be present when the screen is conducted, if they are available.

2. Where will this "screening" be conducted? It is my understanding that many of the clients at the CSOCC must be physically collected and transported to the school for the evaluations that are presently administered. Clearly, if the testing takes place in another city – Conway, Searcy – or even Little Rock – there will be many potential clients who will be unable to make arrangements to attend – and by default, the child will not even be assessed for possible habilitation.
Response: The vendor, Optum, will work with the CHMS or DDTCS coordinating the screen, as well as the parents of the child being screened, to accommodate their preferences for location. We anticipate that most of these screens will occur at the CHMS or DDTCS location. Optum will have assessors located throughout the state and those assessors will be traveling to the city or town where the child resides; it is not expected that the parent needs to travel to a centralized location.

3. If an adequate amount of time is not given to the "screening" many children could potentially be eliminated or mistakenly evaluated based on a few minutes of quick judgment. Any child can have a "good day" for a few minutes – but if given time to warm up and settle in, he/she may present completely differently. I know of one child who screamed and was so terrified during his initial screening that many of the evaluations could not be done. He had to return another time for all tests to be completed fairly and thoroughly. Would he be eliminated as "uncooperative" under the new system?
Response: The screen will not eliminate a child as "uncooperative." The screen is similar to the process used now by many facilities to determine if a child needs a full evaluation for services. The assessor will be trained in how to conduct the assessment to ensure accurate results.

4. Any time you involve Primary Care Physicians, you add yet another layer of "red tape" to the process and risk children getting lost in the shuffle. What if the PCP does not respond quickly and with the proper information? How will the institutions know what has/has not been determined? HIPPA laws prevent representatives of these institutions from asking for – and receiving – much of the needed information. The potential for children to slip through the cracks looms large, in my opinion.
Response: The current process requires a physician to refer a child to a DDTCS or CHMS for an evaluation and services. The screening will not add a new layer to that requirement. If the child is referred for the screen and evaluation by the physician and the screen shows the child needs a full evaluation, then the CHMS or DDTCS may perform that full evaluation. Just as they do now, they will need to send that

evaluation (and the results of the screen) to the physician for a prescription for services. This is a Medicaid service, and under the federal regulations it must be "medically necessary," therefore the physician does need to be involved in the process.

5. If children are denied services at schools like the Community School of Cleburne County and Easter Seals – what then? How will these children receive the necessary tutelage to prepare them for entrance into public school kindergarten? I can assure you that the last thing our kindergarten teachers need is an influx of students with needs that require physical, occupational and speech therapies, behavior modification, and other highly-skilled remediation for which they are not adequately trained – all while trying to meet the educational needs of the other students in their classroom.
Response: The goal of the screen is not to deny children needed services, but to ensure that children receive those services in the least restrictive setting possible, which is best practice. If a child is better served in a regular daycare with physical therapy, occupational therapy, or speech therapy services, then this is the setting the child should be in.

6. Finally, this appears to be a plan that will only serve to harm those who are in lower socio-economic brackets – those who cannot afford private therapies and daycare programs – especially those that would provide the necessary therapies and remedial services necessary to ensure that these children enter public school kindergarten on any semblance of a level playing field with their peers. This will add yet another burden to these children AND the public school teachers who serve them.
Response: Please see the answer immediately above.

Question: Terminology regarding the 3rd Party Vendor functions for children ages 3-entry in kindergarten needs clarification. Will they conduct only screening or will they conduct comprehensive assessments? There are references to independent assessment in this manual, but it has been my understanding that Optum will only be doing screening for children ages 3-entry in kindergarten.
Response: Optum, the third party vendor, will conduct developmental screens, specifically the Batelle Developmental Inventory-2, on children who are referred to the DDTCS or CHMS program. These screens will determine whether a child should receive a full evaluation by the DDTCS or CHMS for services.

Question: Will there be another review and comment to consider a Manual for the merging of DDTCS and CHMS? Will DDS Standards for Certification, Investigation and Monitoring be revised again to address the merger?

Response: This Rule change does not include the DDTCS-CHMS successor program. We anticipate that the rules and manuals for the successor program will be put out for public comment in early 2018.

Question: The level of service for any child should be based on the needs of the child. The specific needs of the child should be outlined in the IPP through the goals/objectives of the IPP. The goals/objectives should be determined based on the results of the evaluation procedures. Should the physician not use this information to determine the level of services? Results of screening procedures will not provide sufficient detail to determine how much service a child needs or what goals/objective should be included in the IPP. If a child passes a screening and the physician feels evaluation procedures are needed, can the physician still refer for evaluation?
Response: Based on conversations with providers, we have determined that the developmental screen will determine whether a child should receive a full evaluation by the DDTCS or CHMS. If the child does receive a full evaluation, that evaluation, along with the results of the screen will be sent to the physician for a prescription for services.

Question: The Manuals address retrospective reviews of speech, occupation and physical therapy. Is there a review of day habilitation to ensure appropriate eligibility instructional content, implementation and progress?
Response: Yes, for all CHMS services prior approval is required. All other services are subject to retrospective review.

Question: There is no mention anywhere regarding a requirement of an agreement with the LEA for programs that Opt-Out for the provision of special education.
Response: There is no requirement for a program that elects to opt-out to enter into an agreement with the LEA for the provision of special education services. The only requirement is that programs electing to opt-out must deliver the required referrals to the appropriate LEA. DDS would highly encourage programs that opt-out to attempt to enter into agreements with LEAs for the provision of special education services; however, DDS cannot require LEAs to enter into such contracts.

Question: How will DDS know how many children are served by providers, who the children are, and what services they receive? To my knowledge, there is no requirement for providers to submit this data to the DDS.

Response: This information is contained in claims data submitted through MMIS and housed in the Data Support Solutions (DSS) warehouse.

Question: The procedures for Opt-In/Opt-Out for DDS providers for the provision of special education services have not been developed at this time. It is my understanding providers will be required by March 1, 2018, to make a declaration of intent with regard to the provision of special education services.
Response: DDS will provide more information on how a facility can opt-in/opt-out of providing special education services on or around January 1, 2018.

Question: There is nothing to indicate that sanctions can be imposed for non-compliance for providers that Opt-In for the provision of special education services.
Response: The manual specifies that the facility can lose Part B funds if it fails to comply.

Question: Will these Standards be revised at which time the Medicaid Manual for the EDIT (merger of DDTCS and CHMS) is developed and out for comment and review and the Opt-In/Opt-Out procedures have been developed?
Response: This Rule change does not include the DDTCS-CHMS successor program. We anticipate that the rules and manuals to the successor program will be put out for public comment in early 2018.

Question: What happens on October 1? Will children that are already enrolled be grandfathered in under their current enrollment until it expires?
Response: Yes, current enrollees would not be expected to meet the new eligibility criteria or undergo an independent assessment until their plan of care date expired.

Question: For CHMS/Diagnosis/Evaluation Services, this section has nothing to do with day treatment eligibility. This is the section of the manual that allows CHMS providers to provide diagnostic testing for children regardless of whether they want to enroll in day treatment. Add language that says this section does not apply to day treatment eligibility.
Response: Agreed.

Question: Language in 203.100(D)(4) says that PCP referral is for 6 months, but the IA is good for 12 months. This needs to be changed.
Response: Agreed, this will be clarified.

Question: In Section 212.000, CHMS Providers do not agree that the state can change the original intent of the screening for physician referral to a full eligibility determination. We will be having legal counsel review the process to ensure this is possible. If it is determined that the state does have the right to make this change, we are asking for the responsibility of coordinating the process of sending the child for the screening. See separate proposal about why providers should send for screening instead of physicians.
Response: We do agree that both CHMS and DDTCS facilities are better equipped to coordinate the developmental screen process and will clarify the language in the manual to reflect that.

Question: We are asking DDS to remove language that says they qualify for at least one hour – they are either eligible or not.
Response: Agreed.

Question: In section 213.200, regarding the ECDS, it currently reads, "12 hours of completed college courses in 'one' of the following." We recommend that it be changed from "one" to "any" of the following areas. So, they can be combined from the different areas. Also, we need 1 – 50 ECDS per child. We don't need the 1 – 30 ECDS to child. That is a Department of Education standard for writing up IPPs.
Response: We agree with these comments as first steps to increasing the qualifications for an ECDS.

Question: We would like ratios changed back to what we presented in our original manual changes. CHMS providers still have core service requirements to provide therapy and nursing, so children will be in and out of the classroom all throughout the day OR the therapist and/or nurse is in the classroom providing services to the children. The ratios below are more appropriate for our services because of the extra required on-site professionals in the classroom throughout the day.
We recommend:
0-18 months 1 to 4
19-36 months 1 to 7
3-6 years 1 to 10
Class size needs to remain twice the current CCL ratios. Otherwise, programs will have to reduce their capacities and discharge children that still qualify on the first day the new manual goes into effect. Families will have to find immediate placement elsewhere. Not to mention, providers built facilities based on the rules that were in place at the time. And, as long as they meet ratios should be able to keep maximum class sizes. What is the timeline for meeting the new ratio criteria? These manuals will be promulgated days before October 1. It may take longer than a couple of weeks to get new staff hired and in place.

Response: The ratios have been considered and discussed. Because of the high needs of this population, we believe the stricter ratios that are currently used by DDTCS providers should be followed.

Comment: Eligibility should read:
Child Health Management Services are delivered to those children with the most significant medical and/or developmental diagnoses and those presenting with multiple/complex conditions. In addition to the developmental screening, children enrolling in CHMS services are required to meet one of the following criteria:
A. Frequent nursing services;
B. Close physician monitoring (availability for consultation in addition to frequent face-to-face contact);
C. Special nutritional services requiring consultation with parents and staff and/or possible special menu planning and adapted feeding regimen;
D. Constant coordination of care (in communication with the PCP) within the interdisciplinary team to maximize provision of individual services and appropriate therapy services and
E. Additional family contact for education and support.
F. Therapy services from at least one discipline (occupational, physical, or speech).
If this eligibility is remaining, then AFMC and providers must be given clear objective criteria to meet in order to prior authorize B, C, D, and E above so children can enroll under these areas. CHMS providers have never been able to get a PA approved for any of those line items due to lack of objective criteria.
Response: Agreed.

Comment: It is my understanding that children enrolling into CHMS also meet eligibility for CHMS by meeting the definition of DD determined in this section and that the eligibility screening testing will give us the scores for the children to qualify based on A. 2. c and d. Does A. 2. A (intellectual disability) work for CHMS for our current cognition testing?
Response: The child's diagnosis and the results of the developmental screen can be used to establish whether the child meets this definition, in addition, if CHMS performs testing that would show a delay in two of the five domains, that testing can also be used to establish eligibility.

Question: In second paragraph of section 218.300, the end needs to say: "physician's prescription, which authorizes day treatment."
Response: Agreed.

Comment: Why do we need a PA if we are getting an eligibility determination? The PA will be verifying the work of the third party developmental screener. Although I know we have to keep a PA number

because cannot make any code changes in MMIS at this time, DDS and AFMC could find a way to do a verification to provide a PA # that would be similar to what they are doing with the therapy PA's. CHMS providers are also asking if we can have the annual PA'd cap on our day treatment codes removed. In July 2016, our day treatment codes were put under daily caps. As of that date, our day treatment codes have been under both a daily cap and an annual cap. If we cannot remove the daily caps because of a CMS decision due to NCCI edits, then we ask that the annual caps can be removed. Both caps put too much restriction on our day treatment codes.
Response: At this time, no MMIS changes can be made. We are looking at ways to change the PA process for CHMS facilities next spring/summer when the new MMIS system has stabilized.

Comment: Add back the parent interview code for psych (90791 U1 & U9).
Response: Agreed.

Comment: In Section 218.200 /Individual Treatment Planning:
"For those children receiving day treatment services on a daily or weekly basis, the individualized treatment plan will be written for a period of 12 months and will be updated as needed. The treatment plan for children birth to 3 years of age may be in the form of the state accepted Individualized Family Services Plan (IFSP)." The IFSP is a federal Part C requirement. The plan for infants and toddlers enrolled in programs outside of Part C must be called something else.
Response: Agreed.

Comment: In Section 205.000 / Referral to First Connections Program Pursuant to Part C of the Individuals with Disabilities Education Act (IDEA):
Federal regulations under Part C of the IDEA require "primary referral sources" to refer any child suspected of having a developmental delay or disability for early intervention services. A CHMS is considered a primary referral source under Part C of IDEA regulations.

Infants and toddlers are referred to a CHMS by a primary referral source, and the CHMS serves as an alternate form of early intervention not recognized under IDEA. Federal regulations do not describe, identify, or define segregated service settings, so a CHMS is not identified as a primary referral source in the IDEA.
Response: Agreed.

Comment: Each CHMS must, within two (2) working days of first contact, refer all infants and toddlers from birth to thirty-six (36) months

of age for whom there is a diagnosis or suspicion of a developmental delay or disability.

The referral must be made to the DDS First Connections Central Intake Unit, which serves as the State of Arkansas' single point of entry to minimize duplication and expedite service delivery. Each CHMS is responsible for maintaining documentation evidencing that a proper and timely referral to First Connections has been made.

It is burdensome and confusing for families as well as a duplication of efforts to refer children already receiving CHMS services when Part C services cannot be provided in conjunction with day habilitation services and families must choose one program or the other.

Preferred: Each CHMS must, within two (2) working days of receipt of referral of an infant or toddler thirty-six (36) months of age or younger, present the family with DDS-approved information about the Part C program, First Connections, so that the parent/guardian can make an informed choice regarding early intervention options. Each CHMS must maintain appropriate documentation of parent choice in the child record.
Response: Agree that the preferred language is more appropriate.

Comment: I am concerned about the lack of details, such as what type of screen this will be. How can a short screen determine whether my child's functionality would benefit from day habilitation? Also, I ask for the credentials of the people performing the screen to be qualified clinicians. I'm concerned that parents and physicians need training to ensure that disruption in services does not occur. I am concerned that in opting out, a parent must relinquish the child's IDEA rights for as long as the child attends that center and/or as long as that center chooses to be opted out. On top of that, I'm concerned that services could be disrupted, especially if a parent chooses not to relinquish those rights and must find another place of service. Also, this may remove the freedom of choice for the parent if there is not another place of service nearby. Last, I'm concerned that disruption of services might occur as a child is transitioned into the school system.

I'm concerned that parents, therapists, educators, and advocates need training to ensure that disruption in services does not occur.
Response: The screen will be the Batelle Developmental Inventory-2, and will be used to determine if the child needs to receive a full evaluation at the CHMS/DDTCS facility. Parents may be present when the screen is conducted, if they are available.

Comment: DDTCS Medicaid Manual – I support the implementation of an independent screen completed by DHS third party vendor to determine eligibility of children for referral for day habilitation/treatment services.

Comment: DHS is proposing the requirement of a developmental screen in order to determine eligibility for Child Health Management Services and Developmental Day Treatment Clinic Services. This developmental screen is in addition to the current prescription/ referral by the beneficiary's primary care physician requirement. Though a particular screening tool is mentioned in the Independent Assessment Manual, there is no commitment to using that tool and no other information provided on what the developmental screen would capture that would be different or somehow an enhancement to the information that is already being provided by a beneficiary's primary care physician.

Our concern regarding a new requirement of a developmental screen before a beneficiary begins to receive services, even though the beneficiary has already received a prescription for services from his or her primary care physician, is that it could lead to a delay in very important intervention services. DRA recommends that DHS provide additional information regarding the specific developmental screening tool and information sought by the screen, as well as timelines for completing, to ensure that the screen does not delay access to services and so that beneficiaries can meaningfully comment on this proposed change.
Response: The screen will be the Batelle Developmental Inventory-2, and will be used to determine if the child needs to receive a full evaluation at the CHMS/DDTCS facility. Parents may be present when the screen is conducted, if they are available.

Comment: The manuals for both the Child Health Management Services and Developmental Day Treatment Clinic Services both have proposed language included for referrals and provision of special education services pursuant to the IDEA. In reviewing, it appears that the information included in the DDTCS manual actually includes the language from the CHMS manual and was not amended to reflect the DDTCS language. DRA recommends that DHS review and revise as necessary. Otherwise, DRA believes it is important for DHS to add the IDEA requirements to the manuals and to include the very important information regarding identifying children as soon as possible in order to provide access to early intervention services. It is helpful for both CHMS and DDTCS settings to understand their obligations when it comes to these services in addition to the obligations of the Local Educational Agency. Furthermore, the inclusion of timelines for not only providing services while in a CHMS or DDTCS setting but also for referrals in preparation of entry into the public school setting will help to ensure that proper transition planning and continuity of services will occur.

Response: Medicaid funded programs must be based off of medical necessity. IDEA is based on educational necessity. Therefore we cannot include requirements that are based exclusively on educational necessity.

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

FINANCIAL IMPACT: Refer to the Financial Impact Statement for the Independent Assessment, as it incorporates the financial impact of requiring the developmental screen for all DDTCS/CHMS beneficiaries.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 20-76-201, the Department of Human Services ("the Department") shall administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it. *See* Ark. Code Ann. § 20-76-201(1). The Department shall also make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76, Public Assistance Generally, of the Arkansas Code. *See* Ark. Code Ann. § 20-76-201(12).

b. SUBJECT: DDS Policy 1076 - Appeals

DESCRIPTION: DDS operates five (5) Human Development Centers, a Medicaid waiver that offers home and community based services, and a variety of community programs and services. DDS Policy 1076 provides the process for appealing decisions made by DDS regarding all of the programs it operates.

Policy 1076 was amended to reflect the appeals procedure in the Medicaid Provider Manual. Pursuant to this manual, all reconsiderations and appeals of DDS decisions shall be made in accordance with the Administrative Procedure Act, the Medicaid Fairness Act, and the Medicaid Provider Manual.

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

Comment: The existing policy includes very specific information regarding timelines for appeals, how to file appeals, and the appeals process for various DDS Programs. The proposed policy eliminates that information. Unless the information is shared with consumers in another

format, beneficiaries will have difficulty accessing information necessary to challenge the State action. DRA recommends that DDS provide clear information to beneficiaries on their rights to challenge adverse actions in an easily accessible format if it will not be included in Policy 1076. In addition, the changes to Policy 1076 make it seem as if an appeal to the DDS Director or designee for reconsideration is the first step in the appeals process, which is vastly different than a beneficiary's rights under the existing policy. DRA recommends clarification on this issue so that beneficiaries are aware of their rights to appeal adverse decisions and to request hearings, when and if appropriate.
Response: We agree with your point and will go into greater detail with clients when apprising them of their appeal rights.

The agency states that CMS approval is not required for this rule. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Pursuant to the Arkansas Administrative Procedure Act ("APA"), codified at Arkansas Code Annotated §§ 25-15-201 through 25-15-219, an agency shall adopt rules of practice setting forth the nature and requirements of all formal and informal procedures available. *See* Ark. Code Ann. § 25-15-203(a)(2). Likewise, Ark. Code Ann. § 20-77-1716 permits the Department of Human Services ("Department") to promulgate rules to implement the Medicaid Fairness Act ("MFA"), codified at Ark. Code Ann. §§ 20-77-1701 through 20-77-1718. Within the MFA, the General Assembly clarified its intent that providers have the right to fair and impartial administrative appeals and emphasized that the right of appeal was to be liberally construed and not limited through technical or procedural arguments by the Department. *See* Ark. Code Ann. § 20-77-1704(a). In accord with the MFA, a provider appeal shall be governed by the APA, unless otherwise provided in the MFA. *See* Ark. Code Ann. § 20-77-1704(b)(1)(B)(i). *See also* Ark. Code Ann. § 25-15-213 (concerning hearings, generally, under the APA).

c. SUBJECT: Human Development Center (HDC) Admission and Discharge Rules Policy 1086

DESCRIPTION: DDS operates five (5) Human Development Centers (HDC) for individuals with intellectual/developmental disabilities. As the operational agency, and by delegation from the DDS Board, DDS proposes the following changes to the HDC Admissions and Discharge Policy (Policy 1086):

1. Require that individuals entering an HDC or being discharged into Home and Community Based Settings undergo an Independent

Assessment for functional needs in accordance with the Independent Assessment Manual.

2. Update the Categorically Qualifying Diagnosis to include Spina Bifida and Down Syndrome so that it reflects the definition established by Ark. Code Ann. § 20-48-101.

3. Incorporate the level of care criteria used by the psychological evaluation team to assess whether someone meets the institutional level of care. This is the criterion that is currently being used to assess level of care need for an HDC.

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

Comment: Section II(a)(3) of the policy discussed the use of an Annual Status review for HDC residents which would, in part, be used to determine continued eligibility for HDC services. There is no mention of what role, if any, the new Independent Assessment will fill as part of the residents' annual review, or if residents will be re-assessed periodically. The Independent Assessment will be used to screen all prospective incoming residents for eligibility, but will not be applied retroactively to the individuals currently residing in the centers. It is unclear if current residents will be assessed moving forward as part of their annual review, or if they will be exempt from the Assessment in perpetuity.
Response: Only clients who are transitioning into or out of an HDC will be required to receive an independent assessment. Current HDC clients will be exempt from the IA requirement unless they choose to transition into the community. They will continue to meet annual long-term care eligibility requirements.

