DHS Responses to Public Comments Regarding Arkansas Independent Assessment (ARIA) Manual, 1915 i

Luke Mattingly
Public hearing held remotely on August 16, 2022, at 11:00 a.m.

Comment: I also have just lately learned of the document being posted. I would like some explanation in the public comment of on page 92 while the projected number of cases is going from 2000 down to 500.

Response: This number reflects the estimated population of those individuals who qualify for Medicaid under the Spenddown category. Approximately fifteen hundred (1,500) individuals who qualified for Medicaid under the Medically Frail Medicaid category were enrolled in the PASSE program in July and August of 2022.

David Ivers, J.D. VP for External Affairs & General Counsel, Easterseals Arkansas

Comment: We appreciate the efforts DHS is making to improve both ARIA and 1915(i). In particular, 1915(i) holds great potential that is underutilized due in large part to confusion about eligibility, services, and licensure requirements.

ARIA-We support the flexibility added for reassessments. This should help expedite and make It easier to coordinate for the parties to be present. For individuals with both behavioral health and IDD needs, can the assessments be combined? They contain similar questions and are lengthy. To require separate assessments seems an unnecessary burden on individuals and their caregivers.

Response: Oftentimes, the Department nor the PASSE is aware of a dual diagnosis or complex care need when the member initially enters the PASSE program. For this reason, we will continue to either assess the member with a BH Independent Assessment or an IDD Independent Assessment based on the member's diagnosis. Once the member is in the PASSE, services are approved based on their functional need and if a dual diagnosis or complex care need is suspected, the member will be assessed with the Complex Care Independent Assessment and can be awarded a Tier 4 designation. The Tier only sets the PASSE's per member per month payment and should not drive any available services.

Comment: *1915(i) General Comments*: Throughout the proposed rules, "HCBS Provider for Services for Persons with Developmental Disabilities and Behavioral Health Diagnoses" has been removed and "Community Support System Provider" (CSSP) inserted. It is a problem from a practical standpoint for HCBS CES Waiver providers to become CSSP providers if the licensure rules for CSSP and the Waiver are not in alignment. More specifically, if providers have some individuals who should be served under traditional CES Waiver and some in 1915(i) through CSSP, it will make it difficult administratively if the Waiver and CSSP licensure standards are significantly different. At the least, providers should be able to meet heightened CSSP requirements through criteria that are "add-ons" to the basic Waiver standards. We realize these are not the licensure rules, but we did want to point out that ongoing problem. A similar concern is present with regard to the qualifications of staff who can provide Waiver vs. 1915(i)

services, as addressed more specifically below. Is there a minimum or standard fee schedule for these services?

Response: Thank you for this question, but it is a question for another policy packet running in public comment at this time.

Comment: *In 3.1-I, Page 6 for Needs-Based HCBS Eligibility Criteria*: It is unclear exactly which individuals are eligible for 1915(i) services as opposed to the CES Waiver. The 1915(i) explanation reads:

> *After medical eligibility has been determined through diagnosis, the following needs-based criteria is used:*
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> *The member must receive a minimum of a Tier 2 on the independent functional assessment for HCBS behavioral health services. To meet a Tier 2, the member must have difficulties with certain behaviors that require a full array of services to help with functioning in home and community-based settings and moving towards recovery and is not a harm to his or herself or others. Behaviors assessed include manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors. Measurement is completed through an assessment of functional deficits through an evaluation of the member and caregiver report. The assessment measures the member's behavior in psychosocial sub-domains and intervention domain that evaluates the level of intervention necessary to manage behaviors as well as required supports to maintain the member in home and community settings. 1915(i) services must be appropriate to address the member's identified functional deficits due to their behavioral health diagnosis.*

These criteria are heavily laden with behavioral health terminology and do not speak well to the IDD population. Many individuals with IDD have not been formally diagnosed with a BH condition but have challenging behaviors or otherwise complex conditions that make serving them extremely time-consuming and resource-intensive. Can the wording be revised to address this population more accurately?

Response: All services under the PASSE model are available to a PASSE member regardless of their diagnosis. Home and Community based services under the 1915c and the 1915i are approved based on the member's functional need, not diagnosis. The 1915 (i) services must be used to address behavioral needs of individuals.

Comment: *Page 7, Target Groups* – This part mentions an income cap of 133% FPL for ARHOME Medically Frail. But the description of BH and IDD does not explain the different income cap of 150% FPL.

Response: This has to do with how a person is eligible for Medicaid. Members in the PASSE are in multiple Medicaid eligibility categories. The 1915i outlines services about to Medicaid recipients once they attributed to a PASSE regardless of their Medicaid eligibility category.

Comment: *Page 11, item 6, Supporting the Participant in Development of Person-Centered Service Plan*: 60 days is often too long to begin care. Even if every element of the PCSP listed is not completed, there should be a minimum requirement for when care must begin, and oftentimes 60 days is too long. The client may rapidly deteriorate and end up in a hospital, HDC or other institutional setting. Please establish a shorter period for when actual care must begin.

Response: This is a maximum date requirement. Members may receive care prior to.

