

DHS Responses to Public Comments Regarding Community Support System Provider

Carol Moore, Universal Health Services Inc.

Comment: For a provider that does not plan to provide DD services, what is the reason to change to CSSP

Response: We are not sunsetting the OBHA or the CES Waiver provider types; it is a business decision on whether to be a CSSP and provide the additional services to your clients. If you become a CSSP provider you could provide more HCBS services to your BH clients, like supportive living, respite, and supplemental supports for example.

Comment: Will providers be required to apply for a new Medicaid category and will it cover all services, including Tier 1

Response: You will have to enroll with Medicaid for the new licensed type and be licensed by DPSQA; The CSSP provider type will be certified to provide the HCBS services under the PASSE program and under the Adult Behavioral Health Services for Community Independence for DD and BH beneficiaries who tier as a II or III.

Supported Employment, Supported Living, Respite, Adaptive Equipment, Community Transition Services, Consultation Intervention, Environmental Modifications, Supplemental Support, Specialized Medical Supplies, Behavioral Assistance, Adult Rehab Day, Peer Support, Family Support Partners, Supportive Life Skills Development, Child and Youth Support Services, Supportive Housing, Mobile Crisis Intervention, Therapeutic Communities, and Community Reintegration.

Any counseling that is included as part of the one of the services listed above under enhanced CSSP, only an enhanced CSSP license is required; however, if you want to provide counseling outside of one of the above enhanced CSSP services, a OBHA or ILP license is still required. Enhanced CSSP services are underlined above.

Comment: In regards to solicitation, is this reported to DPSQA

Response: yes.

Comment: 201A2c – This is specific to site and not provider, correct?

Response: This section refers to a CSSP license; a single location needs one CSSP license and all services are billed under that license for each Medicaid beneficiary.

Comment: 202A2d – Does this require ASP background checks or can they be from another origin?

Response: This section refers to a CSSP license; we will have to follow state statute on the transferability of criminal background checks.

Comment: 202B2 – Are there separate application fees for these licenses for one site?

Response: No.

Comment: 203D – Is there no annual renewal or renewal at time of re-accreditation?

Response: The CSSP license has no expiration or renewal; Medicaid enrollment revalidation requirements still apply.

Comment: 301B1 – Does this need to be CEO?

Response: There must be a single point of contact that has authority but this is a business decision. Please note that DMS has also been added to the list of who needs this contact.

Comment: 302G1 – Does tele-medicine qualify as being on-site?

Response: We will clarify this language to clearly state “in person or remote.” They will continue to have to be on site if circumstances warrant.

Comment: 303B1a – What specifically is the required training? Is 12 hours the amount required for initial training?

Response: The 12 hours of initial training in IDD and BH required modules is an initial requirement not annual at this time; however, there is other training outlined in the manual that is geared towards safety and that is annual training.

Comment: 303B2a – Is DD training if not providing DD services?

Response: yes, the goal of this provider type is to have cross trained staff for the entire population of both IDD and BH Tier II and Tier III.

Comment: 303B3 – So does this include paraprofessionals and non-clinical?

Response: Please see definition of licensed professional in 103Q.

Comment: 303B4 – All staff are required to have CPR/FA including non-clinical?

Response: yes.

Comment: 305C2&3 – These items are required even if not medically necessary?

Response: You need a behavioral management plan if applicable.

Comment: 305C4 – What is required in a medication management plan?

Response: See 604C2 for requirements.

Comment: 309A1 – Is a written emergency plan required for a beneficiary’s personal home and schools if services are provided there?

Response: **yes.**

Comment: 309Ac – Is this required for a beneficiary’s personal home and schools?

Response: **yes.**

Comment: 401B – Is this section required for all CSSP locations or is it limited to residential and if all what are the requirements for an emergency alarm system?

Response: **An emergency alarm system is required for enhanced CSSP locations in 401B5. The standards do not dictate specific requirements other than having the ability to alert employees and beneficiaries in the case of an emergency. You will need to determine if you meet the requirements for an enhanced CSSP location for the business you want to provide.**

Comment: 601B4 – Duration of services in different services ie must the ITP include how many 30 minute individuals vs how many 60 minute individuals, also does this require the length of duration of services that are billed as encounters?

Response: **We require general services be listed in the ITP; however, when submitting treatment to the PASSE for authorization, you may be required to detail units.**

Comment: 601B5 – Can this be in the Goals, Objectives and Intervention area?

Response: **We do not dictate a specific section.**

Comment: 601B6 – Would this be applicable for outpatient services, i.e. Individual 1-6, Group 1-10?

Response: Staff to client ratios are required for adult day rehab, therapeutic communities, and community reintegration. Those overarching services do not supersede the rules around how many people can be in group therapy at one time.

Comment: 601B7 – Would this be applicable for outpatient services, i.e. every location that an individual MAY be provided?

Response: See response above.

Comment: 602 – Is this required in non-residential settings and if so would the EMR record suffice?

Response: yes, as long as the EMR contains all the information required.

Comment: 603A – Does this include a beneficiary’s personal home or school

Response: yes.

Comment: 603C1c – Are there specific requirements for the driver safety training?

Response: The standards do not specify a specific training curriculum; this depends on the type of endorsement the driver is obtaining and those rules are set by Arkansas driver control.

Comment: 604C1 – Must this be completed even for an outpatient client?

Response: yes, if it is applicable and language will be added to clarify.

Comment: 605 – Do outpatient beneficiaries require this? Do these require every behavior that a client may exhibit?

Response: **yes.**

Comment: 605 2 – What format will this need to be in and who reviews it beyond CSSP agency?

Response: **We do not specify a format as long as all requirements are met.**

Comment: 605 3 – What format will this need to be in and is this for the holistic review or individual BMP? Does this include therapeutic interventions or specifically behavioral?

Response: **We do not specify a format if all requirements are met. What must be in the BMP is outlined in the standards.**

Comment: 608D – Is this specifically for the initial crisis or does it include Crisis Abatement?

Response: **Please see definition of mobile crisis intervention in PASSE manual and in the I state plan amendment under PASSE.**

Comment: 609D2 – Does this include Crisis Abatement (can it not be provided by a paraprofessional)?

Response: **Please see definition of mobile crisis intervention in PASSE manual and in the I state plan amendment under PASSE.**

Comment: 701 – Will this be on the provider's Incident Report Form or will DPSQA develop and provide a form?

Response: **DPSQA uses a standardized form that they will post on their website.**

Comment: 702A1 – To whom (what email or phone number) is this to be reported?

Response: DPSQA uses a standardized form that they will post on their website.

Lucas Childers, Researcher, Stateside

Comment: Good Morning,

My name is Lucas and I perform regulatory monitoring for Stateside Associates, and I was recently reviewing a proposed rule addressing Community Support System Provider (CSSP) Standards.