Comment: Under Section II(e)(3) of the policy, which deals with criteria for discharge from the centers, it states that "[e]ven without a request for discharge, an HDC Superintendent must discharge an individual upon determination by HDC professionals that that individual is no longer eligible for admission or retention." More clarity is needed with regard to how the use of the new Independent Assessment tool will affect HDC eligibility moving forward, and what the process will be for any residents of the centers who are determined to no longer qualify for Tier 3 services.
Response: The IA will not be used on current HDC clients. The manuals clearly outline the process of how this tool will be used on incoming HDC clients.

Comment: There is also no mention of how the Independent Assessment will apply in the case of Emergency Referrals. In circumstances in which

an individual is assessed at Tier 2 but requires an emergency admission, it is unclear whether that assessment will disqualify them from receiving those emergency services or whether they will be provided with respite care and not be formally admitted. Again, more clarity in the rules on this issue is needed.
Response: Respite care will be available upon need. There is a provision for assessment after emergency placement.

The agency states that CMS approval is not required for this rule. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: Please see the financial impact statement accompanying the Independent Assessment Manual which details the total cost of incorporating the Independent Assessments, including the costs associated with the HDCs utilizing the assessment.

LEGAL AUTHORIZATION: With respect to human development centers, the Board of Developmental Disabilities Services ("Board") "is charged with the care and training of mentally defective individuals." Ark. Code Ann. § 20-48-403(b). The Board "may make such regulations respecting the care, custody, training, and discipline of retarded individuals in the centers or receiving mental retardation services and respecting the management of the [human development] centers and their affairs as it may deem necessary or desirable to the proper performance of its powers and purposes." Ark. Code Ann. § 20-48-205(b). *See also* Ark. Code Ann. § 20-48-415(i) (providing that the Board "may make such rules and regulations respecting the care, custody, training, and discipline of individuals admitted to the [human development] centers and the management thereof and of its affairs as it may deem for the best interest of the centers and the State of Arkansas"). The Board is further permitted to delegate to the Deputy Director of the Division of Developmental Disabilities Services of the Department of Human Services any powers of the Board upon such terms and for such duration as the Board shall specify. *See* Ark. Code Ann. § 20-48-210(e).

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

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

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

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

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

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

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

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

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

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

Comment: Please clarify 'current state,' 'future state,' and changes for 1) care coordination staffing including case managers, direct care supervisor (DCS), 2) related fees for the services, and 3) responsibility for plan of care between current providers such as DD waiver case management, DCSs, and PASSEs.
Response: Under the PASSE care coordination model, all case management/care coordination activities will be done by the PASSE care coordinator. To ensure continuity of service and consistency, we have changed the definition of case management in the CES waiver and changed the name of it to care coordination. The current case managers will provide care coordination as it is defined in the CES waiver to their clients until such time as those clients are attributed to a PASSE. Then the PASSE will take over providing care coordination.

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

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

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

Question: The DDS Director said that case management and supportive living cannot be done by the same person. How are companies that have done away with case management handling health and safety issues? Including monthly visits? Specifically, for pervasive level of care clients?
Response: The language is clarified to reflect that the PASSE will comply with conflict free case management, which involves several components: assessment of an eligible individual (42 CFR

440.169(d)(1)), development of a specific care plan (42 CFR 440.169(d)(2)), referral to services (42 CFR 440.169(d)(3)), and monitoring activities (42 CFR 440.169(d)(4)). We have stated that the PASSE entity will comply with the overall federal regulation.

Question: If a consumer is pervasive level of care with inclusive opportunities for independence, how will that affect the change within the PASSE?
Response: Under the PASSE model, individuals currently classified as Pervasive level of care are until they are assessed being assigned Tier 2, which is the highest level of need (24 hour paid services and supports). This does not negate the ability for services and supports being provided in inclusive settings that offer maximum opportunities for independence.

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

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

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

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

Two (2) years' verifiable successful experience working with individuals with developmental disabilities."

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

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

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

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

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

Question: Why is rent expected to be one set fee among all? Consumers receive different amounts; why should one that gets $750 a month have to

have a rule that they will pay the same as the one that receives $1200 when they can't afford anything extra as it is now?
Response: DDS does not set rates for rent.

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

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

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

Comment: This section deals with the requirements for a beneficiary's Person Centered Service Plan (PCSP). It states that "The beneficiary (or, if applicable, their legal guardian) must be an active participant in the PCSP planning and revision process." DRA would like this language revised to state "The beneficiary **(and,** if applicable, their legal guardian)." This will ensure that the beneficiary always is considered a participant, even if they have a guardian. The language as written suggests that a beneficiary with a guardian may not be an active participant. Even a beneficiary with a guardian should have the right and opportunity to be an active participant in this process, which the suggested amended language supports more clearly.
Comment: This section contains the language: "If the beneficiary or their legal guardian objects to the presence of any individual at the PCSP development meeting, then the individual is not permitted to attend." DRA recommends that language be included to address situations where the beneficiary and guardian's wishes are in conflict. For example, the following language could be included: "If the wishes of the beneficiary or guardian are in conflict as to persons attending the meeting, the

preferences of the beneficiary will be given primary consideration and take precedence where there is no compelling health and safety reason."
Response: DDS asserts that items regarding guardians will depend on the specifics listed in the actual guardianship order. Because of this, no blanket response can be made.

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

Comment: Section 706(C):
This section discusses the required contact by a care coordinator with a beneficiary while their waiver status is in abeyance. We are concerned about the issue of in-person contact with the beneficiary. When a beneficiary is in the community, the standards require that a care coordinator make monthly contact with the beneficiary, with at least one in-person visit per quarter. However, under the standards, during the period of abeyance when a beneficiary is placed in a licensed or certified facility for up to 90 days (with possible renewal), the care coordinator is required to only "have a minimum of one (1) visit or contact each month." This section does not require any in-person contact as currently written. The language of the abeyance section should be changed to clearly state that even though the beneficiary is institutionalized, the care coordinator is still required to make quarterly in-person visits.
Response: This was the intent and the policy has been clarified to reflect your statement above.

Comment: The language is overly broad, does not honor the central premise of a provider-led, risk-bearing model under Act 775, and flies in the face of years of work between providers and DHS, first on health homes and now with the Provider-Led Arkansas Shared Savings Entity (PASSE) model (Act 775). It further fragments an already disjointed service system, and treats individuals with developmental disabilities differently than those receiving treatment for mental health or substance

abuse. There is nothing in federal law that requires DHS to take the approach contained in the draft rules.

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

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

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

Practical problems with the proposed rules.

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

Under the draft language being promulgated, the PASSEs could contract with DD case managers at Pathfinder, but those case managers would not be able to coordinate care for Pathfinder clients. Instead, they would have

to coordinate care for clients at Easter Seals, Friendship, or UCP, etc., with whom they have no relationship. Conversely, case managers from Easter Seals, Friendship, or UCP would have to coordinate care for Pathfinder clients, and vice versa. The same scenario plays out all over the state.

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

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

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

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

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

For a number of years now, some states have placed requirements on managed care organizations to deliver case management services without conflict in their state MCO contracts for managed long term services and supports (LTSS). We are not opposed to this type of arrangement;

however, it should not be the overly broad approach laid out in these proposed rules. We believe the approach we have designed for our PASSE more than meets the requirements of the law while remaining true to the provider-led nature of Act 775.

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

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

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

We have recommended in the past that the Independent Assessment tool, in this case MnCHOICES, be used to provide a basic plan to fulfill this function, and then the direct service provider would use this tool to provide a more detailed care plan with services, staff, and schedules

within the budget approved by DHS. (This appears similar to the approach taken in Minnesota. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_172354. We still believe this is a good approach that will bring the state into compliance. Alternatively, the CMS final Managed Care Rule does not prohibit the MCO/PASSE from performing this function.

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

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

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

Other examples:

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

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

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

C.9. "determine whether the person is receiving appropriate support in the management of medication." – Yet, the Care Coordination section lists "Medication management plan" as a care coordinator responsibility. (It also says the care coordinator is responsible for coordination of

medication management. Does this have some meaning different than the direct care providers' "support in the management of medication"?)
Response: The role of the care coordinator will be to work closely with all service providers, including the supportive living provider if applicable to ensure appropriate services and supports are being provided to the beneficiary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LEGAL AUTHORIZATION: The proposed rule changes incorporate revisions brought about by **Act 775 of 2017**, which created the Medicaid Provider-Led Organized Care Act, to be codified at Arkansas Code Annotated §§ 20-77-2701 through 20-77-2708. Pursuant to Ark. Code Ann. § 20-77-2708, as amended by Act 775, § 1, the Department of Human Services shall submit an application for any federal waivers, federal authority, or state plan amendments necessary to implement the Medicaid Provider-Led Organized Care Act, and it may promulgate rules as necessary to implement the Act. The Department is further required to administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it, and it shall make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76, Public Assistance Generally, of the Arkansas Code. *See* Ark. Code Ann. § 20-76-201(1), (12).

7. DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES
(Paula Stone, items a, b, and c; and Craig Cloud, item d)

a. SUBJECT: The Provider-Led Arkansas Shared Savings Entity Program – Phase I

DESCRIPTION: DHS is promulgating (1) the 1915(b) Waiver Application for the PASSE program; and (2) the PASSE Provider Manual. The 1915(b) Waiver and accompanying Provider Manual will implement Phase I of the Provider-Led Arkansas Shared Savings (PASSE) Program. Under this Waiver, PASSEs will provide care coordination for attributed

beneficiaries with behavioral health and developmental disabilities services needs who are experiencing complex medical, behavioral, and social issues.

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

Comment: Section 213.100, A. – Does this mean, based on the methodology, ANY specialty service provider could be responsible for the Care Coordination – It appears to be more appropriate for this fall to only BH and DD providers? If that is the intent, please clarify in the language.
Response: The provision of care coordination is the responsibility of the PASSE.

Comment: Section 213.110, B. – The visit point methodology appears confusing and is lacking usable information for just one month. Could you consider looking at all services, per provider, in the 12-month period? It would allow an analysis of where the majority of services are being performed.
Response: All services will be looked at per provider over a 12-month period.

Comment: Will this be "cumulative" scoring? Example, if a recipient fell into
Provider class 5
i. Certified Behavioral Health Provider, also
Provider class 4
i. Physician – Primary Care Physician
ii. Pharmacy
Would Specialty points be added as – 5 points for Provider Class 5, yet 4 points each for Provider Class 4? That would give the BH or DD provider only 5 points, while giving Providers in Class 4 – 8 points (4 points each). Or, if the individual saw two or more providers in One Provider Class, would that only count as one point for that Provider Class (EG – if they saw a PCP and Pharmacy, would that count as only 4 points TOTAL)? It is very difficult to follow this system – Is there a way to clarify and simplify?
Response: Points are calculated by provider within each class. A visit to 2 different providers within the same class would count as separate visit points.

Comment: What relevance will Pharmacy costs play in this equation? Are you anticipating evaluating all service and pharmacy costs together? How do you explain or account for the inequitable difference between

pharmacy costs versus the cost and service intensity of BH and DD service/costs.
Response: All service and pharmacy costs will be evaluated together. Behavioral Health and Developmental Disability service providers are in Service Class 5 while Pharmacy providers are in Service Class 4.

Comment: 213.100 – While we appreciate that a lot of thought and effort went into developing this proposed methodology, it does not achieve the policy goals the Department has articulated to us as:

1. Incentivize participation by providers in more than one PASSE.
2. Maintain the relationship between beneficiaries and their primary BH or DD provider.
3. Promote the success of the PASSE model.

The proposed methodology would do just the opposite. As soon as it came out, providers "locked down" because they realized that under this formula if they sign as a participating provider with another PASSE it will split the attribution of their clients, sending a large portion of them to other PASSEs. This is not just our PASSE – as soon as the methodology came out we received a notice from a big provider in another PASSE that in light of the proposed methodology they were withdrawing their earlier agreement to participate in our network.

Our providers want to be able to participate in more than one PASSE, but they believe strongly that their clients should be attributed to the PASSE in which they are part of the 51% ownership. Throughout the development of this model, we have been repeatedly assured that attribution would be based primarily on the BH or DD provider. This is in keeping with the Patient-Centered Medical Home model. The attached paper details our analysis of the methodology and its problems in this context. Our suggestion on how to improve it:

a. If an individual has an established outpatient BH provider or DD waiver provider, then that individual gets attributed to a PASSE in which that provider is a member ("member" meaning part of the 51% ownership, not mere participating provider).

b. If a DD wait list individual has a DDTCS provider, then that individual is attributed to a PASSE in which that provider is a member.

c. For wait list individuals who are not receiving any DD services, we would recommend use of an informed decision-making process for those beneficiaries and families rather than a random assignment, which could result in establishment of a provider and service plan only to be disrupted during the 90-day choice period.

d. Only in the rare cases where a Tier 2 or Tier 3 individual has no established core provider relationship would random assignment to PASSEs be utilized.
Response: We are not making changes to the attribution methodology.

Comment: Section 214.000 – What allowance will be made for the recipients of services whom due to their illness might not be able to even "understand" this concept? Will the BH or DD provider and/or Care Coordinator be able to assist severely disabled BH and or DD recipients with this request? Please clarify how this will be accomplished for the severely disabled client. Same issue as listed above. Chronically mentally-ill individuals will have "no concept" of how to, or if they even need to, do this. How can they be assisted?
Response: DHS choice counselors will assist beneficiaries understanding their participation in PASSEs.

Comment: Section 231.000 – There is currently a restricted number of SA providers in the state. Is there a possibility of extending the network requirements until there are a sufficient number of SA providers in Arkansas? If not – How will this requirement be accomplished?
Response: DHS may allow a variance in standards in geographic areas of the state. With the allowance of Substance Abuse treatment services within the Outpatient Behavioral Health Services (OBHS) program, DHS expects to have more Medicaid enrolled Substance Abuse treatment providers.

Comment: Section 241.000 – The one to 25 ratio may be an ideal practice goal for a care coordinator. However, this will translate into an estimated 4,000 care coordinators required to meet the care coordination needs of projected 30,000 individuals who are projected to be attributed to a PASSE.

This work ratio coupled with the care coordinator qualifications below appears completely unfeasible in the current Arkansas work force environment. How do you anticipate increasing the workforce capacity?

Comment: The rates being offered to PASSEs for care coordination do not reflect any dollars for any service beyond standard service coordination for providers. There are no admin dollars for PASSE operations of functionality, admin staffing, etc. Again, this seems to more closely align with having providers provide care coordination services until January 1, 2019.

Comment: Section 251 Quality Metrics – Section A states caseloads "must be 25 or less." We would recommend enabling the PASSE to determine caseloads, particularly based on prior experience with

stratification and caseloads. Caseloads can vary by severity and individual patient needs. This should be determined by the PASSE who will in very short order be at risk for the population and should best determine appropriate ratios in order to achieve quality outcomes.
Response: DHS has clarified the ratio to no greater than 1 care coordinator to 50 client ratio.

Comment: G. The ratio of 1:25 is too small for this rate. An individual care coordinator may justify a smaller or larger caseload, depending on the care coordinator's experience and the needs of the clients.

Please make it an average of 1:35 so that we can adjust based on client acuity, employee capability, family supports and other circumstances – or more desirable, eliminate the ratio requirement altogether and allow us to manage care coordination as needed to provide the service in the manner prescribed by DHS. A 1/25 ratio for the rate established exaggerates the fact that there not sufficient funds for administrative support funds. Both the rate and the ratio need to be revised to promote care coordination as envisioned in the manual.
Response: DHS has amended the ratio to no greater than 1 care coordinator to 50 client ratio.

Comment: Section 241.000, H – This is an ideal practice concept – but, likely difficult if not impossible to accomplish. Can technology assisted contact be utilized for monthly contact?
Response: After the initial in person face-to-face contact, video conferencing can be utilized to achieve monthly contact with clients for care coordination.

Comment: PASSE APPLICANT recommends face-to-face contact be driven by individualized needs and levels of care coordination.
Response: After the initial in person face-to-face contact, video conferencing can be utilized to achieve monthly contact with clients for care coordination.

Comment: This definition does not align with Act 203 of 2017. The definition should track the Act's language at Ark. Code Ann. § 17-80-402(7), and then later in the manual say how it can be used. Act 203 requires Medicaid and private insurers to "provide coverage and reimbursement for healthcare services provided through telemedicine on the same basis as the health benefit plan provides coverage and reimbursement for healthcare services provided in person." (The service provided via telemedicine must be "comparable" to the same service provided in person.) Ark. Code Ann. § 23-79-1602. Thus, while we commend the Department for recognizing the value of telemedicine for care coordination, it cannot be limited to that use only.

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

Comment: What is the State's specific definition of telemedicine in this context?
Response: Telemedicine was not used in the proposed manual as a term of art and this term is being clarified.

Comment: PASSE APPLICANT recommends the State provide additional definition around beneficiary contact requirements, which may include: Follow-up must make contact with the beneficiary either telephonically, via telemedicine or in-person. If the beneficiary is unreachable, the Care Coordinator must document their attempts to contact the member, which must include contacting the beneficiary's natural supports and an in-person attempt to the member's last known location before the care coordinator may start the 45-day timeline to classify the member in abeyance.
Response: Within the context of care coordination, we have clarified that the use of video conferencing for the purpose of required contacts is allowable after the initial face-to-face visit. Telemedicine is still allowable under the Medicaid State plan in order to deliver a medical service.

Comment: PASSE APPLICANT recommends the State consider caseload ratios based on the tier of care coordination the beneficiary is receiving and clinical need. Current evidence-based, and best practice models including:
Tier II - Connective – 1: 70 to 100
Tier II & Tier III – Supportive – 1: 30 to 50
Tier III - High Needs Case Management (children) – 1: 20 to 25
Tier III - Assertive Community Treatment – 1: 12
Response: DHS has clarified the ratio to no greater than 1 care coordinator to 50 client ratio.

Comment: Section 242.000 – It will be difficult to find enough individuals who meet the qualifications in this section.
Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator.

Comment: Please note that Care Coordinator Qualifications are very different from case manager qualifications. Existing case managers who do not have a bachelor or RN degree should be grandfathered in as care coordinators. As we understand it, we will need some 1200 additional employees to serve as care coordinators in addition to the existing case managers. Please consider removing the bachelor degree requirement to address workforce realities.

This is another reason not to move forward with care coordination. In a fully capitated program, we will have a care management team, which will provide clinical care management oversight of care coordination. Care coordination shouldn't be defined as a single person, but rather a whole team approach. There is a gulf of a difference in the level of training and skills a person needs to be in an individual's home providing case management support and communicating back to care management team.
Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator.

Comment: PASSE APPLICANT's proposed model of care includes high-touch tiered care coordination in the community, at the provider and at the health plan level that is driven by beneficiary choice and needs. We seek to utilize peer and family supports in addition to a continuum of care navigation, coordination, and management professionals with expertise in mental health, substance use, intellectual and developmental disabilities, chronic disease, etc. To do this, PASSE APPLICANT requests that State allow for a greater variety of care coordination professionals to support the PASSE model of care, including non-degree holding professionals to ensure members get the right care, at the right time, in the right location – expanding Care Coordination definition to separate Care Navigations to enable Community Health Worker or peer support navigator.
Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator.

Comment: PASSE APPLICANT recommends the State allow PASSEs to develop qualification requirements based on the role the staff person is filling (care navigation, case management, care coordination, care management, etc.). PASSE APPLICANT is concerned about the availability of a skilled workforce at the levels included in this requirement, in addition to these requirements being overqualified for the roles and functions required by this program – especially in Phase I.

PASSE APPLICANT recommends the State allow non-licensed technicians with an associate's degree and multiple years' experience. PASSE APPLICANT additionally recommends and advocates that the State push for the intentional use of peers and family members where applicable.

Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator.

Comment: Will the PASSE be required to meet the same suggested caseload standard of 25 beneficiaries per care coordinator for Tier I beneficiaries?
Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator. Tier 1 beneficiaries will not be able to join a PASSE until January 2019.

Comment: For recipients with lower level need – would the use of a telephone contact be permitted?
Response: Telephone contact is permitted and encouraged, but does not count towards the required monthly contact.

Comment: The October 1 start date is not realistic, and the state is providing no money for anything beyond traditional case management. Phase I is not necessary to the success of the program – focus on full capitation go live date.
Response: The October 1 start date is only for care coordination provided by the PASSE. Phase I of the PASSE includes initial attribution of beneficiaries to a PASSE, which is vital to the successful implementation of the program.

Comment: PASSEs have not been given any guidance in terms of what IT capabilities they should have. There has been no mention of member file formats, utilization data type and frequency, etc. and how data would flow from the state to the PASSE.
Response: An agreed upon time frame of data transfer will be discussed with each PASSE. Quarterly quality measure reporting expectations (for instance, file formats) will be discussed with each PASSE.