Comment: *Pages 12-13, Informed Choice of Providers*: We have concerns that the members and their families do not have an accurate picture of the services that will be available to them when selecting a PASSE. At the very least, families should be told each PASSE's standard rates paid to providers for 1:1 care and shared staff, along with restrictions such as benefit limits or exclusions.

Response: We disagree that a parent should be told what a provider will be paid for a particular service. A family should be concerned about the services being offered to their loved one.

Comment: *Page 14, Supportive Employment*: What is the difference between this service in 1915(i) and Supported Employment in the CES Waiver? If providers have some individuals who should be served under traditional CES Waiver and some in 1915(i), it will make it difficult administratively if the service descriptions are not aligned with any differences clearly stated and supported by rationale.

Response: These are different services with different service descriptions. Providers, if licensed, can decide which service to provide.

Comment: *Page 16, Behavior Assistance*: This sounds like it is written only for individuals with "behavioral health treatment plans," as opposed to a "Behavior Prevention and Intervention Plan" mentioned in the DD Waiver. Individuals whose primary diagnoses is IDD need terminology that is IDD-focused and that speaks to Waiver staff who can deliver the service.

Response: We are using the terminology of both currently, but plan to amend to make the language consistent in the future.

Comment: *Page 18, Adult Day Rehabilitation Day Treatment*: Traditionally, this service has been for individuals with chronic mental illness, and the wording still reflects that. Is there a comparable service for individuals with intellectual and developmental disabilities who have complex, higher needs that cannot be met easily in the traditional waiver HCBS setting?

Response: Adult Developmental Day Treatment is the equivalent service for adults with intellectual and developmental disabilities.

Comment: *Page 20, Peer Support*: Is this service for BH clients only? Can we use it for IDD clients to allow peers to demonstrate how they overcame barriers and navigate various systems to live independently, to illustrate self-advocacy, to provide ongoing encouragement and support, etc.?

Response: Peers must be certified and the only way to be certified is to have lived behavioral health or substance use. If those requirements are met, the service is available to all PASSE members.

Comment: *Page 22, Family Support Partners*: Is this service for caregivers of children with BH diagnoses only? This could be a valuable service for parents/caregivers of children with IDD, but it would have to be reworded to include them.

Response: All services under the PASSE model are available to all PASSE members if they are on the PCSP and approved by the PASSE.

Comment: *Page 25, Supportive Life Skills Development*: Thank you for including "habilitation" in the description.

Response: You are welcome.

Comment: *Page 27, Child and Youth Support*: This service also seems written to address BH without IDD in mind. Along with "symptoms of illness" we would suggest adding "challenging behaviors" or words to that effect.

Response: This service is defined to treat behavioral needs of children and youth and their families. Symptoms of a mental health condition include behaviors that can be addressed through this service. This service can be delivered to individuals who have a diagnosis of IDD and symptoms or behaviors that can respond to this treatment service.

Comment: *Page 28, Therapeutic Communities*: This also seems written more for individuals whose primary diagnosis is BH. Also, what is the basis for less than 16 beds? The federal institutions for mental disease (IMD) rules is 16 beds or less.

Response: All services under the PASSE model are available to all PASSE members if they are on the PCSP and approved by the PASSE. That said, the member must be exhibiting significant behavioral health needs. The bed count was established to avoid the IMD rule.

Comment: *Page 30, Residential Community Integration*: Can this be revised to better accommodate individuals with IDD. For instance, the first sentence says it is an intermediate level of care between inpatient psychiatric care and outpatient behavioral health services.

Response: This service is to address the needs of youth that have significant behaviors that do not allow them to be treated in their homes. In most instances, those youth have received inpatient psychiatric services and are not ready to move into home environments. They can also be used to prevent required treatment in inpatient psychiatric settings. Currently, many youths with IDD who have significant behavioral health symptoms are being treated in inpatient psychiatric settings and can benefit from treatment in Residential Community Reintegration as well.

Comment: *Page 33, Assertive Community Treatment*: The last sentence says this service is typically for individuals with serious mental illness or co-occurring disorders. However, there are a number of individuals whose primary diagnosis is IDD who have very serious needs as well and who need intensive intervention.

Response: We agree that individuals with IDD have behavioral needs that can respond to services delivered in home and community settings and ACT is an EBP developed to treat individuals with SMI.

Comment: *Page 41, Partial Hospitalization*: Again, the service description, especially with its emphasis on mandatory individual and group therapy and psychoeducation, appears to be geared toward individuals whose primary diagnosis is BH.

Response: That interpretation is correct.

Comment: *SERVICES*: For each service, for CSSP it states: "All performing providers must successfully complete and document courses of initial training and annual re- training sufficient to perform all tasks assigned by the mental health professional." Can you explain more specifically as to what the training or credentials of the direct caregivers will need to be to satisfy this requirement? We are interested particularly in understanding how much additional training our IDD staff will have to obtain to perform these services.

Response: The certification for Intensive CSSP requires professional oversight of the services being delivered. The services address behavioral health symptoms, and the delivery of these services must be overseen by a professional that has a license to guide direct care staff in addressing behavioral health symptoms. The services goal is to resolve behavior issues. All training should support staff in being part of a team and provide behavioral interventions developed to meet the individual needs identified by the professional.