I have a question as to whether the CSSP providers perform services in-home, or only at "CSSP Locations" as defined by Section 103(k). Or in other words, do CSSP providers only operate at CSSP locations?

Thank you for your assistance and I hope to hear from you soon.

Response: Base level CSSP is conducted in the community; enhanced level CSSP has additional requirements.

Dottie Lou Benedetti

Comment: Section 103. Definitions > (k) > (2)

"CSSP Location" does not include group homes, apartments, or similar locations where residents receive adult day rehabilitation services at another service location.

This phrase is unclear.

Response: We are excluding homes/places that are NOT covered under CSSP locations. It seems that there may be some confusion about the programs; this is referring to Adult Day Rehab which is a service for BH adults and dually diagnosed adults. This is not Adult Developmental Day Treatment (ADDT).

Comment: Section 201. License Required > (b) > (1), (2), (3), and (4)

A CSSP must be accredited by an approved accrediting organization for all home-and community-based services offered or intended to be offered by the CSSP before DPSQA may issue a CSSP license or CSSP license enhancement.

A CSSP must demonstrate its accreditation or accreditations cover each home-and community-based service the CSSP offers or intends to offer.

Please clarify what services are covered. Many agencies provide multiple services from multiple funders.

Response: The language was written broadly to allow flexibility. Please see the service descriptions of the below services.

Supported Employment, Supported Living, Respite, Adaptive Equipment, Community Transition Services, Consultation Intervention, Environmental Modifications, Supplemental Support, Specialized Medical Supplies, Behavioral Assistance, Adult Rehab Day, Peer Support, Family Support Partners, Supportive Life Skills Development, Child and Youth Support Services, Supportive Housing, Mobile Crisis Intervention, Therapeutic Communities, and Community Reintegration.

Comment: Section 303. > Employee Training > (b) > (2) > (C)

The training required in subdivision (b)(1)(A) is in addition to the training prescribed in subdivision (b)(1)(B) through (b)(1)(G) and no training can count towards fulfilling the requirements of subdivisions (b)(1)(A) and any requirements in subdivisions (b)(1)(B) through (b)(1)(G).

Does this mean (b)(1)(B) through (b)(1)(G) cannot count towards the 12 hour training requirement?

Response: yes.

Comment: Section 603. Arrivals, Departures, and Transportation > (a) > (2)> (A) and (B)

A CSSP must document the arrival and departure of each beneficiary to and from a CSSP location.

Documentation of arrivals and departures to and from CSSP locations must include without limitation the beneficiary's name, age, and date of birth, date and time of arrival and departure, name of the person or entity that provided transportation, and method of transportation.

Does this apply to DSPs transporting beneficiaries via CES Waiver?

Response: yes.

Comment: Section 603. Arrivals, Departures, and Transportation > (b) > (1) and (2)

Transportation to which these requirements apply includes without limitation transportation provided to a beneficiary by any person or entity on behalf of the CSSP and regardless of whether the person is an employee, or the transportation is a billed service: and

Transportation to which these requirements apply also includes periodic transportation, including without limitation transportation provided at the request of a beneficiary's legal guardian or custodian to have a beneficiary occasionally dropped off or picked up due to a scheduling conflict with the legal guardian or custodian.

Does this apply to DSPs transporting beneficiaries via CES Waiver?

Response: yes.

Comment: Section 603. Arrivals, Departures, and Transportation > (c) through (f)

These requirements are not reasonable for DSPs transporting beneficiaries in their personal vehicles.

Response: Thank you for comment. We believe this is best practice to ensure the safety of the beneficiary.

Comment: Section 604. Medications > (d) > (2)

Each medication log must be available at each location in which a beneficiary receives home-and-community-based services and must document the following for each administration of a medication

The regulation should recognize electronic medication logs for clarity.

Response: We don't bar an electronic log. The log needs to have all required information contained within.

Comment: Section 604. Medications > (e) > (1) through (4)

This regulation should be clarified to state medications should be locked when CSSP is responsible for administration.

Response: Thank you for comment. We believe this is best practice to ensure the safety of the beneficiary. Please note that this applies when the CSSP is storing “for” the beneficiary.

Comment: Section 604. Medications > (f)

A CSSP must store all medications requiring cold storage in a separate that is used only for the purpose of storing medications.

This regulation is not reasonable or normal in personal homes.

Response: Thank you for comment. We believe this is best practice to ensure the safety of the beneficiary. Please note that this applies when the CSSP is storing “for” the beneficiary.

Comment: Section 605. Behavior Management Plans > (b) > (1) > (2)

If a behavior management plan permits the use of restraints as an intervention, the behavior management plan must also include:

Restraints, as a behavior management method are not allowed under CES Waiver.

Response: We agree and please remember to follow your accreditation requirements.

Comment: Section 606. Restraints and Other Restrictive Interventions > (a) > (1)

A CSSP cannot use a restraint or seclusion on a beneficiary unless:

Add every effort should be made by the staff to exit the dangerous situation.

Remove B – “The use of the restraint is covered by the CSSP’s accreditation.

Response: Although the CES Waiver does not allow restraint usage, this provider type applies to other services outside of the CES Waiver.

Comment: Section 607. General Nutrition and Food Service Requirements. (b) > (8) > (A) and (B)

A CSSP must ensure that all refrigerators used for food storage are maintained at a temperature of 41 degrees Fahrenheit or below.

A CSSP must ensure that all freezers used for food storage are maintained at a temperature of 0 degrees Fahrenheit or below.

When the CSSP is responsible for providing food, providers cannot control personal households, especially those where beneficiaries reside with families.

Response: This applies if a CSSP is providing the meal. This would not apply to a beneficiary who lives in an apartment, duplex or family home because they have control over their own meals. We are focused on congregate settings where the CSSP is controlling the food the beneficiaries consume.

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

Comment: Can you explain the advantage of this model? As it now stands providers can obtain both certifications (DD and OBHA). Are there advantages to obtaining the new CSSP certification other than having one license as opposed to two?

Response: Providers will have the ability to provide a large amount of BH and IDD services under one single license that will not have annual renewal requirements. We believe our beneficiaries will receive more seamless service delivery.

Comment: How many dually diagnosed individuals have been designated under the DHS approval process for the higher per member per month (PMPM) for the PASSEs? Unless the PASSEs can pay more for these more complex, dually diagnosed individuals it will be difficult to treat them under a single or combined model at the current rates. These individuals require more intensive staffing, training, and other resources.

Response: Our initial estimates are around 1,000. Like all PASSE services, each network provider negotiates individual rates.

Comment: Does this replace the plan to merge all DD and BH providers into one credentialed category of HCBS Provider?

Response: This is the single provider type we have been working on.