Comment: There will be a lot of chaos and confusion once an individual is attributed to a PASSE and has to change service coordinators. We do not feel this aspect of the program has been adequately communicated to the individuals and lessons from other states have shown us that this has the potential to be significantly disruptive to individuals, families, and their services and has the potential to start the program off on a negative foot, putting the program at risk. Again, the state should consider delaying or canceling PASSE participation in care coordination and focus on the transition to January 1, 2019.
Response: The next 14 months will be a transition period. Care coordination under the 1915(c) or under the 1915(b) PASSE model includes identical services for this reason. We believe this will offer

beneficiaries a seamless transition regardless of the Waiver under which they receive the service.

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

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

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

Comment: Section 241 details the "Definition of Care Coordination"; however, it does not provide expectations on the separation of

responsibilities of Care Coordinators at the PASSE level and those working for DD providers. Further clarification on the expectations/roles of these positions at the different entities should be provided.
Response: Based on public comment, DHS has clarified that it is the responsibility of the PASSE to comply with Conflict Free Case Management rules.

Comment: The attribution model as it is defined today does not create a structure whereby a provider investing in a particular PASSE would be inclined to join the network of another PASSE until after attribution. This has created a scenario where, seven weeks out from go-live, no PASSE will have an adequate network as outlined by care coordination referral network access standards. We would advise adjusting the attribution methodology to reflect a scoring enhancement if an individual's majority service provider is also an owner/investor in a particular PASSE. This would provide needed certainty that providers joining other PASSE networks would not dilute attributed membership, thereby impacting their investment in a PASSE. Act 775 requires providers to have 51% ownership, and providers are taking this seriously. Additionally, because of the nature of the individuals participating in this program and the types of services most primarily access, there should be an increased emphasis in attribution towards core BH/IDD providers. The scoring methodology as currently outlined does not create a substantial enough variance between core DD/BH providers of service and other, less intensive services (i.e. pharmacy). As referenced above in care coordination, we do not feel individuals are getting a clear picture of the PASSE entity they are being attributed to, because much of the design work for the full-risk program has not been completed. This puts members at a disadvantage when deciding whether or not to retain a particular PASSE with which they have been attributed to.
Response: The success of this coordinated care model is contingent upon the development of robust provider networks for each of the PASSEs. DHS encourages all direct service providers to join all PASSE networks. Behavioral Health and Developmental Disability service providers are in Service Class 5, which means that they have the greatest impact on attribution to a PASSE. A beneficiary has 90 days to transition to a different PASSE upon initial attribution and then has 30 days on the beneficiary's annual anniversary of attribution to a PASSE to transition to a different PASSE. The proposed manual is for Phase I of the PASSE, which includes the provision of care coordination.

Comment: We believe the Department should develop more specific criteria that will enable it to narrow the qualified PASSE applicants to no more than two or three PASSEs. The market will not support five, and it is

not fair to consumers and providers to have churn and chaos as this is worked out over many months.
Response: If a prospective PASSE meets the requirements as specified in Act 775 of the Arkansas Regular Session of 2017, the Arkansas Insurance Department Rule 117, and the network adequacy requirements within the PASSE Arkansas Medicaid Provider Manual, the PASSE will be allowed to enroll as a Medicaid provider.

Comment: We request the Department to include rules regarding tax-payer supported, essential providers, i.e., the state's only teaching hospital and the state's only children's hospital. Specifically, they should be required to participate in all PASSEs and should provide transparency as to the amount and source of their investment interests and their role in governance of any particular PASSE. There are also concerns around (IGT) and other special source of revenue not available to providers in competing PASSEs. We are requesting a meeting to discuss in more detail.
Response: Act 775 of the Arkansas Regular Session of 2017 does not identify these providers as unique.

Comment: "Participating Provider" is defined as "an organization or individual that is a member or has an ownership interest in a PASSE and delivers healthcare services to beneficiaries attributed to a PASSE." In health plans, participating provider status is not linked to membership or ownership. Please revise along the following lines: "A participating provider is an organization or individual that agrees to deliver healthcare services to beneficiaries attributed to a PASSE as part of that PASSE's provider network." "Direct Service Provider" is defined as "an organization or individual that delivers healthcare services to beneficiaries attributed to a PASSE. Participating providers can be direct service providers." This is confusing because it mixes direct service delivery with participating provider status. Suggest delete last sentence.
Response: These definitions are consistent with the enabling legislation (Act 775). A provider can be characterized in both ways.

Comment: We do not understand why the PASSE will be required to stop delivering services because someone has not communicated with the PASSE in 45 days. Do we send them a notice or what happens?
Response: Based upon public comment, DHS has clarified the language to reflect the intent of abeyance. The PASSE as well as the beneficiary or guardian will have the responsibility of regular contact.

Comment: PASSE APPLICANT acknowledges the functional capacity of individuals assigned to Tier II and Tier III levels of care and advocates the State shift responsibility from members and their guardians to maintain contact with the PASSE and share responsibility between the beneficiary

and the PASSE to engage beneficiaries. We suggest neutral language such as: “Loss of contact with the beneficiary or guardian for more than 45 days” with beneficiary contact requirements delineated in section 240.000 Care Coordination Requirements.
Response: Based upon public comment, DHS has clarified the language to reflect the intent of abeyance. The PASSE as well as the beneficiary or guardian will have the responsibility of regular contact.

Comment: PASSE APPLICANT recommends language that defines beneficiary contact requirements, for example: “if the beneficiary is unreachable, the Care Coordinator must document their attempts to contact the member, which must include contacting the beneficiary’s natural supports and an in-person attempt to the member’s last known location before the care coordinator may start the 45-day timeline to classify the member in abeyance.”
Response: Based upon public comment, DHS has clarified the language to reflect the intent of abeyance. The PASSE as well as the beneficiary or guardian will have the responsibility of regular contact.

Comment: The proposed definition is “The Direct Service Providers that join the PASSE.” The word “join” is confusing people. Please revise to say: “The Direct Service Providers that have agreed to provide healthcare services to beneficiaries as participating providers of a PASSE.”
Response: Based on public comment, DHS has clarified the PASSE Provider Manual to read, “The Direct Service Providers that have agreed to provide healthcare services to beneficiaries enrolled in the PASSE.”

Comment: This section makes no distinction between conditional and full licensure. Section 7 of Act 775 contains a timeline that provides initially for conditional licensure with various milestones to achieve full licensure. The PASSE enrollment and licensure process should follow that timeline established in the statute. This is an important distinction under Act 775 and ignoring that distinction is causing the Insurance Department to force PASSE applicants to meet standards prematurely and without sufficient information from DHS. The PASSEs will not be operating as risk-bearing entities until January 1, 2019. Between October 1, 2017, and January 1, 2019, the PASSE/RBPOs will not even be TPAs or ASOs—they will be providing a single service (care coordination) on a rate paid per client by Medicaid. None of the PASSEs will meet the risk-bearing, global capitation part of the definition prior to January 1, 2019. There really is no practical reason to even require PASSEs to enroll anyone until they actually begin operating under the risk-based global capitation model.
Response: Licensure is issued by the Arkansas Insurance Department and is addressed within Rule 117 of the Arkansas Insurance Department. The PASSE enrollment and licensure process is

following the timelines established within the statute and as directed by the Arkansas Insurance Commissioner.

Comment: In the third paragraph, it says the PASSE must have the ability to provide care coordination beginning October 1. DHS is providing no funding for the PASSEs to do anything October 1. See above for the other reasons this is not feasible. The fourth paragraph requires the PASSE to sign the "PASSE Agreement." We have not seen the agreement, which is yet another reason this is not ready for October 1.
Response: DHS will provide a one-time foundation payment to the PASSE upon the beneficiary's initial attribution to the PASSE. This one-time payment will be provided when beneficiaries are attributed to the PASSE. Subsequent monthly care coordination payments will be made for each attributed beneficiary. These prospective payments reimbursed by Arkansas Medicaid will be provided to the PASSE for the provision of care coordination. The PASSE agreement will be between the PASSE and DHS. The PASSE agreement cannot be signed until the PASSE is licensed by the Arkansas Insurance Department.

Comment: While we agree with and definitely need the "foundation payment," it should be in addition to, NOT "in lieu of" the care coordination fee. Otherwise, it is only $35 more than the care coordination fee.
Response: The proposed rates have been established and will not be amended at this time.

Comment: Section 213.000 – Without revision, providers will be disincentivized to participate in other PASSEs. See comments above. Because a primary intent of the PASSE is to offer options to the consumer, it is important for them to understand the same DD program may provide services in different ways depending on which PASSE the service is through. How will DHS assist in conveying this information?
Response: The Department continues to encourage Providers to join the network of all PASSEs. As the PASSE is forming its network, it may offer incentives to Providers to join. Only care coordination will be provided by the PASSE during Phase I. Existing provider relationships will continue in Phase I as those providers will continue being reimbursed on a fee-for-service basis by Arkansas Medicaid until January 1, 2019.

Comment: Section 214.000 – Item "C" says that a beneficiary may transition when a PASSE has been sanctioned. That should be qualified in some way. What if the sanction has nothing to do with beneficiary care, but instead relates to reporting requirements. This is too broad as written.

Item “D” says “Other reasons, including poor quality of care, lack of access to services covered under the PASSE agreement, or lack of access to providers experienced in dealing with the beneficiary’s care needs.” We understand the federal rule allows “other reasons,” but the state needs to say what they are – they should be limited to the ones stated or described more specifically as to what other reasons will suffice.

Please state that DHS will first give the PASSE time to remedy the alleged problem (poor quality, access, experienced providers) the beneficiary is asserting.
Response: DHS has clarified this section, the PASSE for which the beneficiary is attributed may be sanctioned in accordance with Section 152.000 of the PASSE Medicaid Provider Manual.

Comment: Section 221.000, E. – Please provide more detail regarding specificity making auxiliary aids and services available upon request of the potential beneficiary or beneficiary at no cost.
Response: In reference to enrollment into a PASSE, information must be provided to the beneficiary in a manner and format that is easily understood and is readily accessible by beneficiary. This manual does not address auxiliary aids and services as medical services.

Comment: 224.000 – This section states: “The PASSE may only market to potential beneficiaries through its website or printed material distributed by DHS’s choice counselors. All marketing materials and activities must be approved by DHS in advance of use.” This is far too restrictive. We have no problem with DHS reviewing and approving our materials, but we should be able to distribute them ourselves within defined parameters and guidelines. Otherwise, it puts us in the awkward position of telling beneficiaries we can’t put something in writing or give them information they need, that they must go ask DHS. We will be blamed for giving them excuses and “the run-around.” Rules like this go against the intended goal of greater efficiency. The language as written is not workable. Please follow the same Solicitation and Marketing language that has been used for years for other programs managed by DHS. Please provide more detail regarding role of DHS “choice counselors.” What is their relationship to the attribution process?
Response: Information can and is expected to be provided to attributed beneficiaries. Once the beneficiary is attributed to a PASSE, the DHS choice counselors will assist the beneficiary.

Comment: Please reconsider your use of the term “Referral Network” in the manual since that is confusing. Health plans have participating providers and non-participating providers. This section should be addressing all participating providers, regardless of whether they are in the core BH/DD or they are in the referral “halo.”

Response: A PASSE must meet network adequacy requirements of all types of providers regardless of ownership status.

Comment: Section 250.000 – This section states: "Care Coordinators must initiate contact within 15 days of attribution to a PASSE." We don't even know the manner and mechanism the state plans to notify us an individual has been attributed. For now, until we have more information, please change to say the coordinator will contact the individual within 15 days of attribution, but that they would have 60 days to initiate care coordination. But, again, the October 1 date is not realistic.
Response: Notification of beneficiary attribution will be sent weekly to the PASSE via electronic mail. Care coordinators must initiate contact within 15 days of attribution to a PASSE.

Comment: There should be some severity scale applied, so that the state cannot terminate a PASSE for failure to meet quality metrics unless the failure is egregious. (This will be more of an issue going forward with metrics that are more difficult to meet, but we don't want to see the language embedded.) We don't know what the quality metrics are going to be. The funding does not allow for a comprehensive care management approach, which is prohibitive to the success of the program.
Response: DHS may take action to correct the failure or impose penalties on the PASSE if the PASSE fails to meet 2 of the 5 quality metrics for care coordination.

Comment: Please explain in more detail how the grievance process will work between the PASSE level and the state fair hearing process. Similarly, please explain how the PASSE will interface with provider appeal in light of the Arkansas Medicaid Fairness Act.
Response: Please see DHS Policy 1098 regarding the grievance process. Medicaid Fairness is still applicable and provider appeals will go to the Department of Health.

Comment: Based on the review of the proposed PASSE rules by our partners, it is important to clarify what services of the policy manual apply to Phase I (2017 to 2018) of the PASSE implementation ONLY. It is our key assumption that prior to the PASSE assuming risk in 2019, there would be updates to the policy manual (Phase II), contract, and a second readiness review. PASSE APPLICANT seeks verification from the State that this key assumption is accurate.
Response: Yes, these rules apply to Phase I.

Comment: PASSE APPLICANT agrees with the State that the payment model and rates should reflect the resources and activities needed to assess beneficiaries, develop their total care plan and support high quality 24/7 care coordination at the right time and in the right place. We know that

high quality, 24/7 care coordination requires a skilled workforce, adequate network, advanced technological infrastructure. Thus, PASSE APPLICANT requests the State ensure an equal and equitable distribution of attributed members to provide an economy of scale, in addition to utilizing a per member, per month rate of $208. This rate is based on the Phase I scope requirements of the PASSE in acknowledgement of the robust technology infrastructure, provider network development, workforce development, and innovations PASSE APPLICANT seeks to offer the State through our program.
Response: The proposed rates have been established and will not be amended at this time, nor will the attribution methodology.

Comment: Request the per-member, per-month rate be $208 due to the administrative lift to establish technology and resources to provide outlined services.
Response: The proposed rates have been established and will not be amended at this time.

Comment: PASSE APPLICANT wishes to express its concern that the individuals who are completing the independent assessment are unlicensed, non-clinical professionals. Based on the information provided, this role includes making a clinical determination of the level of care a member will be assigned to, including whether or not the member will receive case management, whether they meet institution level of care criteria and whether they require 24-hour care. PASSE APPLICANT believes these are clinical decisions that should be made by licensed clinical professionals who are credentialed and in good standing with the State or for ease of member access needs by key providers throughout the state with follow up audit for compliance. This will allow for the immediate intervention for more complex members; right care, right location, right time.
Response: The Independent Assessment is a functional needs assessment not a diagnostic assessment.

Comment: PASSE APPLICANT appreciates the State's dedication to ensuring beneficiaries have choice and remain connected to the providers with which they have the strongest relationship. PASSE APPLICANT requests clarification on the implications of the attribution methodology, given the expectation that all PASSEs operate statewide and will contract will all providers; it is understood that a beneficiary would continue to see their preferred providers regardless of what PASSE they are assigned to. While assignment to a PASSE would not impact the beneficiary's choice in from whom they get their care, it will however impact the distribution of attributed members. This may skew the attribution process, leading to inequitable and uneven distribution across the PASSEs, which has potentially deleterious clinical, operational and financial implications for

the success of the PASSE program for Arkansas. PASSE APPLICANT recommends the State implement an even distribution methodology for beneficiary attribution.

Response: The proposed attribution methodology has been established and is not being changed at this time.

Comment: PASSE APPLICANT knows that in order to mitigate actuarial risk and maintain a solvent organization, the risk pool we assume must include an appropriate blend of high, medium and low risk membership. To ensure the PASSE program will be stable and solvent by 2019, PASSE APPLICANT recommends that DHS allow Tier I individuals begin to request voluntary attribution no later than January 1, 2018. This will allow PASSEs to assume a solvent risk pool by the time risk is assumed on January 1, 2019.

Response: Voluntary enrollment into a PASSE will not be allowed until January 1, 2019. A rate for Care Coordination for individuals assessed to not be eligible for Tier II and Tier III services was not established.

Comment: Given that the PASSE will not be traditionally contracting with the provider network in Phase I (2017 – 2018), PASSE APPLICANT is requesting the Department of Human Services share member data for the beneficiaries attributed to each PASSE, including: demographic, eligibility, independent assessment, claims history and that the PASSE be included in all prior authorizations, concurrent reviews and retrospective reviews for assigned members. Further, PASSE APPLICANT requests the State define requirements that will be placed on the provider network to collaborate with each PASSE for care coordination, including beneficiary consents, releases of information, collaborative care planning, notification of unexpected changes in care such as urgent care and emergency department utilization, jail booking, disruptions in foster care placements, etc.

Response: DHS has the ability to report on claims filed by providers, procedure codes bill for and paid, dollar amounts paid, units paid, etc. that can be shared with the PASSE. An agreed upon time frame of data transfer will be discussed with each PASSE.

Comment: PASSE APPLICANT seeks clarification on the term ‘network’ in this requirement for Phase I; does it reference a provider network or a referral network? Given the limited scope of care coordination, prior to assuming full risk in 2019, the provider network will be limited to care coordinators, while the referral network will include all Medicaid providers in the State, plus community-service organizations that provide non-covered services to address the social determinants of health (i.e. housing, employment, food boxes, etc.). Further, PASSE APPLICANT recommends the State Phase II include in its definition of

‘network’ not just behavioral health and ID/DD providers, but also hospitals, pharmacy, physicians to ensure statewide coverage of healthcare and access to services.

Response: Phase I requires a referral network. The referral network is the Direct Service Providers that join the PASSE. The PASSE must have the ability to make arrangements with or referrals to a sufficient number of Direct Service Providers enrolled as Arkansas Medicaid providers to ensure that needed services can be furnished to beneficiaries promptly and without compromising the quality of care.

Comment: PASSE APPLICANT appreciates the collaborative process the State has proposed throughout the development of the PASSE program and the critical importance of a readiness review prior to go-live of PASSEs. PASSE APPLICANT is in full support and is prepared to meet the requirements of the State’s readiness review. In order to fully execute the Phase I scope of the PASSE program, PASSE APPLICANT encourages the State to expand the scope of the readiness review to additionally include:

– Cover letter which includes: applicant name, physical address(s) for all locations in Arkansas, tax ID number

– Verification the applicant is licensed or otherwise authorized to transact health insurance as an insurance company under § 23-62-103

– Verification the applicant is authorized to provide healthcare plans under § 23-76-108

– A qualified organization that is capable of accepting and maintaining risk

– Authorized to issue hospital service or medical service plans as a hospital medical service corporation under § 23-75-108

– License from Arkansas Department of Health Services as a provider

– Care coordination model with supporting policies, workflows, and desktop protocols, specifically detailing coordination between behavioral health and developmental disabilities departments and providers

– Referral network directory by county and provider type

– Quality management plan, including composition of committee(s), which, at a minimum, must include a medical management committee and a consumer advisory council

– Business continuity and disaster recovery plan

– Network development plan

– Cultural competency plan

– Data management plan and a data flow diagram(s) that depict how the PASSE will send and receive data with the State and stakeholders

– Contact information for key staff where they can be reached after business hours

– PASSE Organization job descriptions

– Communications plan, including marketing materials, and beneficiary notices

– Copy of the comprehensive, integrated clinical assessment tool that will be used, if any, to assess and re-assess beneficiary functioning
– Member transition plan with supporting policies, workflows, and desktop protocols
– Agency policies including: beneficiary rights policies
– Provider manual
– Provider contract boiler plate
– Provider scope(s) of work
– Identification of 24/7 psychiatric crisis hotline that will be provided to beneficiaries
– Identification of language access vendor
– Provider performance measures and sample reports
– Professional development training map, to include at a minimum:
    – Fraud, waste, and abuse
    – Privacy and confidentiality
    – Complaints, grievances, and appeals
    – Beneficiary rights
    – Care coordination model
    – Motivational interviewing
    – Psychiatric crisis intervention
– Demonstration of ability to exchange care coordination data electronically with DHS and providers
– Within twelve (12) months of go-live, we encourage the State to require PASSEs to produce written care coordination protocols that discuss roles and responsibilities, timeliness expectations, information sharing, and conflict resolution agreements with multi-sectoral partners that also have contact with or provide services to PASSE attributed beneficiaries, including, but not limited to:
    – Out-of-network direct service providers
    – Psychiatric crisis providers
    – First responders (Fire/EMS)
    – Law enforcement
    – Adult & juvenile corrections
    – Adult & juvenile courts
    – Adult & juvenile probation
    – Veteran's Administration
    – Indian Health Services
    – Child welfare
    – Department of Education
    – Emergency departments & hospitals
    – Housing providers
    – Employment providers

Response: Many of the proposed suggestions are addressed by the Arkansas Insurance Department, will be a part of the PASSE provider agreement with DHS, or will be addressed by Medicaid Provider Enrollment.

Comment: PASSE APPLICANT requests clarification if this methodology is to be used only for the initial attribution of members or if this will be the permanent methodology for attributing beneficiaries in perpetuity?
Response: The proposed attribution methodology has been established and is not being changed at this time.

Comment: Will DDTCS and/or CHMSs receive their points based off of their facility type only, or will they receive additional points when their clients also receive PT/OT/or ST?
Response: Points will be based upon provider type as established in Act 775 of the 2017 Arkansas Regular Session including Early Intervention providers certified by DDS.

Comment: Does the State intend for beneficiaries to only receive care from PASSE partners/providers or will they continue to be able to receive care from any Medicaid contracted provider (as stated in 231.100.B)? If beneficiaries will continue to receive care from any Medicaid contracted provider, this implies that all PASSEs will be required to maintain a state-wide network and contract with all Medicaid contracted providers in Phase II. If these assumptions are correct, is the relationship-score attribution methodology necessary – as there is no reason to assume that attribution will impact where or from whom the beneficiary receives their care?
Response: The State will continue to pay for services on a fee-for-service basis. The manual for Phase II of the PASSE will be released in calendar year 2018.

Comment: PASSE APPLICANT requests the State include an equitable distribution of beneficiaries to this methodology to ensure all PASSEs receive an equal number of beneficiaries that are a diverse blend of risk scores, to ensure they are able to achieve critical mass and sustainable risk pool. Including equity in attribution is critical to the financial viability and sustainability of the PASSE model and to eliminate perverse incentives for PASSEs and provider groups to enter into exclusive agreements or otherwise intentionally or unintentionally sabotage the State's intended program model. **Response: The proposed attribution methodology has been established and is not being changed at this time.**

Comment: If the State elects to use the relationship score approach versus the randomized, equitable distribution approach: PASSE APPLICANT recommends the State allow additional points for each visit per month. Many providers see Tier II and Tier III patients routinely, including multiple times per week, in some instances; building and strengthening their rapport and relationship with the member at each visit. In many cases, PASSE APPLICANT has observed that these frequent contacts

result in the member trusting their weekly provider to coordinate their care, seek referrals, and get psychoeducation about their condition. This relationship should be acknowledged and validated in the State's attribution methodology, should it continue to use a relationship score approach.
Response: The proposed attribution methodology has been established and is not being changed at this time.

Comment: PASSE APPLICANT requests clarification on the specialty point weighting methodology for attribution. Will provider class five hold a weight of 5 points compared to provider class one holding a weight of 1 point?
Response: This topic was previously addressed in the white paper released and distributed by DHS on June 27, 2017, see Attachment "A."

Comment: PASSE APPLICANT requests clarification on the definition of an 'outpatient clinic' in this context. Does this align with the outpatient behavioral health clinic, or is there an alternative definition?
Response: In this context, "outpatient clinic" refers to hospital outpatient clinics.

Comment: PASSE APPLICANT seeks clarification if the term 'visits' in this sentence refers to crude/duplicative visits (i.e. if a patient visits the same provider multiple times in a month, are there multiple points, or just a single point assigned) or visit points per the method described in 213.100.B.
Response: If a client visits the same provider multiple times in a month, that will count as one visit point.

Comment: Details regarding the methods for notifying PASSEs that a beneficiary has been attributed, including the frequency/timeliness of notifications.
Response: Notification of beneficiary attribution will be sent weekly to the PASSE via electronic mail.

Comment: Description of the data set that will be provided to PASSEs upon attribution of a new beneficiary. Despite providers owning 51% of the PASSE, it is a separate legal entity and the beneficiary would need to consent to share medical information (specifically HIV and substance use data); thus, we cannot assume the PASSE will have access to information the direct service providers may have by nature of their relationship with the providers. The State providing this information is additionally pertinent, if the beneficiary sees providers not participating in the particular PASSE to which the member is attributed. PASSE APPLICANT proposes this dataset include at a minimum:

– Demographic information, including clinical information and contact information for the beneficiary, their legal guardian, and an emergency contact.
– Independent assessment tool raw data.
– Prior two-years claim history for the beneficiary.
– Based on the information provided about the Arkansas Medicaid Independent
Response: DHS has the ability to report on claims filed by providers, procedure codes bill for and paid, dollar amounts paid, units paid, etc. that can be shared with the PASSE. An agreed upon time frame of data transfer will be discussed with each PASSE.

Comment: PASSE APPLICANT knows that in order to mitigate actuarial risk and maintain a solvent organization, the risk pool we assume must include an appropriate blend of high, medium, and low risk membership. To ensure the PASSE program will be stable and solvent by 2019, PASSE APPLICANT recommends that DHS allow Tier I individuals begin to request voluntary attribution no later than January 1, 2018. This will allow PASSEs to assume a solvent risk pool by the time risk is assumed on January 1, 2019. PASSE APPLICANT requests clarification of requirements for voluntary attribution. Specifically, what is the process a PASSE should follow in the event a beneficiary contacts a PASSE directly and requests voluntary attribution?
Response: Voluntary enrollment into a PASSE will not be allowed until January 1, 2019.

Comment: PASSE APPLICANT recommends that Emergency Department visits and Psychiatric Residential Treatment Units be considered for attribution. While in Phase I, PASSEs are not risk bearing, these levels of care are high cost and if unevenly attributed to PASSEs, high utilizers of these levels of care may disproportionately distribute financial risk to a PASSE when they assume risk in 2019.
Response: The proposed attribution methodology has been established and is not being changed at this time.

Comment: PASSE APPLICANT recommends the State allow beneficiaries the option to change their PASSE no more than once within a thirty (30) day period to align with the State's mission to offer member choice. We are recommending this to ensure members remain in the driver's seat of their care and are not restricted or bound to a PASSE that may not meet the member's needs.
Response: The timelines established comply with federal Medicaid Managed Care Rules and will not be changed at this time.

Comment: PASSE APPLICANT asks for clarification if PASSEs will be responsible to notify beneficiaries of their anniversary or ability to elect a

new PASSE in addition to a definition of a time allotment beneficiaries will have to switch to a new PASSE (i.e. within 30 days before or after their anniversary).
Response: Notification will be provided from DHS or a contractor on the anniversary of the client's attribution to a PASSE. The timelines established comply with federal Medicaid Managed Care Rules and will not be changed at this time.

Comment: PASSE APPLICANT asks for clarification of requirements to notify DHS that a beneficiary has requested a change in their PASSE. Please describe the process, any specific forms, and timeliness requirements.
Response: A beneficiary will be informed of the process to transition to another PASSE in their notification of attribution to a PASSE.

Comment: PASSE APPLICANT requests clarification on the title of this section. This header appears to be an error as this section focuses on communications or language access requirements.
Response: DHS agrees and has clarified this section heading to "General Information."

Comment: PASSE APPLICANT requests clarification on the definition of 'easily understood' and 'readily accessible.'
Response: These terms speak for themselves, and we do not believe they require further explanation.

Comment: PASSE APPLICANT recommends the State require PASSEs to make materials available 'in other languages upon request from beneficiaries or their families.'
Response: The State does require PASSEs to make materials available in other languages upon request from beneficiaries or their families.

Comment: FORVERCARE requests clarification on the definition of 'auxiliary aids' and which aids are classified as covered versus non-covered.

In Phase I, will PASSE APPLICANT be reimbursed for the expense of auxiliary aids?
Response: There will be no additional payments outside of the foundation payment or care coordination payment in Phase I.

Comment: Section 222.000 – PASSE APPLICANT requests clarification on the title of this section. This header appears to be an error as this section focuses on beneficiary rights.
Response: DHS agrees and has clarified the heading of this section to "Beneficiary Policy."

Comment: PASSE APPLICANT recommends the State add a requirement stating the beneficiary has: "the right to file a complaint or grievance with the State at any time and the right to receive assistance filing a complaint or grievance without retaliation."
Response: Please see DHS Policy 1098 regarding the grievance process.

Comment: PASSE APPLICANT requests clarification on the scope of content of the beneficiary handbook that will be provided in Phase I. Covered services offered by a PASSE will be limited to care coordination. Is there an opportunity to update DHS' beneficiary handbook until the PASSE assumes risk in 2019, so as to avoid confusion and multiplication of handbooks beneficiaries must track?
Response: A PASSE is required to have its own beneficiary handbook. DHS must also have a beneficiary handbook as most services will continue to be provided on a fee-for-service basis until January 2019.

Comment: PASSE APPLICANT recommends the State require PASSEs to include "a description of covered services available to the beneficiary" in the beneficiary handbook.
Response: This will be a requirement of the beneficiary handbook.

Comment: PASSE APPLICANT recommends the State add a requirement that the beneficiary handbook include a toll-free number the beneficiary can use in the event of a psychiatric emergency.
Response: Each PASSE may create this number for a beneficiary in the event of a psychiatric emergency for their attributed clients.

Comment: PASSE APPLICANT recommends the State add a requirement that the beneficiary handbook be reviewed/revised no less than annually and that beneficiaries be notified of updates to the beneficiary handbook no less than 30 days prior to their implementation.
Response: A PASSE Provider Manual for Phase II will be available calendar year 2018, which will contain requirements for the beneficiary handbook.

Comment: PASSE APPLICANT recommends the State add a requirement that direct service providers make the beneficiary handbook available in print form free of charge to the beneficiary upon request.
Response: This is an agreement that would be reached between the PASSE and direct service providers, not something that will be mandated upon direct service providers by DHS.

Comment: PASSE APPLICANT requests clarification if there are additional communications requirements that must be followed – for non-

marketing purposes. This request includes State requirements regarding approval of provider and member notices, website-copy, and timelines for submission in order to obtain approval and the point of contact at DHS from whom to seek approval, etc.
Response: No, there are not additional communications requirements that must be followed at this time in Phase I.

Comment: PASSE APPLICANT requests clarification on the State's timeline for notification to beneficiaries of their attribution to a PASSE. Specifically, when will beneficiaries be notified, how, and will the PASSEs receive a copy of the notification materials to train our member services department on the information provided to beneficiaries?
Response: Notification of beneficiary attribution will be sent weekly to the PASSE via electronic mail.

Comment: PASSE APPLICANT requests clarification on the use of social media for marketing purposes.
Response: Any marketing materials must be approved by DHS.

Comment: PASSE APPLICANT recommends that State add a requirement that "the PASSE must maintain a network development plan that is submitted to the State no less than annually. At a minimum, the network development plan shall include:
– An assessment of beneficiary needs, including specialists, and non-covered services that address the social determinants of health.
– Geographic and travel time to care analysis of beneficiaries by tier with referral providers identified by type.
– Network sufficiency gap analysis of provider to beneficiary availability and accessibility.
– A summary of network development activities for the previous year.
– Strategies for network development.
Response: A PASSE Provider Manual for Phase II will be available calendar year 2018, which will contain requirements for the beneficiary handbook.

Comment: PASSE APPLICANT requests clarification from the State regarding a PASSE's ability to ensure time and distance requirements based on the scope of work a PASSE will manage in Phase I. It is our understanding that a PASSE will not be contracting with or managing direct service providers until they assume risk in 2019; therefore, a PASSE is not in a position to ensure network sufficiency, determine where direct services providers are located, what their hours may be, or the type of services available. In Phase I, a PASSE can support the State in identifying network gaps and provide consultation on where specific services are needed by type.

Response: The PASSE must meet network adequacy requirements in both Phase I and Phase II.

Comment: PASSE APPLICANT requests a comprehensive list of policies a PASSE is required to maintain (i.e. fraud, waste and abuse, confidentiality, conflict of interest, covered services, etc.).
Response: Many are addressed by the Arkansas Insurance Department, will be a part of the PASSE provider agreement with DHS, or will be addressed by Medicaid Provider Enrollment. Section 1 of the PASSE Medicaid Provider Manual contains all other required policies the PASSE is required to maintain. The PASSE will also be required to meet the federal Medicaid Managed Care rules.

Comment: PASSE APPLICANT requests clarification on the process for requesting a variance of these referral network standards.
Response: Variance requests will be handled on a case-by-case basis by DHS.

Comment: PASSE APPLICANT appreciates the necessity to utilize technology when providing 24/7 high quality, real-time care coordination for vulnerable populations. We request clarification from the State regarding the timeliness of care coordination requirements and use of technology including any State-led targets for implementation or use of technology platforms, such as a health information exchange or other community-based, cloud-based tools for data exchange platforms between Medicaid providers and with external multi-system stakeholders.
Response: Use of technology is an operational issue that will be addressed between successful PASSE applicants and the Department.

Comment: PASSE APPLICANT requests clarification on ultimate ownership for beneficiary care in Phase I. It is clear that the PASSE will assume risk and ultimate responsibility for the beneficiary in 2019. Prior to then, does DHS, the beneficiary's primary care physician, or the PASSE assume ultimate responsibility for their care?
Response: DHS will continue to reimburse direct service providers (including PCPs, PCMHs, Specialty Providers) for the delivery of services to the beneficiary in Phase I. The PASSE is responsible for providing care coordination to the beneficiary in Phase I.

Comment: PASSE APPLICANT requests clarification regarding the operational expectations for case management and care coordination. We recognize there are many models and types of care coordination, including:
– Care navigation
– Case management (including: supportive, connective, and assertive)
– High needs case management

– Care coordination
– Care management
Further, we understand that beneficiaries with behavioral health and substance use eligibility may have a different array of benefits available to them compared to individuals with intellectual or developmental disabilities; further qualified by their level of care needs and tier of eligibility. PASSE APPLICANT is prepared to develop and propose a care coordination model that ensures beneficiaries receive the highest quality care that achieves health outcomes at a cost savings and seeks to ensure our model meets all requirements from the State.
Response: As you point out this is an operational issue, not a policy issue. DHS will engage successful PASSE applicants in these operational issues.

Comment: PASSE APPLICANT requests clarification if PASSE care coordinators must be employed by the PASSE entity. We recommend and request the State allow for a multi-leveled approach to care coordination that includes care navigation, care coordination and care management through different levels of connectedness and coordination based on the beneficiary's individualized needs. Under our proposed model, some care coordination activities will be managed at the provider level, by their staff, with other activities being directly implemented by PASSE employees. PASSE APPLICANT integrated comprehensive continuum of high touch care coordination that is provided in the right place, at the right time, in the right dose to meet member needs.
Response: The PASSE is required to provide care coordination as described in the PASSE manual to attributed beneficiaries. The PASSE may use various arrangements to satisfy this requirement.

Comment: PASSE APPLICANT recommends the State add a requirement that the total care plan be reviewed no less than semi-annually (every six months) in Phase II when at full risk and with the beneficiary updated no less than annually, with tracking of progress towards treatment goals.
Response: This manual only applies to Phase I.

Comment: PASSE APPLICANT requests clarification on the requirements that DHS will place on the beneficiary's providers to work with the PASSE care coordinator, share information, problem solve, etc. during Phase I, when the PASSE does not have oversight of the providers.
Response: It the responsibility of the PASSE to coordinate those efforts. DHS would encourage all providers to cooperate in the delivery of services to beneficiaries.

Comment: PASSE APPLICANT requests clarification if there is a uniform strategy to be used statewide to obtain beneficiary consent and for

information sharing across multi-sector partners, specifically, for members additionally protected under 42.C.F.R. Part B with substance use and HIV data in both structured data and unstructured data sections of their care plan(s).
Response: It is the responsibility of the PASSE to determine appropriate methods to obtain consents and authorizations for information sharing across multi-sector partners for the release of essential records.

Comment: PASSE APPLICANT recommends the State add 'booked into jail, disrupts from a foster care placement' to the requirements for seven (7) day follow-up.
Response: We are not making changes to this section of the manual.

Comment: PASSE APPLICANT recommends that requirements be imposed upon emergency departments, hospitals, urgent cares, etc. by DHS to notify the PASSE of a beneficiary's contact, so the PASSE will be able to meet the seven (7) day follow-up requirement. Given the PASSE will not have direct oversight of the provider network in Phase I, a PASSE will need a technology based mechanism in place to be notified of their beneficiaries' contact with these entities; concurrently, these external entities will need a mechanism to identify a beneficiary's attribution to a PASSE in order to notify them. PASSE APPLICANT recommends that State add requirements that the follow-up visit include 'assessing for new needs and identifying any changes to the total care plan.'
Response: Linking to these providers is part of the responsibility of the PASSE.

Comment: PASSE APPLICANT recommends the State require that care coordinators report directly or indirectly to the Medical Director.
Response: This is the responsibility of the PASSE.

Comment: PASSE APPLICANT requests clarifications on the claims submission requirements during Phase I and requests the State to provide an allowable procedures code book for the PASSEs to utilize, including any modifiers.
Response: PASSEs will be paid prospectively on a PMPM basis based upon beneficiaries attributed. There are no claims submission requirements because the PASSE will not have any claims to file.

Comment: PASSE APPLICANT acknowledges the importance of the foundation payment and applauds the State's recognition of the volume of work required to successfully establish a new beneficiary into the PASSE program. PASSE APPLICANT recommends the State consider the workload implications of evolving program requirements and provide a more flexible payment model that includes additional payment

mechanisms for annual re-assessment and total care plan development in addition to value-based payments for achievement of quality metrics.

Specifically, the provided definition states the foundation payment is to be used to conduct initial assessment and begin collecting health information from providers; given the requirements that the assessment to review/revise no less than annually, this payment should be available as an allowable procedure code to allow for appropriate compensation for reassessment on an annual basis. Further, PASSE APPLICANT wishes to reinforce the importance of randomized and equal attribution of members to ensure that PASSEs are able to achieve an economy of scale with a blended risk-pool to ensure the solvency of the PASSE program in Arkansas.
Response: PASSEs will be paid prospectively on a PMPM basis based upon beneficiaries attributed. There are no claims submission requirements because the PASSE will not have any claims to file.

Comment: PASSE APPLICANT is concerned this requirement does not accurately reflect the nature of the target population, taking into account the transient nature of this population, their ability to maintain consistent housing, keep their phones connected, and maintain contact with natural supports that can help locate them. PASSE APPLICANT recommends the State allow for: 100% of care coordinators will make monthly face to face contacts with 90% to 95% of their assigned case load.
Response: Our requirements on providing care coordination are clear.

Comment: PASSE APPLICANT recommends the State strengthen this requirement to state "care coordinators must initiate a total care plan within 30 days of attribution" to ensure beneficiaries are not just contacted, but engaged in assessment and treatment planning and access highly coordinated care in a timely fashion.
Response: Our requirements on providing care coordination are clear.

Comment: PASSE APPLICANT recommends the State add 'booked into jail, disrupts from a foster care placement' to this requirement.
Response: Our requirements on providing care coordination are clear.

Comment: PASSE APPLICANT recommends that State remove the requirement that PASSEs must fail to meet '2 of the 5' quality metrics before DHS may take action. PASSE APPLICANT supports the State in monitoring PASSE performance and is willing to be held accountable for failure to meet any of the required quality metrics.
Response: We will not make this change.

Comment: PASSE APPLICANT is committed to and prepared to detect under and over utilization of services and seeks verification from the State that the State will submit claims, pharmacy, and other utilization data to PASSE APPLICANT during Phase I, as the PASSE will not be receiving or processing claims from providers during this initial phase.
Response: DHS has the ability to report on claims filed by providers, procedure codes bill for and paid, dollar amounts paid, units paid, etc. that can be shared with the PASSE. An agreed upon time frame of data transfer will be discussed with each successful PASSE applicant.

Comment: PASSE APPLICANT requests clarification from the State regarding the State's monitoring of 'delivery of services.' In Phase I, the PASSE will not be responsible for provision of services. PASSE APPLICANT seeks clarification from the State regarding how the State will measure the PASSEs' performance for patient outcomes. In Phase I, the PASSE is not managing patient care and thus, cannot be responsible for the oversight or achievement of patient outcomes. The PASSE can only be accountable for coordination of care. PASSE APPLICANT requests the State define the specific outcomes to be monitored to ensure the PASSE has the data needed to monitor the outcomes when we assume risk in 2019. PASSE APPLICANT requests clarification on the specific efficiencies the system seeks to achieve and measure.
Response: All outcome measures refer to the provision of care coordination. This manual is for Phase I of care coordination.

Comment: PASSE APPLICANT requests clarification on the specific efficiencies the system seeks to achieve and measure.
Response: This topic was previously addressed in the white paper released and distributed by DHS on June 27, 2017. See Attachment "A."

Comment: PASSE APPLICANT recommends beneficiaries are allowed up to 90 days at a minimum from the date of the action to file a grievance.
Response: The federal managed care rule allows up to 90 days for a beneficiary to file a grievance. DHS has chosen a shorter timeframe due to the specialty needs of the covered population, to permit a faster resolution for the beneficiary.

Comment: PASSE APPLICANT recommends that State add requirements that:
– The PASSE shall include information about their complaint, grievance, and appeals process in the beneficiary handbook, on their website, and must make this information publically available upon request.
– The PASSE shall offer beneficiaries assistance submitting a complaint, grievance, or appeal without retaliation.