Comment: In the webinar you explained that “clinical” or professional services were not included, only HCBS, but many dually diagnosed individuals need those professional services. How will we bill for those, e.g., can a CSSP bill for a physician, counselor or PT, ST, OT service under the CSSP license?

Response: no, professional services continue to be billable under their own provider type.

Comment: There are a number of services from the PASSE program that are not included in the CSSP column, including Partial Hospitalization, Peer Counseling by RN, Recovery Support Partners for Substance Use Disorder, Aftercare Recovery Support (ABSCI – may be same as PASSE Support Partners?), Substance Use Detox, and Treatment Plan. Some are professional services, some are not. Why are those left out?

Response: These services are different in nature and scope from the services that fall under the CSSP.

Comment: Section 103 Definitions:

Can you add a definition of CSSP “Base License” to differentiate from CSSP Enhanced License? The Fact Sheet explains that, but the Definitions in the draft rules do not make it clear.

“CSSP License Enhancement” – This definition is not clear, especially where it says “or other home and community-based services.” Maybe reword to say the Base Level (see preceding comment) plus the specific services that fall under Enhancement Level, naming those specific enhanced services.

“Employees” – Employees and independent contractors are different legally and ideally should not encompassed in the same definition. While we understand it is easier to include

independent contractors in the definition, and some provisions should apply to contractors, other provisions, such as background checks should not apply to ALL contractors, such as vendors and professionals who do not have contact with beneficiaries. You have explained in the text when certain sections apply to independent contractors, so it does not seem necessary to blur the distinction.

“Home and Community-Based Services” – It says these are services available under ABHSCI and PASSE, but as noted above, not all of them are listed here for CSSP.

“Professional Service Encounter”—Not sure what is meant by “a licensed professional or other professional...” How can it be “other” and still be professional?

Response:

CSSP license: Supported Employment, Supported Living, Respite, Adaptive Equipment, Community Transition Services, Consultation Intervention, Environmental Modifications, Supplemental Support, Specialized Medical Supplies, Behavioral Assistance, Peer Support, Family Support Partners, Supportive Life Skills Development, Child and Youth Support Services, Supportive Housing,

CSSP licensed Enhancement: All CSSP services plus Adult Rehab Day, Mobile Crisis Intervention, Therapeutic Communities, and Community Reintegration.

Section 103(m) will be broken into subsection (1) and (2). Section 103(m)(1) will remain as currently written. Section 103(m)(2) will be added stating:

- (2) “Employee” does not mean an independent contractor if:
 - (i) the independent contractor does not assist in the day-to-day operations of the CSSP; and
 - (ii) the independent contractor has no beneficiary contact.

As it pertains to the services available under the ABHSCI vs. the PASSE, please see appropriate Medicaid manuals for both programs for service availability and descriptions.

Lastly, not all professionals hold a license. See definitions.

Comment: 302 Employees and Staffing Requirements

These sounds like requirements for the direct care staff, not admin or other staff. Can you clarify?

Response: This applies to all employees (a-f) and g discusses licensed professional requirements.

Comment: Section 303 Employee Training

This is confusing. Would it be possible to simply list what additional training is required above the current CES Waiver or OBHA requirements? In other words, if you are a CES provider, you must have the training listed for that plus X additional training. If you are an OBHA provider, you must have the training listed for that plus Y additional training.

Response: This is a freestanding provider type where businesses can become this provider type without being a CES Waiver or an OBHA. The requirements must be outlined accordingly.

Comment: Section 304 Employee Records

Drug screen results. Those should be in medical files not personnel files as required by DOL. We have no opposition to providing a copy to DPSQA, but they should be segregated.

Response:

Thank you for your comment. The current Section 304(b) will become Section 304(c) and a new Section 304(b) will be added that states:

(b) (1) A CSSP must ensure that each personnel record is kept confidential and available only to:

(A) Employees who need to know the information contained in the personnel record;

(B) Persons or entities who need to know the information contained in the personnel record;

(C) DPSQA and any governmental entity with jurisdiction or other authority to access the personnel record;

(D) The employee; and

(E) Any other individual authorized in writing by the employee.

(2) (A) A CSSP must keep personnel records in a file cabinet or room that is always locked.

(B) (i) A CSSP may use electronic records in addition to or in place of physical records to comply with these standards.

(ii) A CSSP provider that uses electronic records must take reasonable steps to backup all electronic records and reconstruct a personnel record in the event of a breakdown in the CSSP's electronic records system.

Comment: 305 Beneficiary Service Records

In (b), the summary document, we recommend add "assigned PASSE."

Response: Thank you for your comment. Section 305(b)(12) will be changed to add, "or managed care organization information."

Comment: 310 Infection Control

This should be changed to "contagious" diseases or similar term. Not all infectious diseases, such as HIV, are contagious or easily transmittable. This may violate the ADA and Rehab Act as written. The EEOC guidance and court cases do not allow discrimination against individuals with diseases not transmitted through casual contact.

Response: Thank for your comment; however, this is a term of art (infection control) that ADH utilizes.

Comment: Facility Requirements

401 General Requirements

It is confusing as to which service locations these provisions apply to since definition of CSSP Location includes residential and non-residential.

Response: If you are a CSSP residential location there are additional requirements outlined in the standards that go above and beyond a nonresidential CSSP location.

Comment: Can you please allow for waivers of these requirements where health and safety will not be compromised? Some providers may want to use existing facilities that need to be waived/grandfathered in.

Response: Thank you for your comment. We disagree and spent a significant amount of time working with the providers to lower the physical plant requirements to the point where safety wasn't compromised.

Comment: Section 402 Residential Requirements

Shouldn't this be specific to a CSSP Enhancement location?

Response: It is specific to an enhanced CSSP location.

Comment: 502 Exits

(d) says "A CSSP shall remain responsible for the health, safety, and welfare of the existing beneficiary until all transitions to new service providers are complete." It is not within the CSSP's control as to when another provider the beneficiary has chosen will accept the individual. Also, in some cases individuals are provided transition assistance but do not follow through. If the individual chooses to remain with a particular CSSP until transition, and is complying with health and safety requirements, it is not an issue, but it should not be mandated. Mandating the "reasonable assistance" in (c) is understandable and do-able.

Response: We disagree. We continue to have consistent problems with providers stopping service without another provider in place that puts the beneficiary at risk of harm.

Comment: 602 Daily Service Logs

(b)(6) – Please change progress notes frequency to allow weekly. Otherwise, you end up taxing staff time with a lot of documentation that can just as easily be summarized in weekly progress notes. Working toward objectives takes time, and ordinarily significant changes do not occur on a daily basis.

Response: We are not asking for daily progress notes; we are asking for a daily log of the services provided to the beneficiary and a brief statement on how the service that was provided work towards a goal or objective for that particular beneficiary.