Response: The PASSE is required to have a beneficiary handbook.

Comment: PASSE APPLICANT recommends the State add requirements that:
– The consumer advisory council include at least one (1) parent/caregiver of a child in care.
– The consumer advisory council must meet no less than annually; must be provided information about the PASSE's performance, beneficiary outcomes, complaints, grievances, and appeals; and be provided opportunities to provide recommendations to the PASSE's executive leadership.
– Consumer advisory council meeting minutes shall be kept on record and made available to DHS upon request.
Response: Act 775 addresses this issue.

Comment: Beacon Health Options Conflict of Interest
Response: DHS is aware of this potential conflict and has put measures in place to avoid any misuse of data or non-private information. A Mitigation Plan is in place, subject to amendment as needed that will be monitored. Any potential conflict will not exist for Phase II of the PASSE program. Any knowledge of any impropriety should be reported to DHS.

Question: Please clarify dates and timeline.
Response: Phase I of the PASSE model will be implemented on October 1, 2019. This includes the beginning of Independent Assessments and people being attributed to a PASSE to receive care coordination. The PASSE will take full risk and provide *all services* to attributed beneficiaries in Phase II, beginning on January 1, 2019.

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

Question: How do we handle medical care in South Arkansas if what few doctors we have don't/won't sign up on PASSE?

Response: Under Phase I, which is going into effect on October 1, 2017, all services remain fee-for-service. So, you do not have to see a PASSE network provider under this model. The PASSE will have to have the ability to provide referrals and make connections between beneficiaries and providers for needed services. We are anticipating that PASSEs will use the time until January 1, 2019, to build their network so that they can provide statewide coverage for all services to all beneficiaries.

Question: What kind of supervision will the State be utilizing to oversee PASSE units?
Response: DMS is creating a new Office which will oversee the PASSE, as well as other organized care models. This office will review all quarterly reports provided by the PASSE office to ensure that quality metrics are being met.

Question: When a client has been assessed tier 2, does every tier 2 client get the same annual amount of money or are the dollars still individualized to clients' varying levels of need? Will it just be an annual figure or will we bill on a daily rate, as now? Will the dollars be assigned as now, with the amount calculated for hours/week of one-on-one care with staff and another dollar amount for shared staff time?
Response: A rate study will be conducted to determine what amount should be assigned to the tiers and to the clients within those tiers. This will be part of Phase II of the PASSE model and the rates and methods for determining the individual's plan will be put out for public comment in that Phase.

Question: Will each PASSE do business with providers in the same, standardized way, or will providers have to use different case notes, plans of care forms and billing approaches depending on what each PASSE requires? If the latter, then how does the provider interact with the annual DDS auditors based on non-standardized paperwork and structure of info?
Response: These issues will be specifically addressed in Phase II of the PASSE model, which will be put out for public comment before taking effect in January 2019.

Question: How are projected Medicaid savings impacted by people who are dually eligible for Medicare and Medicaid, since Medicare will pay most of the medical costs?
Response: Services paid for by Medicare are excluded in the global payment amount; therefore, the PASSE will not be accountable for those costs and they will not factor into the State's savings numbers.

Question: How does DHS plan to educate the insurance companies, doctors, hospitals, pharmacist partners in each PASSE about housing and employment?
Response: DHS has several training contracts that will be utilized to educate providers and consumers about the new PASSE model and independent assessments, as well as other transformation efforts.

Question: Will I have money to pay for my services?
Response: Yes. Under Phase I, starting on Oct. 1, 2017, the services on the case plan will still be paid the same way they are now, through fee for service billing. In Phase II, starting on Jan. 1, 2019, Medicaid will still pay money for the services on your case plan, but it will be a global payment to a PASSE, who will ensure you get the services on your case plan.

Question: How will this affect my work and living arrangements?
Response: Under Phase I, the only service moving into the PASSE is care coordination. Therefore, work and living arrangements will not be affected by your enrollment into a PASSE. The PASSE care coordinator will be responsible for coordinating work and living services, if you need them and do not already have them provided.

Question: Will we be able to get Medicare and Medicaid?
Response: Yes. But, all Medicare paid services are excluded from the PASSE.

Question: What role will the PASSE Stakeholder Advisory Council play? Real input or just be advised of decisions?
Response: According to Act 775 of 2017, each PASSE must ensure that they have a Consumer Advisory Council. The role of the Consumer Advisory Council will be left up to each PASSE.

Question: What is Medicaid prepared to do and support with money and training (and DDS) to change things for improvement in quality of life, health care savings (no ER), and how do we not interfere with client choice and independence in setting goals and staff working them to change their choices?
Response: The care coordination fee that will be paid to the PASSE or Waiver care coordinator each month is designed for many of the purposes listed in this question. For example, the care coordinator is responsible for conducting follow up visits after a client goes to an ER. The care coordinator is also responsible for assisting the client when they have a service need they are not able to meet and for identifying health education and health coaching needs for their clients and making sure those needs are met. Each client will get a 90 day choice period after attribution, so that if they are not happy with their

PASSE, they may change. After that, the client will be able to change PASSEs once per year on their annual attribution date for any reason, or anytime for cause. Under Phase I of the PASSE model, all services other than care coordination remain fee for service, and the client is not limited to any particular service provider by the PASSE. Under Phase II, beginning on Jan. 1, 2019, the client will have to choose a service provider within their PASSE. However, to avoid change of providers, DHS is basing attribution on the client's existing provider relationships. DHS is also encouraging all providers to join all PASSEs.

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

Question: Providers are currently reimbursed $217.00 for case management, plan of care, and related supports. The proposed rate is $173.33 (along with a $208.00 one-time assessment fee for a PASSE and a $90.00 care plan fee for a DD Waiver provider). Please explain the reduction in fee and the plan for how assessment, care planning, and care coordination will be administered with current providers and PASSEs. For instance, how does DHS envision the user change to case managers, DCS, and PASSE integrated, whole-person care management?
Response: Providers are currently reimbursed $117.00 for case management and $100.00 for care coordination. "Whole-person" case management is the premise behind the PASSE model. Having a single care coordinator will allow a global view of each client's needs and ensure all health needs are addressed.

Question: Once a tier 2/3 client is in a PASSE and the PASSE takes over in 2019, will the PASSE be developing the programming goals/objectives for adult day programs?
Response: Once the PASSE takes over full risk of Tier 2 and Tier 3 DD and BH clients, beginning on January 1, 2019, the PASSE will be responsible for developing the consumer's overall plan of care. This will include any billable Medicaid service.

Comment: Please clarify 'current state,' 'future state,' and changes for 1) care coordination staffing including case managers, direct care supervisor (DCS), 2) related fees for the services, and 3) responsibility for plan of care between current providers such as DD waiver case management, DCSs, and PASSEs.
Response: Under the PASSE care coordination model, all case management/care coordination activities will be done by the PASSE care coordinator. To ensure continuity of service and consistency, we have changed the definition of case management in the CES waiver and changed the name of it to care coordination. The current case managers will provide care coordination as it is defined in the CES waiver to their clients until such time as those clients are attributed to a PASSE. Then the PASSE will take over providing care coordination.

Comment: We strongly believe this section loses sight of what the purpose of "conflict-free case management" is. It is not supposed to be an attempt to separate every possible "case management" or "care coordination" function from "direct care." As the sections above indicate, this is not even possible, e.g., where the roles are assigned to either direct care or care coordinator, that person is then required to cooperate with or monitor the other person, to the point it is not clear who is in charge.) That does not promote integrated, whole-person care. Instead, the issue would be more appropriately addressed in program policy through the Medicaid Provider Manual. We believe the goal of "conflict free case management" should simply be to ensure that direct care providers do not control decisions of resource allocation that should be handled by the Independent Assessment or DDS or the PASSE. Beyond that, direct care providers are not only suitable but they are in the best position to effect better care coordination because they are the ones who see the clients on a regular basis and have the closest relationships with the clients and their families. That is the very premise of "health homes," dozens of which have been promoted and approved by CMS over the years, and which underlie the work we have done with DHS for some seven years.
Response: We agree. The language is changed to reflect that the PASSE will comply with conflict free case management, which involves several components: assessment of an eligible individual (42 CFR 440.169(d)(1)), development of a specific care plan (42 CFR 440.169(d)(2)), referral to services (42 CFR 440.169(d)(3)), and monitoring activities (42 CFR 440.169(d)(4)). We have removed the restrictive language and stated that the PASSE entity will comply with the overall federal regulation.

Comment: Section 211.000 – It says that the PASSEs should begin October 1, 2017. I believe that this model is not ready to begin taking on

clients for several reasons. Rules like this one still have to be sent through the legislature for their approval. The Insurance Department isn't supposed to approve the PASSEs until mid-September, which will only leave them a couple of weeks before they start managing people's care. We don't know what the rules will be, and we don't know who the PASSEs will be. On top of that, they are required to prepare resources for their attributed clients like a handbook, and for that handbook, they will need time to develop policies such as an internal appeals policy. If the PASSEs aren't ready and don't do a good job, they could make mistakes. This will hurt people. I want DHS to push the date back and allow us to keep things the way they are until the PASSEs have had adequate time to review all of the finalized rules and to hire and train people who understand the rules.

Comment: Section 214.000 – It says that people can choose another PASSE during the first 90 days and once every year. How will we know what the differences between each PASSE is? I want to pick the best PASSE, but I don't understand all of the rules or what they all offer. (At this point, I have reason to wonder if the PASSEs themselves understand the rules, as they have not been finalized.) It also says "on the beneficiary's annual anniversary of attribution to a PASSE." Is this a single day to respond, or is it a week? You need to define how long that amount of time would be.
Response: Beneficiaries will be attributed to a PASSE that is heavily weighted by their use of a Developmental Disability or Behavior Health provider. After the initial 90 day choice period, beneficiaries will have an annual 30 day PASSE choice period starting on the beneficiary's anniversary date of attribution to a PASSE.

Comment: Section 214.000 D – It says a client can move because of "poor quality of care," but how do we prove that? That is a relative term. Who determines what kind of care is poor? I believe that the patient should determine whether care is poor and what that means in their situation.
Response: DHS will monitor through outcome measures and families will be consulted. We also anticipate that the Consumer Advisory Councils will be involved.

Comment: Section 215.000 – What if the abeyance is due to DHS/Medicaid's fault in paperwork (and the client can prove that)? Will the coordinator help the recipient to know that their Medicaid eligibility is in dispute and help them to figure that out?
Response: Yes.

Comment: Section 222.000 G – "The right to be provided written notice of a change in the beneficiaries care coordination" should be at least 14

days, not 7 days. If you are relying on snail mail, half of the time can be used simply in sending the notification, leaving the receiver very little time to respond or make other arrangements. Why isn't this policy the same as 223.000 B, allowing 30 days from the time it goes into effect?
Response: These are two different types of activities.

Comment: Section 231.000 – The travel times and distances listed need to be cut in half, especially for DD and BH providers who are seen on a more frequent basis. For example, it is not in the best interest of a child or adult to have to travel an hour to and then an hour to return from a location to see a therapist multiple times per week.
Response: Thank you for your comment but we disagree and think the distance is appropriate.

Comment: Section 241 G, 242 A, & 243.000 – DHS needs to give the PASSEs enough money to have a qualified individual available to help me whenever I need them, as many times as I may need them. Many providers seem to be concerned that the amount announced at the AR Waiver Conference (in July 2017) of $177 is not enough. I want them to get what they need so they can give me what I need. After December 31, 2018, they should have a different funding source and should not use any money from recipients' care for administrative funding needs.

Comment: Section 242.000 – It says in the document that care coordinators will be employees of the PASSE (241 B). However, it does not say where the care coordinators should be located. Because Arkansas is so rural, care coordinators located in the communities they serve would be most knowledgeable for their clients.

Comment: Section 254.000 – Will DHS be required to submit the data received from PASSEs, such as data that shows savings or lack thereof, for public viewing? We want to see that data as well.
Response: Beginning in the fall of 2017, DHS will begin reporting on savings targets to the Arkansas General Assembly. Those meetings are open to the public.

Comment: Section 261.000 – This says that grievances must be resolved within 30 days of the filing date. What will happen in the meantime? If a person needs treatment, do they have to wait all that time to receive it?
Response: There is not one standard answer to this question; the response depends upon the nature of the grievance.

Comment: Section 264.000 – This description needs more definition. Who may serve on a Consumer Advisory Council? I believe that beneficiaries or direct consumers should serve, but caregivers who speak

in place of beneficiaries who can't speak for themselves should also be able to serve.
Response: The Consumer Advisory Councils are mandated by Arkansas law and there will be one Council per PASSE entity. The potential PASSE entities are forming their council.

Comment: PASSE Phase 1 timeline is unrealistic. The timeframe should be pushed back and committee should be created for implementation transition like what was done for the children's DDTCS rules.
Response: Thank you for your comment. We believe the timeline is realistic and obtainable for Phase I.

Comment: The whole fiscal structure of the PASSE is unrealistic.

Comment: Current case managers that do not have the degree should be grandfathered in.
Response: In response to public comments, DHS is clarifying the qualifications of a Care Coordinator.

Comment: Services should start within 60 days after attribution not 14 days, again an unrealistic timeframe.
Response: Please note that manual states that the care coordinator will initiate contact within 15 days of attribution.

Comment: At the top of the page, as part of the program overview, assurances are made that the State will "ensure" that at least two PASSEs will always remain enrolled in order to provide beneficiaries with a choice. DRA would like to see the steps which would be taken by the State in order to ensure that at least two PASSEs are available to beneficiaries. We are concerned that without at least two functioning PASSEs, the Provider-Led Care model will not operate as intended and cause harm to beneficiaries who will be unable to receive care.
Response: We agree that clients should have a choice. If two PASSE entities do not remain, the State will not move forward with the organized care model.

Comment: Section 241 – subsection E states "Care coordination services must be available to attributed beneficiaries 24 hours a day through a hotline or web-based application." Can you clarify if the expectation is that Care Coordinators be on an on-call rotation or if a call-center is adequate during after-hours or holiday hours? Also, are existing DD provider care managers expected to be available for this 24/7 support? What is the required standard of Arkansas Medicaid today?
Response: These are operational decisions the PASSE will have to make as it meets the requirements of care coordination.

Comment: Section 254 – DHS Review of Outcomes - Subsection B references "Patient outcomes" – can you specify expected outcome measures? National established standardized?
Response: This requirement comes from Act 775 of the 2017 Arkansas Regular Session. An agreed upon time frame of data transfer will be discussed with each PASSE. Quarterly quality measure reporting expectations (for instance, file formats) will be discussed with each approved PASSE applicant.

Comment: What is the process for appeals/grievances? Does the State anticipate appointing an independent Ombudsman?
Response: Please see DHS Policy 1098 regarding the grievance process. DHS has choice counselors who will assist beneficiaries in transitioning between PASSEs.

Comment: Will Sections 260.00 – Grievances and 262.00 – Appeal Rights be required for Oct. 1, 2017, or will this be required when we are at full risk in 2019?
Response: Please see DHS Policy 1098 regarding the grievance process. These requirements in the manual are for Phase I and are required for October 1, 2017.

Comment: Section 224 – Marketing Materials states: "The PASSE may only market to potential beneficiaries through its website or printed material distributed by DHS's choice counselors. All marketing materials and activities must be approved by DHS in advance of use." What is the process for review/approval of materials and what are the maximum response times expected by the Department with an expected 10/1 go-live date?
Response: DHS will review and approve marketing materials in a timely manner once received.

Comment: Will participating providers in the PASSE's network be required to be participating providers with Medicaid in 2019?
Response: Rules for Phase II will be released in calendar year 2018. Medicaid Managed Care regulations require that participating providers be enrolled as Medicaid providers.

Comment: Will Arkansas Medicaid require the PASSE to offer all Medicaid participating providers an opportunity to join the PASSE as a participating provider in 2019? We are assuming that the PASSEs will be subject to Arkansas' Any Willing Provider Statute?
Response: Rules for Phase II will be released in calendar year 2018.

Comment: In assessing network adequacy, who will determine which providers are considered Substance Abuse treatment providers?

Response: DHS.

Comment: Will the Medicaid definition of substance abuse provider be used? If so, can we get the list of providers that already meet the test?

Comment: May the PASSE allow providers who are not recognized by Arkansas Medicaid to join their network in 2019?
Response: Rules for Phase II will be released in calendar year 2018.

Comment: How are we to distinguish between behavioral health and substance abuse providers who are very specific as to the client they serve (family, children, adults, etc.)? How will the adequacy test be measured in this case?
Response: Each provider who joins your network will be able to help assist you in determining what population they serve. Referral network adequacy will be determined by DHS.

Comment: If a provider type is not covered by the 'Any Willing Provider' laws, will the PASSE be required to add them as a participating provider in their network in 2019?
Response: Rules for Phase II will be released in calendar year 2018.

Comment: When will network adequacy be audited for final approval of the PASSE's network, and who will be completing this review?
Response: DHS will be completing this review for Phase I referral network adequacy by October 1, 2017. Rules for Phase II will be released in calendar year 2018.

Comment: What documentation is required to prove a contract exists between the provider and the PASSE during the network adequacy audit?
Response: Documentation reflecting contracts and agreements will differ by PASSE and potentially by provider. There is no standardized requirement for these.

Comment: What format will enrollment and eligibility data be provided in – 834? What is the frequency of data provided – daily, weekly, etc.? How will this information be delivered to the PASSE STFP, encryption, etc.?
Response: An electronic listing will be provided to the PASSE (see question 1) in a file that is not in 834 format that will simply be a listing of the individuals attributed to the PASSE for Care Coordination.

Comment: Will PASSEs receive an audit file and what is the frequency?
Response: This question needs to be further articulated to ensure that DHS understands what is being asked.

Comment: Readiness review – When would DMS/DHS anticipate this review? Presently the published timeline wouldn't support a review prior to 10/1/17.
Response: Referral network adequacy will be determined by DHS and is required for AID Licensure as well as required by federal Medicaid Managed Care regulations.

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

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

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

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

Question: If a consumer is pervasive level of care with inclusive opportunities for independence, how will that affect the change within the PASSE?
Response: Under the PASSE model, individuals currently classified as Pervasive level of care are until they are assessed being assigned Tier 2, which is the highest level of need (24 hour paid services and supports). This does not negate the ability for services and supports being provided in inclusive settings that offer maximum opportunities for independence.

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

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

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

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

Given the low rates of unemployment in many areas of the state and the workforce crisis in the field of direct services, coupled with low wage reimbursements, requiring applicants to have previous experience will be a

significant hardship for providers who already experience notable challenges in maintaining an adequate workforce.
Response: The cited section has been changed to require that a DSP has either (1) a high school diploma or GED; (2) one year of relevant work experience with a public health, human services, or other community services agency; OR (3) two years of verifiable experience working with individuals with developmental disabilities. Therefore, experience is no longer a requirement.

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

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

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

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

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

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

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

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

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

Comment: This section contains the language: "If the beneficiary or their legal guardian objects to the presence of any individual at the PCSP development meeting, then the individual is not permitted to attend." DRA recommends that language be included to address situations where the beneficiary and guardian's wishes are in conflict. For example, the following language could be included: "If the wishes of the beneficiary or guardian are in conflict as to persons attending the meeting, the preferences of the beneficiary will be given primary consideration and take precedence where there is no compelling health and safety reason."
Response: DDS asserts that items regarding guardians will depend on the specifics listed in the actual guardianship order. Because of this, no blanket response can be made.

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

Comment: Section 706(C):
This section discusses the required contact by a care coordinator with a beneficiary while their waiver status is in abeyance. We are concerned about the issue of in-person contact with the beneficiary. When a beneficiary is in the community, the standards require that a care coordinator make monthly contact with the beneficiary, with at least one in-person visit per quarter. However, under the standards, during the period of abeyance when a beneficiary is placed in a licensed or certified facility for up to 90 days (with possible renewal), the care coordinator is required to only "have a minimum of one (1) visit or contact each month." This section does not require any in-person contact as currently written. The language of the abeyance section should be changed to clearly state that even though the beneficiary is institutionalized; the care coordinator is still required to make quarterly in-person visits.
Response: This was the intent and the policy has been clarified to reflect your statement above.

Comment: DRA understands the State's desire to utilize a single instrument to determine beneficiaries' needs for consistency across programs. However, the information provided by the State regarding the move to the new Independent Assessment is vague. For example, the State has not provided access to the planned instrument it will be using for the assessments, only referencing the MnChoices assessment tool utilized in Minnesota. According to the information provided, the State intends to "build upon" that assessment tool and will "customize an Independent Assessment and algorithms and tiering criteria" for use in Arkansas.