Comment: 603 Arrivals, Departures, and Transportation

(a)(2) We do not understand why all the information is needed on the transportation documentation for every arrival and departure. Why wouldn't name, time of arrival or departure, and name of person or entity transportation suffice?

Response: Thank you for comment. We believe this is best practice to ensure the safety of the beneficiary.

Comment: Some of these transportation requirements contain new mandates without funding. Reimbursement rates are not sufficient to cover the added costs.

Response: Thank you for comment. We believe this is best practice to ensure the safety of the beneficiary.

Comment: The unload within one-minute rule in (f)(2) is not realistic for individuals with disabilities; in many cases, it would make the option unusable.

Response: The language gives several options and the one you site above is only used if the individuals are able to exit within one minute.

Comment: 608 Service Requirements

(a)(1) says the CSSP must provide all services in the beneficiary's ITP, "including home and community-based services." What other services would be in a CSSP ITP?

Response: The ITP should include all services being provided by the CSSP.

Comment: 701 Incidents to Be Reported

(7) includes interruptions in service for more than one hour. If a beneficiary arrives later or leaves early is that considered an "interruption." We would suggest that the other categories of incidents encompass any concerns from negative events that interrupt services.

Response: Thank you for your comment. Section 701(7) will be changed to any “unanticipated” situation where services to a beneficiary are interrupted for more than two (2) hours.

Comment: 702 Reporting Requirements

In (a)(1) reports of a certain type of events are required to be submitted within one hour of the event. One hour is a very short time frame. We understand the need to report quickly and same day, but perhaps more leeway (4 hours) could be considered. The priority needs to be taking care of the individual served first, the family second, any staff involved third and then reporting.

Response: We do not agree. A beneficiary’s death or serious injury should be reported immediately.

Comment: 1001 Reconsideration of Adverse Regulatory Actions

(a)(1) Reconsiderations should be handled by someone not involved in the original determination nor reporting to someone who was.

Response: Thank you for your comment. A reconsideration request under Section 1001 is required to be addressed to and will be conducted by the DPSQA Office of the Director, which means it would not be conducted by an individual involved in the original determination or anyone reporting to an individual that was involved in the original determination.

Brad Holloway, Ph.D, LCSW, Brad Holloway, Ph.D, LCSW, Chief Operations Officer/Clinical Director, Birch Tree Communities

Comment: 103 - Definitions

(i) CSSP License Enhancement means an enhancement to a CSSP license that meets additional requirements necessary for a CSSP to offer Adult Day Rehabilitation, Community Reintegration, Therapeutic Communities, or other home- and community- based services at a location operated by the CSSP. Does this mean that any provider who is Adult Day Rehabilitation a separate enhancement? If so, how would this impact only 1 enhancement per location since 20 hours of Adult Rehab Day are required within Therapeutic Communities?.

(o) - should this also include services available under the Outpatient Behavioral Health Services Manual for professional services?

Response: This section refers to a CSSP license; a single location needs one CSSP license and all services are billed under that license for each Medicaid beneficiary. The location itself will be a licensed CSSP location rather than an Adult Rehab Day location or a Therapeutic Communities location. You can bill both out of that location.

Comment: Licensing -

202 (a)(2)(D) & (E) - criminal background requirements are different for DD providers than for BH providers. DD requirements do not have a time frame where the background applies. Many people with mental illness have criminal records and would never be eligible to work for the provider. We like to hire beneficiaries in housekeeping and dietary and some to provide services as they reach milestones in their recovery process. This will result in the loss of employment for several beneficiaries that currently work for our organization.

The way this reads, a provider would have to submit background checks and maltreatments for all employees and contractors with our application. That is a lot of paper. Please revise the compliance piece but remove the requirement to submit all employee backgrounds with application.

305(c)(1) - ITP for each home and community based service that the beneficiary receives - so is this multiple ITPs? Rework - "to include each service"

305(c)(4) - medication management plan and medication logs - add "if applicable"-

Response: We disagree. While we understand that you may want to provide some vocational services to beneficiaries while they receive treatment, our focus is on integrated supported employment in the community.

Each beneficiary should have an Individual Treatment Plan (ITP) that list all services received.

We agree to add "if applicable" to this section on medication management plans.

Comment: CSSP Locations –

401(b)(8) - carbon monoxide detectors are unnecessary in buildings without gas or propane (all electric). Specify Carbon monoxide detectors in buildings with gas or propane.

401(b)(21) - prohibit smoking, use of tobacco products, consumption of medication without a prescription (would this include otc), alcohol and illegal drugs - needs to be edited to say it is OK to smoke outside in designated areas.

Response: We disagree with the carbon monoxide comment. As for smoking, we will clarify the language to state that smoking is allowed outside in designated areas.

Comment: Residential

402(a)(3) - 1 window that can open in each bedroom - is not always appropriate for BH clients. Can leave in the view part. We have locked units that would no longer be secure with windows that open.

Response: b4 allows an exception for secure locations.

Comment: 402(a)(4) - Many TC members prefer to cook his/her own evening meals after services. Edit this section to allow for individual to prepare his/her own meals. This is a necessary step in beneficiaries preparing to transition to the community and out of TC services.

Response: The language does not bar the individual from cooking their own meal; however, the CSSP TC provider must ensure the meal timeframes are met and must provide the meal if the individual doesn't.

Comment: 604(a) - "a beneficiary can self-administer medications as provided in the beneficiary ITP" - this needs to go on to say that if a beneficiary self-administers medications that the rest of this section will not apply.

Response: We disagree. The CSSP still has the obligation to ensure the requirements are met. A TC is a high level of care and it is assumed by the State that they need that high level of oversight and supervision. If not, a lesser restrictive program should be considered.

Comment: 607 – food - some beneficiaries manage their own meals and this does not give members enough latitude to manage meals. Learning food and meal management is a key

component in the recovery process and preparation to move to an independent setting in the community.

Response: If a CSSP is providing the meals then they must comply with USDA guidelines. This does not prohibit the beneficiary from preparing their own meal.

Comment: 701.(a)(6) & (7) - Any situation where the whereabouts of the beneficiary are unknown for more than 1 hour. Any situation where services to the beneficiary are interrupted for more than 1 hour. This is extreme for BH members. Currently defined in PASSE program as 2 hours for whereabouts unknown elopement or wandering - and we don't have a provision for interruption of services for more than 1 hour, what does this mean for a behavioral health setting.

Response: We agree and will make the change to 2 hours to be consistent.

Comment: 701.(a)(13) - any event that requires notification of the police, fire department or coroner. Does this include when a beneficiary sets off the fire alarm cooking or calls the police on himself for no real reason.

Response: no.

Comment: 702.(a)(1) - Submit the following within 1 hour - death, serious injury any incident that a CSSP should reasonably know might be of interest to the public or media. Current standards are 24 hours for death due to natural causes and serious injury.

Response: Currently, the PASSE manuals require providers report the following incidents to the DHS PASSE Quality Assurance unit emergency number (501) 371-1329 within one (1) hour of occurrence, regardless of hour as well as the on call emergency number for the appropriate PASSE:

- A death not related to the natural course of the patient's illness
- Serious physical or psychological injury to a beneficiary

We are remaining consistent with the above current practice.

Comment: 806 – monetary penalties up to \$500 for each violation of these standards. This is not specific and does not state at what point penalties may be imposed - such as after reconsideration, a CAP and time to correct – just \$500 penalties for EACH violation. There is no mechanism to appeal a monetary penalty, only a 60-day time frame in which to pay. We recommend that this is removed or edited.

Response: There is an appeal process in the standards; this language reflects existing Arkansas state law. In section 803(c)(3) factors are listed.

Carol Moore, LCSW, LADAC

Comment: CSSP Comment Period comments/questions Submitted 10/27/2020 Carol A. Moore, LCSW, LADAC

CSSP location” means: non-residential location operated by the CSSP and at which the CSSP offers any home- and community-based services.

201 b1 A CSSP must be accredited by an approved accrediting organization for all home- and community-based services offered or intended to be offered by the CSSP before DPSQA may issue a CSSP license or CSSP license enhancement. Does this mean that ILPs can apply for this and provide the paraprofessional services as well? When stating “approved”, what are the requirements for being an approved accrediting organization.

Response: Anyone can apply as long as they meet the requirements set out in the CSSP standards. As stated in the CSSP standards, “Approved accrediting organization” means the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission, the Council on Accreditation (COA), and the Council on Quality and Leadership (CQL).

Comment: 023 a1 The applicant submits a complete application under Section 202(a); Is this application currently available and if not when will it be.

Response: DPSQA will post the application online after the promulgation process is complete but prior to January 1, 2021.

Comment: 302 d1 DPSQA determines that all employees and operators have successfully passed all required criminal background and maltreatment checks; Does this require criminal

background checks must be completed by Arkansas State Police and is there a frequency required for maltreatment checks

Response: yes, and it is outlined in state statute depending on the type client you serve.

Comment: 302 e2 Employees must have at least one of the following: A high school diploma or a GED; Is this sufficient or is it actually this in conjunction with B or C

Response: it is e1 and e2A and EITHER B or C; in other words, must be 18 or older, have a high school diploma or GED and have either one year of work experience with public health, etc. OR have two years of experience working with individuals with behavioral health issues or developmental disabilities.

Comment: CSSP location” means:

non-residential location operated by the CSSP and at which the CSSP offers any home- and community-based services.

303 b4 Employees required to receive the training prescribed in subdivision (b)(1) must receive annual re-training on those topics at least once every twelve (12) months. This means that all staff require at least 20 hours of annual training per year:

304 a12 Documentation demonstrating the employee meets all continuing education, in-service, or other training requirements applicable to that employee under these standards and any professional licensures, certifications, or credentials held by that employee. Does this mean that documentation of a renewed license for a professional is not enough? They must also show documentation of all CEUs required

Response: Please see definition of CSSP location; we disagree with your first comment. As for the training, there is initial IDD/BH module training. However, there is annual re-training of certain topics, but it does not equal 20 hours per year. Also, please review the specific training around licensed professionals which is different from paraprofessionals.

Comment: 305 c A beneficiary’s service record must include at least the following information and documentation: This would be required for clients only that are billed under the CSSP billing codes and not other clients served by the agency, correct?

Response: yes.

Comment: 309 a1 A CSSP must have a written emergency plan for all locations in which the CSSP offers home- and community-based services, including without limitation beneficiary residences and CSSP locations. Does this include beneficiaries private homes, schools and other community locations that a client may be seen?

Response: yes.

Comment: Subchapter 4 Facility requirements Is this addressing residential locations only? If not the following comments/questions apply.

Response: If you are a CSSP residential location there are additional requirements outlined in the standards that go above and beyond a nonresidential CSSP location.

Comment: 401 A CSSP location may be a residence or an office that provides the services ? If an office, from which these services are provided in an out-patient fashion, is it still limited to 16 or is this only residential

Response: We have stated in the standards what a CSSP location is NOT and what it is. It does not include group homes, apartments or residences. See definition section for more detail-- 103K(1) CSSP location.

If you are a CSSP residential location there are additional requirements outlined in the standards that go above and beyond a nonresidential CSSP location.

Comment: 601 b4 The delivery schedule for the home- and community-based service that includes the frequency and duration of each type of service, therapy, activity, session, or encounter for that home- and community-based service; So you must outline how many of each 30, 45, 60 minute sessions you will be providing, even if they are the same type of service?

Response: We require general services be listed in the ITP; however, when submitting treatment to the PASSE for authorization, you may be required to detail units.

Comment: 601 b7 The setting in which the home- and community-based service will be provided, including if applicable the name and physical address of the place of service; So you have to list every setting in which it MAY occur? I.e. home office school ect

Response: It is standard practice for Medicaid to require a place of service; the address is where the beneficiary is receiving the service.

Comment: 601 b9 The schedule for completing re-evaluations of the beneficiary's condition and updating the ITP. What is the expected frequency of re-evaluations

Response: The provider sets the schedule for re-evaluations. We do not specify in the standards. It needs to be outlined in the ITP.

Comment: 605 c2 A CSSP must regularly collect and review data regarding the use and effectiveness of all behavior management plans, including as to the use and effectiveness of restraints and other interventions. Is this on an individual or data regarding all BMPs that an agency has? Is there a reporting requirement for this.

Response: The requirement is to ensure the beneficiary's BMP continues to be effective and appropriate and should be reviewed on a regular basis.

Comment: 702 b A CSSP must submit reports of all incidents to DPSQA as provided through DPSQA's website: <https://humanservices.arkansas.gov/about-dhs/dpsqa>. What format is this completed in and is this format currently available for review?

Response: DPSQA uses a standardized reporting tool that will be made available online. However, you are likely using the tool now.

Jared Sparks, PHD, LCSW, CHC, Vice President of Compliance, Arisa Health

Comment: Arisa Health, Inc.

Public Comments for the Community Support System Provider (CSSP) Manual

In the Definitions Section, it appears that a CSSP provider is able to provide a wide array of services.

These services would include traditional outpatient services as well as the most intensive services.

If an organization wishes to be a CSSP and provide a full continuum of care, these standards are going to be challenging to apply to non-residential and intensive programs and buildings.

The CSSP Manual does not seem to differentiate and anticipate the organization that offers a full continuum of care and the flexibility that will be needed if CSSP is to be an umbrella certification. There is an excellent emphasis on “license enhancement” or intensive services, but the CSSP Manual has not adequately anticipated and strengthened its approach to accommodate traditional outpatient services and less intensive clients.