There has been no information regarding the algorithms and no information provided regarding what services are available to a beneficiary once categorized into a tier. The tool itself is not included for review or comment. Additionally, there is not enough information

included within the proposed document to know how or if the State intends to consider data provided by beneficiaries or their medical providers in determining a beneficiary's level of need.
Response: For DD Clients:
1) DDS will continue to determine institutional level of care eligibility.
2) The independent assessment (IA) is a functional assessment tool, not a diagnostic tool. The client will have a diagnosis before the assessment is conducted.
3) The tool will look at the following domains for purposes of assigning a tier:
(a) Neurodevelopmental; (b) Psychosocial; (c) Caregiving/natural supports; (d) Self-preservation; (e) Treatment/monitoring; (f) Activities of Daily Living (ADL); and
(g) Instrumental Activities of Daily Living.
4) The assessment tool can also be used to create an individualized PCSP based on the client's needs determined by his or her answers to all applicable areas of the assessment, including mental health, neurological/central nervous system, therapies, geriatric depression screen, suicide screen, CAGE substance abuse questionnaire, mental status, and functional communication.

Comment: Furthermore, the proposed Independent Assessment Manual states it is intended to be used across two divisions within the Arkansas Department of Human Services. Namely, the proposed information states that the Division of Behavioral Health Services and the Division of Developmental Disabilities Services will be utilizing the new Independent Assessment. However, it is our understanding that the current Division of Behavioral Health Services will be merging with the current Division of Adult and Aging Services to form the new Division of Adult and Behavioral Health Services. Therefore, it is unclear whether the Independent Assessment will also be used for the aging and adults with physical disabilities population that is currently being assessed with the ArPath Assessment tool. This needs to be clarified.
Response: The MnCHOICES will be replacing the ArPath Assessment tool beginning calendar year 2018.

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

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

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

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

Practical problems with the proposed rules.

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

Under the draft language being promulgated, the PASSEs could contract with DD case managers at Pathfinder, but those case managers would not be able to coordinate care for Pathfinder clients. Instead, they would have to coordinate care for clients at Easter Seals, Friendship, or UCP, etc., with whom they have no relationship. Conversely, case managers from Easter Seals, Friendship, or UCP would have to coordinate care for

Pathfinder clients, and vice versa. The same scenario plays out all over the state.

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

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

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

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

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

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

more than meets the requirements of the law while remaining true to the provider-led nature of Act 775.

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

Regardless of whether the conflict-free rules apply or not, the proposed language is not in compliance.

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

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

We have recommended in the past that the Independent Assessment tool, in this case MnCHOICES, be used to provide a basic plan to fulfill this function, and then the direct service provider would use this tool to provide a more detailed care plan with services, staff, and schedules

within the budget approved by DHS. (This appears similar to the approach taken in Minnesota. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_172354. We still believe this is a good approach that will bring the state into compliance. Alternatively, the CMS final Managed Care Rule does not prohibit the MCO/PASSE from performing this function.

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

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

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

Other examples:

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

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

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

C.9 "determine whether the person is receiving appropriate support in the management of medication." – Yet, the Care Coordination section lists "Medication management plan" as a care coordinator responsibility. (It also says the care coordinator is responsible for coordination of

medication management. Does this have some meaning different than the direct care providers' "support in the management of medication"?)
Response: The role of the care coordinator will be to work closely with all service providers, including the supportive living provider if applicable to ensure appropriate services and supports are being provided to the beneficiary.

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

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

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

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

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

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

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

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

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

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

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

Comment: As stated in other comments specifically on the proposed Independent Assessment Manual, the information shared by DHS on the Independent Assessment is vague. Therefore, it is difficult to meaningfully

comment on any addition to the use of the Independent Assessment for personal care services, which DHS proposes to amend in multiple manuals, without additional information regarding the tool, algorithms, tier system, service allocation, and population impacted by the use of the new Independent Assessment across differing programs. Though many of the proposed changes direct the public to the Independent Assessment Guide for more information, the Independent Assessment Manual, as the only "guide" published by DHS directly discussing the Independent Assessment, does not provide the information needed. Consequently, the public is left with little information regarding the process and no way to fully comment on the proposed rule changes.
Response: The independent assessment for the aforementioned population will begin in calendar year 2018. Additional information will be forthcoming.

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

FINANCIAL IMPACT: The estimated cost to implement the rule is $15,520,632 in the current fiscal year ($4,521,160 in general revenue and $10,999,472 in federal funds) and $12,644,401 in the next fiscal year ($3,683,314 in general revenue and $8,961,087 in federal funds).

Since there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined, the agency submitted the following information:

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

This proposed rule implements Act 775.

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

A PASSE is a new type of Medicaid provider; the proposed rule describes the responsibilities of a PASSE.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule:

The proposed rule describes the responsibilities of the PASSE that will meet the federal requirements for a Primary Care Casement Management waiver under Section 1915.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs:

The cost of a care coordination system will offset by savings in Medicaid benefits.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule:

N/A

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule:

N/A

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response:

N/A

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

DHS will continue to monitor the cost and benefits to the PASSE system.

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

administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it, and it shall make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76, Public Assistance Generally, of the Arkansas Code. *See* Ark. Code Ann. § 20-76-201(1), (12).

b. SUBJECT: Independent Assessment Manual

DESCRIPTION: DHS is promulgating the Independent Assessment Manual for beginning independent assessments of the functional needs of beneficiaries with high levels of behavioral health and developmental/intellectual disabilities service needs.

This manual describes:

1. The process that will be used to independently assess these beneficiaries;

2. The tiering process that the independent assessment vendor will utilize to make a tier determination for these beneficiaries;

3. The qualifications that an independent assessor must have; and

4. The training that an independent assessor will have to undergo.

PUBLIC COMMENT: A public hearing was held on August 8, 2017. The public comment period expired on August 11, 2017. The Department received no public comments.

The agency states that CMS approval is not required for this rule. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: The cost to implement this rule is $9,563,368 for the current fiscal year ($2,785,809 in general revenue and $6,777,559 in federal funds) and $12,751,157 in the next fiscal year ($3,714,412 in general revenue and $9,036,745 in federal funds).

Since there is a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined, the following information was submitted:

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

The IA system will determine the level of needed services to implement Act 775, support the state's Home and Community Based Services (HCBS) waivers, and avoid duplication of personal care services between the state plan services and waiver services. It is critical to implementation of the PASSEs and to help meet the savings goal of $835 million for the Medicaid Transformation initiatives.

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

Federal law requires an IA for HCBS waivers. Act 775 requires an IA to identify the target populations for enrollment into the PASSEs.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule:

The role of and need for an IA system was included in the recommendations of The Stephen Group to the Legislative Task Force.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs:

The cost of an IA system will offset by savings in Medicaid benefits.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule:

The IA was procured through an RFP.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule:

Some providers opposed the use of an IA system. That alternative would forfeit Medicaid savings.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response:

The existing system is not on a stable IT platform which produces inefficiencies in program management.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives:

DHS will continue to monitor the cost and benefits to the IA system.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 20-76-201, the Department of Human Services ("Department") shall administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it. *See* Ark. Code Ann. § 20-76-201(1). The Department shall also make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76, Public Assistance Generally, of the Arkansas Code. *See* Ark. Code Ann. § 20-76-201(12).

c. SUBJECT: Outpatient Behavioral Health Services Update 1-17, Inpatient Psychiatric Services for Persons under Age 21 Update 1-17 and Residential Community Reintegration Program Certification

DESCRIPTION: Effective October 1, 2017, Arkansas Medicaid proposes to move the Residential Community Reintegration Program service from the Inpatient Psychiatric manual to the Outpatient Behavioral Health Services manual and to establish certification requirements for the Residential Community Reintegration Program. This service was previously approved in the Behavioral Health Transformation package that was filed with the Secretary of State's Office on December 27, 2016, and given rule number 016.06.16-024. The proposed rule is necessary to comply with CMS approval of the new OBHS services.

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

Cookie Higgins, Centers for Youth and Families

Comment: There is no DHS application form for the Residential Community Reintegration program posted.
Response: The form mirrors the existing programmatic application forms (i.e. Therapeutic Communities, Partial Hospitalization) and

requires information to be entered in a similar manner in order to begin application for certification as a Residential Community Reintegration program and has been added to the packet for promulgation.

Comment: Please verify that the documentation required for this per diem service is only one summary note a day.
Response: The daily note required in the beneficiary's medical record must document the services provided to that individual during the day and the progress or lack of progress towards meeting goals identified in the beneficiary's treatment plan. The required documentation in the provider manual is described as "Daily description of activities and interventions that coincide with master treatment plan and meet or exceed minimum service requirements.

Comment: If documentation is completed by a mental health paraprofessional, is a signature by a mental health professional also required?
Response: Documentation must be signed by the supervising professional as well as reviewed by a physician.

Comment: Section 168.000, In-service (5) of Certification Policy – Please add mandatory Child Maltreatment reporting, 2010 Arkansas Code Annotated Title 12 – Subtitle 2, Chapter 18.
Response: This will be added to this section of the Certification requirements for in-service training.

Comment: Section 171.000, Facility Environment (j) – Recommend removing the requirement for actual hours of operation to be posted at all public entrances. Residential Community Reintegration Programs are 24/7 facilities. They are always in operation.
Response: This requirement will be removed from the Certification requirements for Facility Environment. This section will now read "The Residential Community Reintegration Program's telephone number(s) shall be posted at all public entrances."

Comment: SPA 010-Attached 3.1A.doc and SPA 010-Attach-1b.doc – Both of these documents state that the "Residential Community Reintegration Programs shall be certified by the Department of Human Services as a Therapeutic Communities provider." Shouldn't that read "certified by the Department of Human Services as a Residential Community Reintegration Program"?
Response: Yes, this oversight has been corrected.

Comment: Section 254.003, OBHS manual – Residential Community Reintegration Program – Please consider adding other Places of Services.

Location 14 is group home location. As youth stabilize and transition into the community/school, etc., they could receive services in other locations – 12, Patient's Home; 03 – School; 99 – Other Locations (which would be specifically identified on a progress note). Services could also be provided in 11 – Office (Outpatient Behavioral Health Provider: Facility Service Site).

Response: The Residential Community Reintegration Program is a residential service to be provided to beneficiaries who are identified by the Independent Assessment as eligible for Tier III services. The per diem payment is for the beneficiary to receive services at a location where the beneficiary is being provided 24/7 care. Once beneficiaries stabilize and transition into the community, other services are available for those beneficiaries with the Behavioral Health program as reimbursed by Medicaid.

Comment: We request RSPMI providers be allowed reimbursement for Residential Community Reintegration services until June 2018 while they complete their transition to a Behavioral Healthcare Agency under OBHS regs (similar to PH and Therapeutic Communities).

Response: Providers will be allowed to be certified as and be provided reimbursement for the Residential Community Reintegration program prior to making the switch to full reimbursement under the Outpatient Behavioral Health Services Program, as allowed for Partial Hospitalization and Therapeutic Communities.

Julie Meyer, PFH

Comment: OBHS Rate Process Concerns, including:

- Data utilized to determine rates for OBHS program are from 2012
- The OBHS program became effective on July 1, 2017, three years after rates were published and five years beyond the data utilized.
- The OBHS Medicaid Manual and necessary certification policies were promulgated, but the rates for the OBHS program were not subject to a process that included public comment or legislative review.

Response: The approved reimbursement rates for the Outpatient Behavioral Health Services program are based upon the 2014 Public Consulting Group (PCG) Rate study. The rates were shared with all stakeholders and anyone who requested a copy of the proposed rates during the promulgation of the Outpatient Behavioral Health Transformation that was approved by the Arkansas Legislature in December of 2016. Once the related underlying rule or methodology is promulgated and effective, the rates are also effective and posted to the "fee schedules" section on the Medicaid site.

Comment: OBHS Rate Concerns:

- The rates for therapeutic services provided by a licensed clinician are a significant reduction from the current RSPMI rates.
- Therapeutic services provided by licensed clinicians are the foundation for the care of individuals with mental health conditions; lower rates diminish the value of these services.
- These lower rates will be effective during the timeframe that DHS plans to collect data to determine the Global Payment for the PASSEs.
- Inadequate rates could set the PASSEs up to fail due to an inaccurate Global Payment.

Response: The approved reimbursement rates for the Outpatient Behavioral Health Services program are based upon the 2014 Public Consulting Group (PCG) Rate study. All rates for Global Payment for the PASSE must be actuarially sound to comply with Federal Manage Care Waiver rules. The Centers for Medicare and Medicaid Services (CMS) must also approve of the methodology and determination of the DHS global payment to a PASSE.

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

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 20-76-201, the Department of Human Services ("Department") shall administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it. *See* Ark. Code Ann. § 20-76-201(1). The Department shall also make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76, Public Assistance Generally, of the Arkansas Code. *See* Ark. Code Ann. § 20-76-201(12).

d. SUBJECT: Independent Assessment for Personal Care and Criminal Background Check Requirements for Providers

DESCRIPTION: This rule requires an Independent Assessment and Prior Authorization for individuals receiving Personal Care Services through State Plan Services. Additionally, the state is updating provider manuals to clarify that the owners, principals, employees, and contract staff of certain providers must submit to criminal background checks.

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

During the public comment period for the ARChoices and Personal Care Provider Manual revisions, Arkansas DHS received comments from an attorney representing an Area Agency on Aging (AAA), the Arkansas Association of Area Agencies on Aging, Disability Rights Arkansas, two large providers of waiver and personal care services, an attorney representing the Arkansas Residential Assisted Living Association (ARALA), and a company that owns several Residential Care Facilities (RCFs) who provide personal care with a separate letter from the RCFs' attorney.

Comment: The majority of commenters were concerned with the requirement of all owners, principals, employees, and contract staff must submit to a national criminal background check, identity verification, and fingerprinting. It was called excessive and unnecessary. Many said that this would be a financial burden for agencies and contracted employees with no Medicaid reimbursement. There was also a concern that it could delay services due to the length of time it takes to receive results of national background checks in some areas of the state.
Response: DAAS will amend the language to require the provider to comply with current state law and regulations, ensuring consistency with other Medicaid programs. That is, a State criminal records check every 5 years and a Federal records check if the individual hasn't lived or worked in the State for 5 consecutive years.

Comment: One commenter suggested changing the wording in Personal Care at 213.230 (item C) from "Employ and supervise direct care staff who:" to "Ensure supervision of employed or contracted direct care staff who:"
Response: As this was not part of the scope of this revision, we will take this under advisement and consider the change at the next revision.

Comment: A couple commented that the added language in Personal Care at 201.120 (items D-K) do not fit under the heading.
Response: This was a mistake. This language is a duplicate of other sections. We will make the correction.

Comment: The forms still reference physician signature, which is presumably an error since the physician has been removed from the authorization process.
Response: Yes, those will be removed from the forms with the implementation of the policy.

Comment: Section 200.130 – The section deletes a statutory requirement that Personal Care Agencies be licensed by the Department of Labor. That

requirement is also part of the Health Department licensure requirements. Is it the Department's intent to make it easier for agencies to become Personal Care Agencies and, by extension, Personal Care Providers? Can existing Class B Home Health providers change their licensure to Personal Care Agencies? Will Personal Care Agencies have geographic restrictions like Home Health Agencies? It was our understanding that DHS and OMIG were planning to impose more program integrity requirements on Personal Care Providers. This change seems to do just the opposite.
Response: Yes, providers will no longer have to be licensed by the Department of Labor. DHS will work with the Department of Health so regulations are consistent and comply with State law.

Comment: Section 214.200 – This section retains the current six-month timeframe for the validity of a case plan. However, at stakeholder meetings, Optum, the state's Independent Assessment (IA) contractor, has stated its intent to complete IAs on an annual basis, with the ability to request a revision if the client's condition changes. ARChoices plans already provide for one-year authorization of personal care if it is included in the plan. Given the additional steps added to the process, the state should provide for all Personal Care Plans to be effective for one year.
Response: The provider manual will be amended to allow Personal Care Plans to be in effect for 1 year.

Comments: Section 215.330 – A reference to physician authorization in Subsection 3.a. is presumably an error and should be removed. And, Section 214.200 – The Note in this section refers to a "physician's authorization." Given that the physician has been removed from the process, this is presumably an error.
Response: Those are noted and will be corrected.

Comment: Sections 215.320 and 340 – Given that the initial request for Prior Authorization can be submitted via fax according to Section 242.000, there is no reason why original documents of notices of service initiation delay or termination of services in these sections should have to be submitted via mail. We would suggest that these follow-up requirements be deleted or changed to allow submission via fax.
Response: This was not part of the original revisions. DHS will consider this at the next revision.

Comment: Section 242.000 – This section says that the care plan, completed by the provider RN, must be submitted to DHS. We have been told at stakeholder meetings that the submission will be to DHS, which will then transmit the information electronically to Optum on a periodic basis for Optum to actually perform the assessments. After the IA is completed, the results will be submitted to DHS, and a DAAS RN will meet with the client to develop a plan and choose a provider. This means

that the provider who spent the time, money, and effort to have its RN complete the DMS-618 may have done that work for another provider to end up serving the beneficiary. The Independent Assessment Guide does not provide any details on how the process will occur for Personal Care, but if an individual makes an initial choice of a provider to do the initial RN assessment and submit the form for Prior Authorization, that choice should be honored after the IA if the individual is approved for services.
Response: DHS will engage stakeholders to discuss the process prior to the January 1, 2018 implementation date.

Comment: Related to the previous comment: Section 242.000 – This section says that the provider—in this case, the RCF or ALF—submits the first six pages of the DMS-618 to DHS, who then provides it to the IA contractor, who then performs the in-person assessment. At stakeholder meetings, we have been told that after the IA results are provided to DHS, a DHS employee will contact the individual to discuss a care plan and their choice of a Personal Care provider. Does this mean that the beneficiary will have the choice of changing providers at the suggestion of a DHS employee? That puts the residential Personal Care provider in the untenable position of accepting a resident for admission, completing the occupancy agreement, having an RN fill out the care plan, commencing services, beginning the process of helping the resident acclimate to a new environment, arranging for mental health or other services that the beneficiary might require, and then facing the possibility of the resident choosing a different provider based on their discussion with the DHS staff regarding provider choice. This is an unacceptable risk for a provider who makes the initial investment in admitting a resident. If a resident has chosen an ALF or RCF, there should not be a risk that the new resident will be influenced to choose another provider after the IA is completed.
Response: DHS will engage stakeholders to discuss the process prior to the January 1, 2018 implementation date to ensure no delay in access to services.

Comment: Section 242.000C – Given the availability of easy-to-use email encryption, DHS should consider allowing submission of the required documents for Prior Authorization via encrypted email.
Response: We will take this into consideration.

Comment: Section 243.000 – Will a Prior Authorization Number be provided for each individual that the provider will have to use for billing purposes, or will the authorization be automatically entered into the claims processing system so that claims consistent with the approved claim are paid and those that are not consistent with the approved plan are not paid?
Response: DHS will engage stakeholders to discuss the process prior to the January 1, 2018 implementation date.

Comment: A representative for Residential Care Facilities (RCFs) commented that RCFs should be exempt from the Prior Authorization (PA) process through the Independent Assessment (IA) because of their unique situation. Paraphrasing: the individual is already in the RCFs care and the PA would add an "administrative layer" that would delay authorization of services that RCFs are required to provide. She also states that the proposed regulations appear to conflict with the RCF regulations through the Office of Long Term Care, but doesn't specifically say how.
Related Comment: Representative from ARALA requests, due to the above issues and that RCFs and ALFs are required to provide services from the time of admission, DHS retains the current mechanism, or, if the IA is to be used, allow RCFs and ALFs to bill from the date of admission until the IA results are received, regardless of whether the individual is eventually approved.
Response: All Personal Care services will be subject to the Independent Assessment and Prior Authorization based on assessed need. DHS will engage stakeholders to discuss the process prior to the January 1, 2018 implementation date.

Comment: Two commenters requested that DHS hold a public hearing.
Response: A public hearing was held on August 8, 2017, at 4:30 at AEDD. It was published in the notice of rulemaking that was advertised in the Arkansas Democrat Gazette and the Medicaid website.

Comment: State Plan Amendment – The SPA removes the 64-hour benefit limit and replaces it with language that states that Prior Authorization would be pursuant to the IA. Does that mean there is no benefit limit for Personal Care anymore? Can residential providers get more than 64 hours per month equivalent if a resident's needs justify it?
Response: That is correct. The benefit limit will be based on their assessed need through the IA. This will eliminate the need for extension of benefits requests.

Comment: Related to the IA: Will the full MnCHOICES assessment be used for the Personal Care population? What is the algorithm that will be used to translate responses on the IA into a determination of which of the ten rate tiers an RCF or ALF resident falls into? What is the appeal process for the IA if the tier level is lower than necessary to support the services required by the RCF or ALF resident? Who can appeal the IA results? All of these issues should be addressed for Medicaid Personal Care. As stated previously, the regulations should allow the current assessment, care plan, and tiered reimbursement to remain for residents of RCFs and ALFs as the provision of Personal Care in the residential setting is very different than going into an individual's home.

Response: For Personal Care, the Independent Assessment will take into account the Activities of Daily Living as an eligibility criteria similar to the criteria listed in Medicaid State Plan.