Is it anticipated that an organization will have to have both BHA and CSSP certification? Can a facility that offers outpatient services and rehabilitative day under the same roof have multiple certifications? Will this be required?

Response: You will have to enroll with Medicaid for the new licensed type and be licensed by DPSQA; The CSSP provider type will be certified to provide the HCBS services under the PASSE program and under the Adult Behavioral Health Services for Community Independence for DD and BH beneficiaries who tier as a II or III.

CSSP license: Supported Employment, Supported Living, Respite, Adaptive Equipment, Community Transition Services, Consultation Intervention, Environmental Modifications, Supplemental Support, Specialized Medical Supplies, Behavioral Assistance, Peer Support, Family Support Partners, Supportive Life Skills Development, Child and Youth Support Services, Supportive Housing,

CSSP licensed Enhancement: All CSSP services plus Adult Rehab Day, Mobile Crisis Intervention, Therapeutic Communities, and Community Reintegration.

Any counseling that is included as part of the one of the services listed above under enhanced CSSP, only an enhanced CSSP license is required; however, if you want to provide counseling outside of one of the above enhanced CSSP services, a OBHA or ILP license is still required. Enhanced CSSP services are underlined above.

Comment: Will BHAs be allowed to grandfather their current certification to a CSSP certification?

Response: Please see answer above.

Comment: In Section 103 Definitions, (m) “Employee” includes independent contractor. By IRS definition, an independent contractor is not an employee. Can “independent contractor” be removed from this definition?

Response:

Section 103(m) will be broken into subsection (1) and (2). Section 103(m)(1) will remain as currently written. Section 103(m)(2) will be added stating:

- (2) “Employee” does not mean an independent contractor if:
 - (i) the independent contractor does not assist in the day-to-day operations of the CSSP; and
 - (ii) the independent contractor has no beneficiary contact.

Comment: In Section 103 (n) (2) should read as follows: “...cooking classes, and support groups and other activities that promote holistic health and well-being”.

In Section 103 (q) can definitions be added for Qualified Behavioral Health Professionals? Can the omission of nurses (LPNs and RNs) be added as well?

Response: Thank you for your comments about Section 103 (n)(2) and Section 103(q).

Comment: In Section 103 (v)(1) Can “on-site” be stricken or can permissive language be added for the use of technology?. This will allow the use of technology for crisis services as an option when appropriate. Technology can result in a much more timely response and disposition especially in rural settings.

Response: This is the service description written in the PASSE waivers and the PASSE manual; however, we do plan to allow the use of technology within this service and continue to work to develop an integrated crisis response across the State.

Comment: In Section 103, please replace “doctor” with “Medical Service Encounter”

Response: There is a definition for “medical service encounter” in Section 103(t).

Comment: Section 201 (b) (1) Please clarify that a provisional accreditation is acceptable.

Response: It is not our intention to allow provisional accreditation for CSSP licensure purposes. The requirement is accreditation.

Comment: Section 201 (a)(2)(G) and (b)(1) (C) can this be clarified to include “All other reasonable documentation or other information requested in writing by DPSQA?”

Response: Thank you for this comment. We disagree that the word “reasonable” should be added to the documentation subgroup.

Comment: Section 301 (c)(2) What is the implication? Is it intended to say: A CSSP that is contemplating a change in ownership and that desires to maintain its CSSP status, must seek DPSQA approval or a full licensure application will be required?

Response: We disagree. DPSQA must approve the new application prior to change in ownership to ensure the new owner meets the requirements outlined in the CSSP standards.

Comment: Section 201 (f) (2) Should “of” be stricken in this sentence?

Response: Thank you for your comment we will strike the extra word that isn’t needed.

Comment: Section 303 (b) (1) (A) Would it clarify the intent to have the language as follows: “Twelve (12) hours of training for employees. Additionally, they must have training in the following areas:?”

Response: Thank you for your comment. We think the training sections are outlined appropriately in the standards.

Comment: Section 303 (b) (3) Can it be clarified that a “certified or” licensed professional is not required to receive the training prescribed in subdivision (b)(1)?

Response: The standards outline the training required for professionals vs. paraprofessionals. We think it needs to remain as licensed.

Comment: Section 303 (b)(4) Would you specify that “those topics” is referencing B through G only?

Response: We will clarify this language.

Comment: Section 303 (d) (2) (A through E) this section will likely not be relevant to those clients who are not facility based. Can (2) clarify When relevant, Beneficiary-specific training...

Response: We will clarify this language in b and c.

Comment: Section 308 (e) (1) Will you please clarify that this is separate accounting not accounts? Client funds can be preserved when they do not have to pay separate bank fees. Client funds should be segmented from operational funds and each client’s balance should be accounted for separately in accordance with generally accepted accounting principles. Sophisticated software allows for proper accounting without separate accounts. This complies with SSA requirements as well.

Response: yes, we agree; separate accounting but not necessarily separate bank accounts.

Comment: Section 309 (c) (2) Can an allowance for quarterly fire drills be added for locations that are traditional outpatient offices?

Response: Thank you for your comment. Quarterly fire drills are best practice to ensure the safety of the beneficiaries.

Comment: Section 310 (b) (1) Can a known be added before ...infectious disease...?

Response: We will clarify this language.

Comment: Section 401 (b) (21) Can this language be expanded to allow for smoking in designated or approved smoking areas?

Response: This language has been amended.

Comment: Section 602 (c) (1) Can language be added so this reads ...be signed or authenticated electronically...?

Response: Electronic signature is fine.

Comment: Section 603 This section seems to reference commercial transportation rather than the use of a personally owned vehicle. Is this correct? If so, can that be stated?

Also, it seems that compliance with Medicaid Regulations for transportation should be an option here as well. Can the manual reflect compliance with either the CSSP manual or the Medicaid Transportation regulations?

Response: It isn't commercial vs. personal vehicle. The trigger is whether a CSSP is providing the transportation, however they choice to do so, the standards then apply. This is consistent with Medicaid transportation.

Comment: Section 702 (a) (2) Can the report submission be within 48 hours or the next business day for situations that arise during a holiday or weekend?

Response: no, thank you for your comment.

Comment: Section 703 (a) Can you insert substantial before injury?

Response: no, thank you for your comment.

Comment: Section 801 (a) (2) (A) Can the word “reasonable” be inserted before monitoring?

Response: no, thank you for your comment.

Comment: Section 801 (c) Can language be added that clarifies the CSSP will be informed in advance of these third parties, clarify credentials will be provided to the CSSP and outline what the feedback loop is from the CSSP to DHS?

Response: A contractor would be acting on behalf of DHS and would follow these standards.

Comment: Section 803 (a) (2) (A) Can this language be clarified? ...provide voice to voice notice to the CEO and Compliance Officer ...

Response: The language requires immediate notice and does not specify a format or medium for doing so. See section 301(b)(1) as well please.

Comment: Section 807 Can language be added to specify timelines and recourse the CSSP would have if suspension or revocation of licensure occurs? (Subdivision 10?)

Response: Subdivision 10 outlines the appeals process.

Shari Willding, LPE-I, Administrator, Methodist Behavioral Hospital

Comment: The proposed manual is geared toward Developmental Disability Services without much consideration to the needs and requirements of Behavioral Health.

A beneficiary must have a behavioral health diagnosis and be independently assessed as Tier 2 or 3 and be on waiver to be eligible for CSSP. Therefore, the expectations of the Behavioral Health Services should be consistent with standard industry practice and more closely aligned with the expectations of the Behavioral Health Agencies, anything else is substandard and irresponsible.

The manual, as proposed, doesn't afford quality or responsible Behavioral Health care for this vulnerable population, as intended. More attention and diligence (with collaboration from providers) is needed.

No direct care provider training is outlined to meet behavioral health standards (similar to that of QBHP initial and ongoing training), nor are any documentation requirements clarified.

Bachelor's level individuals work under the guidance and supervision of the therapist, however, there are no therapist services under this provider type. This provider type is seemingly allowing bachelor's level individual work autonomously.

Treatment planning indicates bachelor's level practitioners are completing these however, in Behavioral Health, the therapist and physician drive the treatment planning and the bachelor's level practitioners carry out the plan, accordingly.

Response: Thank you for these comments.

Comment: By all accounts, it is being stated and reported that this provider type will allow providers to serve dual diagnosis population under one certification. It does NOT. There is no master's level therapist services or substance abuse services incorporated into the CSSP certification. However, the proposed manual does require "three professional encounters". This is not defined nor is there the provision to bill for these services under CSSP. Furthermore, in the response to question #91 (CSSP questions and answers 9.21.20) it is stated that "it will be billed as it is today". If therapy services are not covered under this certification, retention of both certifications is necessary to bill for the services required. This provider type may allow a provider to provide service to this very limited population, however, for most providers to expand into this provider type, they will still have to retain existing certifications.

Response: We disagree. The enhancement level of CSSP allows clinical services under this one certification type for Therapeutic Communities, Community Reintegration, Adult Day Rehab, and Mobile Crisis. Professional service encounter is defined in 103(x), as well as a medical encounter.

Comment: Reimbursement:

While the rates are determined by the PASSEs, what is the structure of billing for services? DD and BH bill very differently. What will the structure of billing for services look like and what is the expected role of a beneficiary's SSI?

Council on Quality Leadership (CQL) accreditation is not to the same standard as CARF, COA and TJC. CQL does NOT have accreditation for Behavioral Health services, specifically. Therefore, this should NOT be an allowable accrediting body.

To clarify the response to question #99 in the CSSP Questions and answers 9.21.20, "it is not our intention to have all services accredited. The requirement is that the provider must be accredited in a related field." Why would a provider not be required to be accredited for the services they are providing? This would allow for substandard care to a vulnerable population.

Response: If the beneficiary is in a PASSE, yes, the provider can negotiate an individual rate. Some beneficiaries under the ABSCI are still fee for service. All services under this provider type have existing codes and fee schedules. Those are currently not changing. Thank you for your comment on accrediting agencies. You are free to utilize any of the accreditations listed in the standards. It is not our intention to mandate all services be accredited; the topics are usually bundled into like topics under accreditation—we expect the provider to get an accreditation in services appropriate for IDD and BH.

Comment: In question #52, CSSP Questions and answers 9.21.20, the response indicates: "Under CSSP, the direct worker under this provider type is combining the IDD DSP and the BH QBHP; however, in the definition section, we outline minimum educational and training requirements; for high school diploma/GED levels, the training is 12 hours. For college degreed employees, the training is 24 hours because we are expecting higher educated staff to complete a higher level of service consistent with the service descriptions and rates that are already in place." A college degreed individual is requiring more training than a non-degreed individual, but in the services outlined, there is no distinction between a degreed individual's services and the non-degreed individual's services. A degreed individual does not constitute a licensed individual.

Response: We clarified this language in the version out for public comment and promulgation.

Comment: Was there early Behavioral Health and Developmental Disability provider collaboration in developing this proposed provider type? If so, how was this communicated to providers during development to offer collaborative insight?

Response: We have been working with providers for the last 2 years and did extensive outreach prior to formal public comment.

Comment: Why is the population to be served limited to those on waiver? Shouldn't these support services be available to all those with Developmental Disabilities to alleviate the need for more

supportive care as adults? Specifically, if a child is tiered 2 or 3 under BH and has a DD diagnoses, why wouldn't they qualify for the least restrictive (Base Level) of these services?

Response: We believe you are referring to those on the CES Waiver waitlist. Under the PASSE model, services may be provided to those members if in their PCSP. Also note that many may be dually diagnosed and placed in that rate cell under the PASSE.

Comment: Can a Behavioral Health Agency, who chooses not to seek CSSP Certification, see dually diagnosed individuals, if that is the client/guardians' choice?

Response: yes.

Rusti Holwick, LPE-I LADAC AADC, Chief Executive Officer , The Guidance Center

Comment: Good afternoon all:

I hope everyone is well and having a great Tuesday! Marla mentioned you asked for our ideas on Community Re-integration. Here are our thoughts on the manual:

Public comments for CSSP Manual

Mobile crisis are allowable under OBHA. Will mobile crisis for dually diagnosed still be allowed as only OBHA provider type?

Response: yes. No changes to OBHA.

Comment: Page 10 (1) and (2). These statements specify these standards versus accreditation standards. My question is if we hold both OBHA and CSSP provider types and have programs in each, will there be conflict in the standards? It would be helpful for the requirements and standards to match more closely in the case we both provided Mobile Crisis or Community Re-integration, the standards might more closely align. The CSSP manual standards are far more prescriptive.

Response: It is the choice of the provider whether to have a CSSP and an OBHA license if the only services you wish to provide fall under CSSP. You can choose to remain only an OBHA and provide the services under those standards. The goal of this provider type is to better provide a continuum of care of home and community-based services for the beneficiary.

Comment: Crisis Prevention Intervention (non-violent crisis intervention) (CPI) training needs to be required.

Response: You are free to use any additional training and most likely, your accreditation will require a crisis intervention training curriculum.

Comment: Maintaining screens on all windows and doors can become costly and a burden with youth.

Response: Thank you for your comment. Section 401(b)(11) and (12) outlines this standard and it is for ventilation.