Comment: Medicaid Personal Care rates are inadequate and rate increases occur years apart. We have attempted to resolve these funding issues with DHS and legislatively, all to no avail. Because the IA has the potential to reduce reimbursement even further if clients are denied or are assigned to lower tiers, this process should be delayed until adequate rates are established. Our providers will vigorously oppose any apparent attempt to finance the new IA process by reducing services and tier levels to beneficiaries. DHS' interests would be better served in focusing on providing adequate reimbursement rates rather than implementing an untried IA process that is likely to reduce care to high-need residents of RCFs and ALFs.
Response: Increasing the rate is not part of the scope of this revision; however, the Personal Care rate increased to $18 per hour on January 1, 2016.

Comment: Though many of the proposed changes direct the public to the IA Guide for more information, the IA Manual, as the only "guide" published by DHS directly discussing the IA, does not provide the information needed. Consequently, the public is left with little information regarding the process and no way to fully comment on the proposed rule changes.
Response: DHS will engage stakeholders to discuss the process prior to the January 1, 2018 implementation date.

Comment: The State Plan proposed changes continue to use outdated terminology. ICF/MRs should be ICF/IIDs.
Response: This is noted and will be corrected.

Comment: Section 213.300 – Is this an exclusion of "dual-eligible" recipients completely, or for only the services covered and paid by Medicare?
Response: The exclusion is for services covered by other non-Medicaid payors.

Comment: Section 213.300 – In regard to Attribution – will there be an allowance for the accounting for the cost of unpaid services that an individual receives, but is in a spend-down category? Although the state does not pay for services while they are in spend-down, those services are still a cost to the provider; thus will you consider looking at those unpaid services as a part of attributing to a given PASSE based on primary BH/DD provider? How will the unpaid services in a spend-down category be considered?

Response: No, there is no allowance for the accounting for the cost of unpaid services that an individual receives for attribution.

Comment: Clarification for how beneficiaries will be identified to undergo an independent assessment and/or be referred for an independent assessment, including self-referral. Will this be the same or similar to that of the Office of Behavioral Health Provider Manual Section 213.100?
Response: For DD, a client must be on the DD waiver or seek admission to an ICF. For BH, clients who are currently receiving RSPMI services and recommended by DHS; clients who are currently receiving RSPMI services and recommended by RSPMI provider; clients seeking inpatient psychiatric admission; and clients who are utilizing high amounts of Tier 1 services. DHS will continue to review service data to identify individuals that may need higher levels of care.

Comment: A description of the criteria, algorithm, and thresholds for each tier level.
Response: See Attachment "B."

Comment: Assessment for Beneficiaries with Behavioral Health and Developmental/Intellectual Disabilities Service Needs1 provided on July 13, 2017, PASSE APPLICANT has the following comments:
– It is unclear regarding the methods (survey tool, observation, interview, etc.) that are used to complete this assessment and requests clarification from the State how the assessment is conducted. PASSE APPLICANT requests clarification if the assessment will take place in person, telephonically, and a detailed description of methods used.
– PASSE APPLICANT requests a copy of the tool to further assess its assessment of the identified domains.
– The assessment tool does not appear to take into consideration the beneficiaries' diagnoses, including their comorbidities or the acuity of their conditions. PASSE APPLICANT advocates that this information be included as it is critical to the appropriate Tier assignment and corresponding level of coordination of member care.
– The assessment tool does not appear to assess for natural supports. PASSE APPLICANT requests that the tool includes an assessment of natural supports.
– The assessment tool does not appear to take into consideration utilization of health care services, including urgent care, emergency department, or psychiatric placements. PASSE APPLICANT recommends that utilization of high-cost levels of care be included in the assessment tool as this is directly correlated with one of the principle objectives of Act 775 of the 2017 Arkansas General Session to "slow or reverse spending growth for enrollable Medicaid beneficiary populations," in addition to statute-required performance measures to monitor "reduction in unnecessary hospital emergency department utilization," "reduction in

avoidable hospitalizations for ambulatory-sensitive conditions," and "reduction in hospital readmissions."
– The assessment tool does not appear to take a forensic/legal history, including if the beneficiary is currently assigned to court ordered treatment, is a sex-offender, or has any other legal implications that may be deterministic in their care.
Response: See Attachment "B."

Comment: PASSE APPLICANT requests clarification of the 'broader array of services' that will qualify a beneficiary for Tier II.
Response: Please see the Outpatient Behavioral Health Services manual, which specifies the services contained within Tier II (Rehabilitative Level).

Comment: PASSE APPLICANT requests clarification of the 'additional criteria' that will be used to qualify a beneficiary for Tier III.
Response: See Attachment "B."

Comment: PASSE APPLICANT requests clarification of the 'institutional level of care criteria' referenced herein and recommends the State include a citation for this criteria in this policy manual.
Response: Institutional Level of Care Criteria is the eligibility criteria for the DDS waiver. Please see DDS Policies 1035, 1086 – DDS Community Employment Supports Waiver, Document, Manual, and Standards.

Comment: PASSE APPLICANT requests clarification regarding the Independent Assessment and the information the PASSE will be provided by the State in order to develop the total care plan. PASSE APPLICANT recommends this information include, at a minimum:
– Demographic information, including clinical information and contact information for the beneficiary, their legal guardian, and an emergency contact
– Independent assessment tool raw data
– Prior two-years claim history for the beneficiary
Please see comments submitted in section 213.300 of this document.
Response: DHS has the ability to report on claims filed by providers, procedure codes bill for and paid, dollar amounts paid, units paid, etc. that can be shared with the PASSE. An agreed upon time frames of data transfer will be discussed with each successful PASSE applicant.

Comment: At the top of the page, as part of the program overview, assurances are made that the State will "ensure" that at least two PASSEs will always remain enrolled in order to provide beneficiaries with a choice. DRA would like to see the steps which would be taken by the State in order to ensure that at least two PASSEs are available to

beneficiaries. We are concerned that without at least two functioning PASSEs, the Provider-Led Care model will not operate as intended and cause harm to beneficiaries who will be unable to receive care.
Response: We agree that clients should have a choice. If two PASSE entities do not remain, the State will not move forward with the organized care model.

Comment: When discussing the tiers of service for Behavioral Health Clients, the application says that eligibility for Tier III levels of service will be identified by "additional criteria." These additional criteria are not explained any further in the document. While this may refer to information gathered during the independent assessment process, it is unclear in this instance.
Response: See Attachment "B."

Comment: On the topics of timely access to services and capacity standards for the PASSEs, the application states that each PASSE must have an adequate referral network and an adequate number of care coordinators for all attributed beneficiaries. No mention is made of ongoing oversight to ensure that these standards are being maintained, or of penalties for failing to meet these standards.
Response: The PASSE Provider Manual Section 250.000 "Metrics, Accountability, Reports, and Quality Assurance and Performance Improvement (QAPI)" addresses these standards. Section 152.000 in the PASSE Provider Manual addresses sanctions.

Comment: The section on disenrollment from a PASSE states that the good cause reasons for a beneficiary to disenroll from a PASSE during the 12 month lock-in period are "all of the reasons listed in 42 C.F.R. 438.56(d)(2)." Among the reasons listed in the statute is "poor quality of care," which is not defined in the statute or clarified in the waiver application. We are concerned about situations when there is a conflict between the beneficiary and DDS about quality of care and who decides whether the beneficiary can disenroll from a PASSE. Given that the lock-in period can keep a beneficiary with a PASSE for up to 12 months, the grounds for disenrollment during the lock-in period should be both as clear as possible, especially when there are quality of care issues. To the greatest extent possible, the system should also defer to the choice and judgment of the beneficiary.
Response: We agree the system should defer to the beneficiary's choice.

Comment: On this page a reference is made to an Attribution Methodology Concept Paper attached to the application. There are references made throughout the application to other attached documents which flesh out the various topics of discussion. None of these

attachments were provided with the materials released for public comment. All attachments should be provided with material available for public comment, in order to provide stakeholders with the full context for the materials they are meant to discuss.
Response: This topic was previously discussed in the white paper released June 27, 2017. Please see Attachment "A."

The agency states that CMS approval is required for these rules; as of August 23, 2017, that approval is pending. The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: The estimated savings of implementing this rule is $17,268,000 for each of the current fiscal year and the next fiscal year ($5,030,168 in general revenue and $12,237,832 in federal funds). There is a $200,000 estimated cost for each of the current fiscal year and the next fiscal year to entities affected by the rule.

The state is moving forward with a CMS requirement for providers to submit to an independent, national criminal background check, identity verification, and fingerprinting.

Since there is a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined, the agency submitted the following information:

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

The purpose of the rule is to improve Arkansas Medicaid program integrity and meet federal requirements for national fingerprint-based criminal background checks and identify verification of Medicaid providers and other persons with an ownership interest or management or supervisory responsibility for a provider organization.

The proposed rule will require national criminal background checks, identity verification, and fingerprinting of all owners, principals, employees, and contract staff of personal care providers, individuals providing self-directed personal assistance, home health agency providers, hospice providers, and private duty nursing providers in order to prevent provider fraud and abuse and protect vulnerable Medicaid beneficiaries from caregivers and others affiliated with provider organizations who have criminal records, are not qualified, or are otherwise excluded from participation in federally funded health programs.

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

See Response below to question (3).

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs:

The proposed rule is necessary and appropriate to:

- Strengthen the integrity of the Arkansas Medicaid program and reduce the risk to taxpayers and beneficiaries of waste, fraud, abuse, overpayments, improper care, and participation by unqualified or excluded providers, owners, or supervisors.

- Meet applicable federal requirements including 42 U.S.C. 1396a (a)(77) and (kk), 42 U.S.C. 1396b(i)(2)(A), 42 CFR Part 455 Subpart E, the Medicaid Provider Enrollment Compendium (MPEC), and other program integrity guidance issued by the Centers for Medicare and Medicaid (CMS) and the federal Office of Inspector General (OIG).

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule:

There are no reasonably effective, efficient, or less costly alternatives to the proposed rule given: (a) the explicit purposes and functions of fingerprint-based national background checks and identity verifications, (b) the processes and safeguards necessary to fully and securely perform the tasks involved, (c) the scope and goals of new federal requirements, (d) proven best practices in Medicaid program integrity, and (e) the potential risks to the State and beneficiaries in the absence of the proposed rule policies.

The data systems, technology, processes, and procedures for valid, reliable, and independent fingerprint-based national background checks and identity verifications are well established and widely used by government agencies and the private section throughout the US. There is ample competition among qualified vendors who are able to meet federal and state requirements in a cost effective manner.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule:

The Department of Human Services will respond to public comments as appropriate following the public comment period. At this time, it is not believed that any alternatives exist that would meet federal requirements and meet Medicaid program integrity needs.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response:

This proposed rule expands the scope of current background check-related requirements to (a) improve Medicaid program integrity in home care services; (b) strengthen existing rules which either do not include these requirements or require them only in certain circumstances; (c) strengthen safeguards to reduce risks of limited, inadequate, or unavailable background checks, fingerprinting, or non-verified identities; and (d) meet federal requirements under 42 U.S.C. 1396a (a)(77) and (kk), 42 U.S.C. 1396b(i)(2)(A), 42 CFR Part 455 Subpart E, the Medicaid Provider Enrollment Compendium (MPEC), and other program integrity guidance issued by the Centers for Medicare and Medicaid (CMS) and the federal Office of Inspector General (OIG).

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives:

On an ongoing basis, the Department of Human Services monitors Arkansas Medicaid program requirements for providers and makes or proposes modifications to rules, processes, and procedures as appropriate in response to best practices, innovations, experience, program integrity risks, feedback from stakeholders, and changes in state law or federal statutes, regulations, waivers, and guidance.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 20-76-201, the Department of Human Services ("Department") shall administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it. *See* Ark. Code Ann. § 20-76-201(1). The Department shall also make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76,

Public Assistance Generally, of the Arkansas Code. *See* Ark. Code Ann. § 20-76-201(12).

8. ARKANSAS INSURANCE DEPARTMENT (Booth Rand)

a. SUBJECT: Rule 117: Provider-Led Organization Licensure Standards

DESCRIPTION: The rule proposed is to adopt AID Emergency Rule 117, Provider-Led Standards, issued on May 22, 2017, before its expiration in 120 days (September 19, 2017). The permanent rule amends the earlier issued emergency rule by the same number and subject to remove emergency language and to change the effective date. Act 775 of 2017 requires the Arkansas Insurance Commissioner to adopt a rule implementing the Organized Care Act before June 1, 2017, and to begin issuing licenses to entities participating in the program on and after July 1, 2017. AID issued an implemental rule on an emergency basis on May 22, 2017. AID now proposes to permanently adopt the emergency rule requirements, which provide application requirements of the RBPO participating in the program; address standards for imposing additional funds above reserve requirements to adjust to risk in Ark. Code Ann. § 23-61-117(b)(2); and, finally, prescribe the reporting, forms, and requirements related to the payment of the quarterly tax under Ark. Code Ann. § 23-61-117(b)(3).

PUBLIC COMMENT: A public hearing was held on August 10, 2017. The public comment period expired that same day. The Department provided the following public comment summary:

#1. Written Comment from the Arkansas Provider Coalition, August 9, 2017

As we indicated when the draft rule was published, we believe more flexibility should be provided in regards to risk-based capital (RBC) for true provider-led entities. This is a Medicaid-only product backed by the state of Arkansas. If any of the PASSEs become insolvent, the members will be enrolled into another PASSE or Medicaid fee for service. Medicaid still will have claims processing capability in place, and the provider network that has existed in Arkansas Medicaid for many years still will be here. This is not akin to a commercial HMO becoming insolvent with enrollees left to fend for themselves. We understand the Department of Human Services is seeking to provide stop-loss at 102%, which should help, but we believe the Insurance Commissioner should take into account other factors unique to this model and the Investment by providers themselves when calculating the RBC.

Conditional Licensure: We do not take issue with the rule's other provisions as they relate to full licensure of a risk-based provider organization as authorized by Act 775 of the 91st General Assembly. However, the PASSEs (Provider-Based Arkansas Shared Savings Entities) will not be operating as risk-bearing entities until January 1, 2019. Between October 1, 2017, the PASSE/RBPOs will not even be TPAs or ASOs–they will be providing a single service (care coordination) on a rate paid per client by Medicaid. Your rule adopts the definition of RBPO from the Act which states that an RBPO is paid by ADHS on a capitated basis with a global payment. None of the PASSEs will meet that definition prior to January 1, 2019.

Consistent with the services that will be provided, Section 7 of Act 775 contains a timeline that provides initially for conditional licensure [§7(a)(2)]. The licensure application submitted on July 1, 2017 is for conditional licensure [§7(a)(2)(A)]. The conditional license is to expire on December 31, 2017, or a later date as established by the commissioner [§7(a)(2)(C)]. The surety bond is to guarantee that the PASSE does not abandon efforts to obtain full licensure [§7(a)(3)(C)]. On or before January 1, 2018, an organization with a conditional license shall demonstrate that it has met the solvency and financial requirement established by the commissioner [§7(a)(4)]. On or before April 1, 2018, an organization with a conditional license shall demonstrate that it is capable of assuming the risk of a global capitation payment and arranging for provision of healthcare services to Medicaid beneficiaries [§7(a)(5)]. Once an organization meets these requirements, it can receive full licensure [§7(b)(2)], although the commissioner has flexibility to extend the dates and still award full licensure [§7(b)(3)]."

AID RESPONSE ON REQUIRING RBC: The Department and its actuaries spent several months reviewing other state regulation of provider managed care organization risk bearing activities and solvency requirements, including those assuming risk in the administration of state-based Medicaid programs. We have met with and discussed our position on why we are using risk-based capital requirements (RBC) with most of the prospective RBPOs interested in participating in this program. The Department actuaries and a substantial majority of states financially regulate these organizations under statutory accounting principles as HMOs requiring adherence to RBC solvency requirements, given their assumption of downstream risk to medical providers, and this is significantly the case here given that the RBPOs have to assume full medical assumption of risk for the beneficiaries, and not just behavioral or DD care. The RBPOs in this program are proposed to manage over 100 million dollars in annual premium for each RBPO. RBC requirements provide a tried and true method of ensuring a safe and financially solvent program given the substantial amounts of money involved.

AID RESPONSE ON REQUIRING 6 MILLION AT START UP BEFORE 1-1-2019 FULL RISK: As stated several times to the organizations, AID interprets Act 755, the Organized Care Act, specifically now codified at § 20-77-2706(f)(4) to require an RBPO to have capital of 6 million dollars "upon licensure by the Commissioner," and "at initial licensure." This means to AID that such capital needs to be in place by the RBPO at the initial licensure(s) this summer and fall as AID grants licensure, rather than to be in place at either the end of this year or later on 1-1-2019. Both AID and ADHS support the 6 million dollar initial capital requirement even before full risk as a reflection of a solvency commitment to the program by the particular RBPO.

#2. Written Comment from ForeverCare, August 10, 2017, was in favor of the proposed Rule.
AID RESPONSE: N/A

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The proposed rule addresses and provides a risk-based capital methodology for calculating additional capital and surplus as required by Act 775 under the Organized Care Act. Act 775 states in Ark. Code Ann. §20-77-2706(f)(4): "Upon licensure by the Commissioner, a risk-based provider organization shall maintain 'a reserve of six million dollars ($6,000,000.00) *and an additional amount as determined by the commissioner at initial licensure based upon the risk assumed and the projected liabilities under the standard's promulgated by rules of the State Insurance Department.*"
(Emphasis added).

The proposed rule is providing the financial methodology as to how the Insurance Commissioner will calculate the additional amounts of capital or reserves required beyond the six million dollars in the statutory phrase which is emphasized and underlined above. Therefore, AID believes it is not THIS particular which is providing or creating a "cost," but simply providing a methodology for a capital requirement already authorized in the statute. This methodology does create an annual and ongoing financial impact on the organization's requirements to maintain net capital to avoid being financially impaired, but the department believes this is clearly authorized and established in the statutory language above.

LEGAL AUTHORIZATION: The proposed rule is currently in effect as an emergency rule. The rule includes revisions made in light of **Act 775 of 2017**, which created the Medicaid Provider-Led Organized Care Act. Act 775 also served to designate that a risk-based provider organization is an insurance company for certain purposes under Arkansas law. Pursuant to Arkansas Code Annotated § 23-61-117(a), as amended by Act 775 of

2017, § 3, the Insurance Commissioner shall regulate the licensing and financial solvency of risk-based provider organizations, as defined in Ark. Code Ann. § 20-77-2703, as amended by Act 775, § 1, participating in the Medicaid provider-led organized care system. The Commissioner may issue rules to implement section 23-61-117; may impose and collect a reasonable fee from a risk-based provider organization for the regulation and licensing of the organization as established by rule of the State Insurance Department; and may administer collection of the quarterly tax imposed on risk-based provider organizations under Ark. Code Ann. § 26-57-603, as amended by Act 775, § 4, pursuant to a rule issued by the Department. *See* Ark. Code Ann. § 23-61-117(b), as amended by Act 775 of 2017, § 3. It is further provided that the Commissioner shall prescribe the reporting, forms, and requirements related to the payment of the quarterly tax in a rule issued by the Department. *See* Ark. Code Ann. § 23-61-117(b)(3)(B), as amended by Act 775 of 2017, § 3.

9. STATE MEDICAL BOARD (Kevin Odwyer)

a. SUBJECT: Regulation 1: Changing Name of Executive Secretary to Executive Director

DESCRIPTION: This is an amendment to Regulation 1 to change the name of the Executive Secretary to Executive Director as required by Act 69 of 2017.

PUBLIC COMMENT: A public hearing was held on August 3, 2017, and the public comment period expired on that date. No one spoke against the proposal. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Arkansas State Medical Board is authorized to adopt rules and regulations necessary or convenient to perform its duties as required by law. Ark. Code Ann. § 17-95-303(1). These rules implement Act 69 of 2017, which changes the references to Executive Secretary to Executive Director.

b. SUBJECT: Regulation 28: Educational Licenses

DESCRIPTION: This allows a physician with an educational license to work in an accredited facility other than UAMS. Act 1061 of 2017 requires the Medical Board to permit physicians with an education license to work in accredited medical schools in Arkansas other than UAMS.

PUBLIC COMMENT: A public hearing was held on August 3, 2017, and the public comment period expired on that date. No one spoke against the proposal. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Arkansas State Medical Board is authorized to adopt rules and regulations necessary or convenient to perform its duties as required by law. Ark. Code Ann. § 17-95-303(1). These rules implement Act 1061 of 2017, which provides flexibility for educational licensure for physicians in Arkansas.

c. SUBJECT: Regulation 33: Providing Ongoing Contact Information to Patients and Healthcare Providers

DESCRIPTION: This ensures that patients and healthcare providers are given access to ongoing contact information. Act 754 of 2017 requires the Medical Board to amend the regulation to give patients and healthcare providers necessary contact information.

PUBLIC COMMENT: A public hearing was held on August 3, 2017, and the public comment period expired on that date. No one spoke against the proposal. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Arkansas State Medical Board is authorized to adopt rules and regulations necessary or convenient to perform its duties as required by law. Ark. Code Ann. § 17-95-303(1). These rules implement Act 754 of 2017, which creates the Patient Right-to-Know Act.

d. SUBJECT: Regulation 38: Telemedicine

DESCRIPTION: This amendment adds physician assistants to provide telemedicine services, and it prohibits prescriptions for marijuana based on a telemedicine assessment.

PUBLIC COMMENT: A public hearing was held on August 3, 2017, and the public comment period expired on that date. No one spoke against the proposal. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Arkansas State Medical Board is authorized to adopt rules and regulations necessary or convenient to

perform its duties as required by law. Ark. Code Ann. § 17-95-303(1). These rules implement Act 438 of 2017, which amends the Arkansas Medical Marijuana Amendment of 2016 to prohibit physicians from issuing a written medical marijuana certification to a patient based on an assessment performed through telemedicine.

e. SUBJECT: Regulation 40: Surgical Technologies

DESCRIPTION: This establishes the registration of surgical technologists which is required by Act 390 of 2017.

PUBLIC COMMENT: A public hearing was held on August 3, 2017, and the public comment period expired on that date. No one spoke against the proposal.

The board is proposing a $25 application fee and an annual renewal fee of $10 for surgical technologists registered with the board. Act 390 directs the board to register surgical technologists, but it does not specifically authorize the board to impose any registration fees. Jessica Sutton, an attorney with the Bureau of Legislative Research, asked the board for its specific fee authority to charge the application fee and annual renewal fee. **RESPONSE:** The act directs the board to register surgical technologists, and the fees are for such registration.

The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Arkansas State Medical Board is authorized to adopt rules and regulations necessary or convenient to perform its duties as required by law. Ark. Code Ann. § 17-95-303(1). These rules implement Act 390 of 2017, which creates the Arkansas Surgical Technologists Act, establishes the registration of surgical technologists, and authorizes the board to promulgate rules.

f. SUBJECT: Regulation 41: Governing Use of the Prescription Drug Monitoring Program

DESCRIPTION: This mandates physicians and physician assistants to use the Prescription Drug Monitoring Program as required by Act 820 of 2017.

PUBLIC COMMENT: A public hearing was held on August 3, 2017, and the public comment period expired on that date. No one spoke against the proposal. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Arkansas State Medical Board is authorized to adopt rules and regulations necessary or convenient to perform its duties as required by law. Ark. Code Ann. § 17-95-303(1). These rules implement Act 820 of 2017, which amends the Prescription Drug Monitoring Program to mandate that prescribers check the program when prescribing certain medications.

10. STATE BOARD OF NURSING (Sue Tedford and Fred Knight)

a. SUBJECT: Chapter Four: Advanced Practice Registered Nurse

DESCRIPTION: The proposed changes to Section III are made to ensure nurses have a minimum of 2,000 hours of active practice of nursing before acquiring the ability to progress through advanced practice educational programs and becoming Advanced Practice Registered Nurses (APRNs).

PUBLIC COMMENT: A public hearing was held on July 11, 2017, and the public comment period ended on July 14, 2017. Public comments were as follows:

Susan Kehl, PhD, RN, CNE – Dean and Associate Professor at Harding University

COMMENT: Email dated 5/31/17. I believe this is a needed requirement for APRN licensing. We require verification of at least 2,000 work hours as an RN before beginning our FNP clinical course sequence of 4 semesters. MSN students may take non-clinical graduate nursing courses while they are earning the 2,000 work hours in our program. Most of our students have more than one year of RN work experience. **RESPONSE:** Comment taken under advisement.

Ronette Wise

COMMENT: Email dated 6/1/17. I have reviewed the proposed change of adding 2,000 hours of active practice as an RN to the licensure requirement for an APRN. I understand why this is added and I agree with the proposed change. **RESPONSE:** Comment taken under advisement.

Dr. Katherine Darling, DNP, PMHNP/FNP-C – President of the Arkansas Nursing Practitioner Association

COMMENT: Email dated 6/1/17. I wonder what the background is for this change. Did we have a bill pass and a new act requiring this? Was this due at the request of the Medical Board? I wonder if you could provide some of the history of this proposal. I didn't think that we passed a bill like this in this legislative session, but may have missed this. Your input is appreciated. **RESPONSE:** Ms. Tedford spoke with Ms. Darling regarding the background regarding the proposed addition to Chapter 4.

Regina Welch, RN, Arkansas Children's Hospital Burn Center

COMMENT: Email dated 6/24/17. I spoke with the president Ramonda Housh, APRN, and I believe you are whom she said to email regarding the discussion of the hours before applying to grad school. I am currently in grad school and I was a nurse for almost seven years when I decided to continue my education journey. In my experience, those nurses with limited years of experience lack the ability to add depth and breadth to discussion. This I feel puts them at a disadvantage. I feel that per my experience the nurse should have at least 2 years' experience before starting back to school and up to 3 years before clinical rotation begins. **RESPONSE:** Comment taken under advisement.

Stacy Harris, APRN, Graduate Program Coordinator at the University of Central Arkansas

COMMENT: At public hearing on 7/11/17. Ms. Harris stated that "the change is appropriate." She further stated that the proposed 2,000 hour requirement takes into account a nurse's need to be away from work for personal and other reasons. Ms. Harris indicated that there is no evidence which delineates that a certain number of practice hours create a successful student. She went on to express her concern that unnecessary licensure requirements would create further limitations for a nurse to continue his or her education and further their careers. Ms. Harris stated that on-line schools do not have the same criteria as in-state nursing programs. She indicated that her program at UCA is working toward becoming accredited by the State of Tennessee, which is now a requirement for Tennessee students enrolled in their program. Ms. Harris indicated that UCA conducted a survey and found that all of the nursing students who responded were working full time jobs. Therefore, she concluded there should not be a problem with their students meeting the 2,000 hours of practical nursing experience. **RESPONSE:** Ms. Tedford thanked Ms. Harris for attending the public hearing and for her comments.

Susan Gatto, Director of Nursing Program, University of Central Arkansas

COMMENT: At public hearing on 7/11/17. Ms. Gatto indicated that nurses who have been out of school for a while may have trouble transitioning into a provider role or being a novice. She went on to say that it may be necessary for a nurse to work after receiving certification before being able to obtain an APRN license. **RESPONSE:** Ms. Tedford thanked Ms. Gatto for attending the public hearing and for her comments.

Harold Simpson, Attorney with the Arkansas Association of Nurse Anesthetists

COMMENT: At public hearing on 7/11/17. Mr. Simpson pointed out that CRNA's are already required to work one year in an emergency care setting before obtaining their certifications. Mr. Simpson questioned whether the requirement for practice could be enumerated by using the term "one year" versus "2,000 hours" due to ambiguities concerning the way work hours are calculated. Mr. Simpson indicated one year of work experience most commonly translates into 2,080 hours according to the accrediting body for CRNA's. **RESPONSE:** Ms. Tedford thanked Mr. Simpson for attending the public hearing and for his comments.

Skyler Mankin, Student at Arkansas State University

COMMENT: At public hearing on 7/11/17. Skyler Mankin stated that she started out in medical school and was an EMT but is now a full-time student in the Master's program. She currently has about six months of experience working as a nurse and indicated that she did not believe the 2,000 hour requirement would hinder her or fellow students with obtaining their APRN licensure. Ms. Mankin indicated that the ASU second degree accelerated program has a rigorous interview process for applicants. **RESPONSE:** Ms. Tedford thanked Ms. Mankin for attending the public hearing and for her comments.

Brittany Benton, Student at Arkansas State University

COMMENT: At public hearing on 7/11/17. Brittany Benton stated that she has five (5) years' experience practicing as an RN. Ms. Benton concurred that students who attend Arkansas programs should not have any problem meeting the 2,000 hour requirement. **RESPONSE:** Ms. Tedford thanked Ms. Benton for attending the public hearing and for her comments.

Arkansas State Board of Nursing Board Members

COMMENT: At Board meeting on 7/12/17. After discussing all comments and concerns regarding the proposed changes, the ASBN Board members decided that it would be necessary to include an effective date of the 2,000 hour requirement of nursing practice before obtaining APRN licensure. The Board members decided the best date for nurses and nursing educational institutions would be July 1, 2019, in order to allow ample time to inform those affected by the change. **RESPONSE:** Revision made to proposed change to Chapter 4 to include effective date of July 1, 2019.

The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Arkansas State Board of Nursing is authorized to promulgate whatever regulations it deems necessary for the implementation of Ark. Code Ann. § 17-87-101, *et seq*. The board is authorized to prescribe minimum standards, approve curricula for licensure as advanced practice registered nurses, and to license and renew the licenses of qualified applicants for advanced practice nursing. *See* Ark. Code Ann. § 17-87-203.

11. PUBLIC SERVICE COMMISSION (John Bethel)

a. SUBJECT: Net Metering Rules

DESCRIPTION: On April 29, 2016, the Arkansas Public Service Commission (Commission) established docket 16-027-R, to gather information to determine appropriate rates, terms, and conditions, for net-metering contracts under Act 827 of 2015 (Act 827), including any changes necessary to the Commission's Net Metering Rules (NMRs). The Commission also expressed its intent to consider possible changes to the NMRs to implement provisions of Act 827 regarding facilities larger than 300 kW.

APSC Staff prepared revisions to the NMRs, which incorporated the language of Act 827 regarding establishing rates, terms, and conditions for net-metering contracts; however, APSC Staff recommended bifurcating the hearing to allow a working group consisting of the parties and other interested individuals to develop guiding principles for the development of net-metering tariffs. The Commission bifurcated the hearing on August 18, 2016, pursuant to Order No. 3.

PUBLIC COMMENT: A public hearing was held on October 4, 2016. The public comment period expired that same day. The Commission provided the following summary of public comments:

On 6/15/16, Mr. **Mike Shah** commented that publication was insufficient/too late to participate. In addition, solar panels fight carbon emissions; reduce transmission needs; and support jobs and tourism.

On 6/24/16, **Randolph Covey** commented that the net buyback of surplus solar power is a must for growth of economy.

On 6/24/16, **Bob Munger** commented that he supports net metering.

On 7/4/16, **Sharon Burch** commented that she adamantly opposes penalties; however, since legislation already passed, limit the penalty to zero.

On 7/4/16, **Karen Willis** commented that legislation to charge fixed fees to customers who use less is un-American and contributes to national security.

On 7/4/16, **Sky Canyon** commented that Entergy has only one focus: profit. Entergy is a company that is irresponsible and attempting to make legal their criminal intent. The logic of increasing fixed-fees could be extended to energy efficiency. This decision will set bad legal precedent. Current net-metering customers represent only a small fraction of overall customers. As such, they have a negligible effect on revenue. This will kill solar in Arkansas. Solar adds grid robustness. Solar reduces need to build capacity. Solar also provides the benefit of delivery during peak times.

On 7/4/16, **Roxana Wallace** commented that a fee for producing excess power shows poor judgment.

On 7/6/16, **Ann Hair** commented that she supports roof top solar.

On 7/6/16, **John R. Nino**, commented that he supports roof top solar at no surcharge.

On 7/7/16, **Denise Marion** commented that she is a solar owner. Please don't increase costs. A cost-benefit analysis that shows a net loss due to net metering should be doubted. The real intent of this action is to discourage competition and curb growth of technology that disrupts the utilities' business model. The Commission should follow Oklahoma's example. A fee on so few will have no effect on utility's revenue and will kill
Solar. She said residential solar is beneficial to economy.

On 7/7/16, **Jesse J. Davis** commented that the Commission should encourage solar and that solar offsets peak load and prevents need for peaking plants or purchase power, boosts employment, will reduce carbon emissions, and help with compliance with new EPA regulations.

On 7/10/16, **Laura Lee Williard** commented that increasing fixed costs unfairly burdens low-use, low-income customers.

On 7/13/16, **Rocky Vannucci** commented that he supports rooftop and residential solar at no surcharge.

On 7/14/16, **Mike Shah** provided an article "Is burning trees still green?"

On 7/14/16, **Daniel Marion** commented that there is no data to support that contribution of surplus solar power to local grid by NEM produces any increase costs to the utilities. Utilities should be required to supply the listed data.

On 7/14/19, **J. Alan Clingenpeel** commented that any fee imposed should be on actual costs. The fee proposed is greater than the dollar amount derived from the panels. This is punitive, stifling a fledgling industry.

On 7/29/16, **Mike Shah** provided "Solar Myths & Facts."

On 8/1/16, **Jack Fuller** commented that NEM is complex and needs extensive research and study. Any proposed rate structure should be evaluated in terms of the impact it might have on current and future NEM customers. He doesn't need an immediate answer, but current NEMs should be granted a grace period of at least 20 yrs.

On 8/19/16, **Jerry Landrum** commented that he believes in equal pricing for energy consumed and energy produced is implicit in NEM. In order to quantify the benefits, you have to meter and price consumption and production separately, and that is no longer net-metering. A net metered customer producing and self-consuming clean energy cannot possibly be fairly charged and compensated so long as non-renewable energy sources are allowed to externalize the social costs of their releases of waste carbon to the environment. Since the ratepayers of Arkansas suffer the consequences of pollution from the non-renewable energy production, the carbon fee revenue should become a dividend for ratepayers. It should show up on the electric bill as a credit, offsetting other charges. I ask that the REMI Study be included in these dockets.

On 9/15/16, **Joseph Corcoran** commented that Cooperatives should not fight against clean energy produced by their own members, they should encourage the practice.

On 9/18/16, **Russel Rainey** commented that he supports net-metering.

On 9/20/16, **Scharmel Roussel** commented that he is opposed to efforts to stall use of renewable energy and this docket creates barriers. He will move off grid – so will others.

On 9/20/16, **Emily Kelly** commented to not charge users of renewable energies and distributed generation so big companies can squash renewable energies for profit. She supports solar.

On 9/21/16, **Michael Barre** commented that charging fees is outrageous and the commission needs to promote clean energy.

On 9/28/16, **David Gill** commented that he is in favor of clean energy in Arkansas and in favor of encouraging home owners to invest in net-metering.

On 9/28/16, **Peter Hildebrand** commented that he supports the transition to clean renewable energy.

On 10/2/16, **Dina Nash** commented that she is in favor of policy that encourages correct value of renewable energy to be paid to the producer and that costs at the pole and beyond be borne by all ratepayers. She refers to the article "The Toll of Coal." She states that clean energy needed.

On 9/30/16, **Jo Kelly** commented that promotion of localizing usage of energy will help energy security.

On 10/3/16, **Mike Shah** commented that he supports solar.

On 10/3/16, **Scott Thompson** commented that the commission shouldn't discourage alternative energy.

On 10/3/16, **Tom Stolarz** commented that the commission shouldn't discourage solar power in Arkansas.

On 10/4/16, **Anthony Newkirk** commented that the commission should support net-metering.

On 10/4/16, **Katie McGee** commented that she supports the right of homeowners to choose to use clean energy source. Extra fees penalize

people for energy that they did not consume. Unfair and contributes to destruction of planet.

On 10/4/16, **Marie Mainard O'Connell** commented in favor of individual use of solar power for home and transition to clean, renewable energy. She is against barriers to distributed generation or net-metering. Support of grid is encompassed in my taxes and fees as a utility customer. Potential taxes or fees on private individual's solar production would constitute a restriction on my religious freedom to pursue ecological stewardship as part of my Christian faith. It would impinge my freedom of religion.

On 10/4/16, **Ashley Nipp** commented that she supports clean renewable energy, oppose barrier to distributed generation or net-metering.

On 10/5/16, **AJ Zolten** commented in favor of PSC development of rules that increase likelihood that other individuals will opt to develop solar and other non-polluting energy solutions with the least possible economic burden to the individual. Wants complete grandfathering clause. The number of customers is too small which would make any cost to utilities negligible. PSC should include incentives for continued development including maximum reimbursement.

On 10/7/16, **Emily Lane** commented that she supports clean, renewable energy and is opposed to barriers to distributed generation or NM. Net-metering will benefit public health. It can create jobs. It will benefit utilities and ratepayers through increased reliability, reduction of peak requirements, reactive power; improved power quality, reductions in land-use effects and ROW acquisition costs, reduction in vulnerability to terrorism and improvements in infrastructure resilience, reduced greenhouse gas emissions, reduced social and regulatory costs of carbon and emissions of criteria pollutants, etc.

On 10/7/16, **Evan Yocham** commented that he supports renewable energy.

On 10/7/16, **Jordan Rainwater** commented that he supports renewable energy and opposes barriers to distributed generation or net-metering.

On 10/10/16, **Nathan Lazarus** commented that the commission should move forward toward clean and renewable energy sources because climate issues will only get worse.

On 10/11/16, **Erin Smith** commented that he supports renewable energy and opposes barriers to distributed generation or net-metering.

On 10/13/16, **Thomas Snead** commented that he requests PSC review of "Solar Thermal Policy in the US." PSC should help people put power on grid and reimburse them for that power. The industry puts people to work.

On 10/18/16, **Caleb Freeman** commented that he supports renewable energy. He opposes barriers to distributed generation or net-metering.

On 10/20/16, **MarDarius Butler** commented that he doesn't agree with penalizing solar home owners.

On 1/18/17, **Tommy Lowden** commented that the net metering laws should be changed as it will only allow for more monopolization by the electric utilities. Solar net metering provides him the opportunity to keep competitive pricing for a need for his home. Without it electric companies can continue to increase rates on a regular basis without any repercussion.

FROM THE HEARING:

On 10/4/16, **Scharmel Roussel** commented that he supports transition to clean, renewable energy and is opposed to barriers to transition. Without barriers, jobs would increase. Fees have gone up 30%.

On 10/4/16, **Ann Owen** commented that she supports a progressive energy policy and has made a substantial investment in rooftop solar. She wants PSC to encourage individuals to participate in renewable energy economy.

On 10/4/16, **Carol Young** commented on behalf of the League of Women Voters of Pulaski County. She said solar energy is an important component of protecting natural resources for future generations, public health, national security, job creation. She feels need to assure lower income families have access.

On 10/4/16, **Calvin Murdock** commented as a representative of Forrest City Water Utilities. The City is proposing a net-metering facility in excess of 7MW. Net-metering has more pros than cons. He is concerned about impact of new rules on investment. He states that lower rates will result in saved resources to be applied to other public programs. He feels proportional costs should be considered.

On 10/4/16, **Marie Mainard O'Connell** commented asking whether attachment of a fee would infringe on religious freedom.

RESPONSE: The Commission considered each comment in accordance with Arkansas's statutes and the Commission's Rules of Practice and Procedure.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Following notice and opportunity for public comment, a commission shall establish appropriate rates, terms, and conditions for net-metering contracts. *See* Ark. Code Ann. § 23-18-604(b). As used within the Arkansas Renewable Energy Development Act of 2001, codified at Ark. Code Ann. §§ 23-18-601 through 23-18-604, "commission" means "the Arkansas Public Service Commission or other appropriate governing body for an electric utility" as defined in Ark. Code Ann. § 23-18-603(2). Ark. Code Ann. § 23-18-603(1). The Commission is empowered, after hearing and upon notice, to make, and from time to time in like manner to alter or amend, such reasonable rules pertaining to the operation, accounting, service, and rates of public utilities and of the practice and procedure governing all investigations by and hearings and proceedings before the Commission as it may deem proper and not inconsistent with this act. *See* Ark. Code Ann. § 23-2-305. **The instant changes further implement Act 827 of 2015, which required electric utilities to compensate net-metering customers for net excess generation credits in certain circumstances.**

12. ARKANSAS SENTENCING COMMISSION (Nathan Smith, Lindsay Wallace, and Tawnie Rowell)

a. SUBJECT: Arkansas Sentencing Standards Seriousness Reference Table and Sentencing Grid

DESCRIPTION: This amendment adds offenses to the Seriousness Reference Table which were created or redefined during the 91st General Assembly and makes changes to the presumptive sentencing ranges found on the Sentencing Grid.

PUBLIC COMMENT: A public hearing was held on August 11, 2017. The public comment period expired on August 5, 2017. No public comments were submitted. The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: The financial impact is unknown. The intent is that sentencing courts will adhere to the guidelines more often if given a range for sentence duration as opposed to one option with only upward or downward departure as alternatives. With higher compliance, and with an expanded list of offenses and sentence ranges deemed appropriate for

community correction facilities, there is a potential result for savings to the state.

LEGAL AUTHORIZATION: The Arkansas Sentencing Commission is authorized to make appropriate and necessary revisions to the sentencing standards. Ark. Code Ann. § 16-90-802(a). Any revision of the standards shall be in compliance with provisions applicable to rulemaking contained in the Administrative Procedure Act, § 25-15-201 *et seq*. Ark. Code Ann. § 16-90-802(d)(2)(C).

E. Adjournment.