Comment: Not sure a safety alarm in vehicles is needed when staff-to-client ratios are appropriate in transport. That's additional modification and cost that seems unnecessary with regular minivans and vans for transport.

Response: We disagree.

Comment: Page 44. Community Re-integration.

The requirements seem okay here with the exception of #2. The prescriptive manner of the requirements in item #2 seems to interfere with the mission and purpose of the program.

Response: This is intensive level service paid on a daily rate. Minimum service requirements are appropriate.

Comment: As you know, having not often received the appropriate support, parenting, and guidance, these children become “institutionalized,” unable to care for themselves and maintain in a lesser restrictive environment. In community reintegration, adolescents who are in DCFS custody who have been in facilities will have an environment to help them to transition out of these higher level of care facilities and into foster and adoptive homes or otherwise in the community. It is our mission to turn patients into citizens. Previous facility placements have not been designed or meant to raise children and these children do not get the proper guidance that they require in order to be successful adults. Without the proper guidance, resources, and support, they are destined to walk down a path of destruction with little hope for a successful future.

Unlike other group “home-like” settings, Fostering Change, a community re-integration program is a therapeutic group “home-like” environment with a therapist assigned to each resident to provide intensive outpatient therapeutic services. Each employee is also a Qualified Behavioral Health Professional (QBHP) and consistently provides independent living skills and behavioral interventions to each resident. This therapeutic environment allows for residents to have an appropriate transition into the community, provides the necessary guidance to develop needed independent living skills, and helps to create and maintain a support system that benefits the youth for years to come. Therefore, we would suggest a statement that reflects the mission, goal and intent with greater flexibility as to how “intensive” plays out in a day for each unique youth. This paints a very different lens of intensive than our counterparts of institutions define intensive services. The goal is to move away from service structure to home and life adaptation models and move away from being institutionalized. Crisis intervention is heavily utilized day-to-day, support and guidance and de-escalation as well as problem solving.

During the school year, most of these children are in a public school setting. The day, aside from the challenge of waking up and getting themselves prepared to get on a bus or be transported to school (a challenge in itself), is a 7:30am-3:30pm day in a school setting. A therapist goes to the schools to provide therapy, as well as on-site; QBHPS as well. This leaves a transition time from 3:30pm-4ish for youth to settle in from their day. That leaves the evening for group, other supportive life skills, dinner, homework, and extracurricular

activities. Remember we are also helping them engage in activities and other independent skill activities. Would your own child have the time for 20 hours in a structured activity around school in the evenings and on weekends? The day is also filled with transporting youth from school to appointments, visitation, crisis occur heavily and with frequency.

Some thought might be given on the daily logs for youth. Electronic medical record systems make it challenging to enter daily logs on each client in a useful and functional manner. The information might get into a chart, but may not be as functional for the program as a notebook, even an electronic notebook for each shift to learn what has happened, events, issues, crisis, etc on the entire milieu/group versus without having to comb through 12-16 charts when entering a shift.

#3. Assumes there's medical necessity to see a physician for medication monthly. Might consider making this frequency based on the medical provider.

Response: It is frequency based.

Christy Mathis-Conway, Special Projects Assistant, Mid-South Health Systems, Inc, Administration

Comment: .a.2 pg. 13

Clarification is needed on the requirement "enough employees onsite to supervise beneficiaries in a CSSP location". Does that mean "on the floor" or in the building?

Response: They need to be located in a place where they supervise and monitor beneficiaries.

Comment: 302. f.1 pg.14

Having to list all individuals on shift in the daily note would be very difficult with call-ins, etc. In most facilities we maintain a schedule of employees to work. But the only way to reconcile who actually covered would be to compare via our timekeeping system. Would our schedule and timesheet records count toward this requirement?

Response: yes, there is no specific format required.

Comment: 302. f.2 pg.14

It is not clear why shift days and shift times must be documented on the staffing notes. The staffing may include people from different shifts when working with residential programs.

Response: We need to know which staff were present, on which days, and at what times.

Comment: 302.g.2 pg. 15

Please provide further guidance in regards to this requirement if the agency uses Telehealth providers; the requirement states “a licensed medical professional must respond onsite in person if needed’.

Response: This question was answered previously above.

Comment: 305. b.3 & 14 pg.18

The requirements states that the beneficiary’s telephone number and email address is required. It further states that “email address of the beneficiary’s legal guardian or custodian” is required. Not all clients have email addresses. We have tried to obtain them in the past without much success. Should this be required? Setting up client emails could be a useful activity and even work as a part of an intervention. If this is required, can it be amended to an item that we can mark N/A in the event they are in a secured program?

Response: We will clarify the language to include “if available.”

Comment: 310.a.2 pg.23

More information about how PPE is required as a result of COVID. Can more specific language and directives be provided?

Response: DHS follows the guidance of Arkansas Department of Health which changes depending on the issue and nature of the facility so it would not be helpful to include specifics in these standards.

Comment: 401.b.17 pg. 27

Emergency power systems should not be required for rehab day facilities which are not residential locations. This should be moved to Section 402 Residential Requirements.

Response: Thank you for your comment. Physical plant requirements for the enhanced CSSP are best practice and ensure the safety of the beneficiaries.

Comment: 601. b.6 pg. 31

More clarification is needed on this requirement. What are indicators for the necessity of increased or decreased ratios? If something happens that causes the client to need closer monitoring, would the treatment plan need to be updated with each occurrence?

Response: yes.

Comment: Is this requirement with regards to increased attention due to a crisis (i.e. 1 to 1 monitoring, 15 minute checks, etc.)?

Response: no, any time there is a change not necessarily just crisis.

Comment: 603.a.2a-b pg. 33

More clarification is needed on these requirements. Is this necessary as rehab day programs have daily sign-in and sign out sheets? Should the current logs be modified or expanded to include all of the required information?

Response: You can expand your sign in and sign out to meet the requirements of arrivals and departures. We do not mandate any formats for the documentation requirements under these standards.

Comment: 603.b pg. 33

CSSP providers should be able to adhere to Medicaid Transportation requirements or these requirements but not both.

Response: All beneficiaries served under CSSP have tiered at a II or III for IDD or BH and are receiving high levels of support. The transportation service safety measures are consistent with the functional needs of these clients.

Comment: 604 Medications. pg. 33-38

Please clarify if the medication plan is a separate document from the medication log. They both record the same information. Logs captures all the required information and includes administrations.

Response: We just need the information available and do not prescribe the format.

Comment: 608.c.5 pg. 45

The requirement states that “enrichment activities for each beneficiary based on each beneficiary’s treatment objectives and needs”; should this be documented in the daily rehab day notes?

Response: We answered this question above.

Bess Heisler Ginty, Managing Member, Arkansas Healthcare Alliance, LLC

Comment: Director Mann,

On behalf of the Arkansas Healthcare Alliance (“Alliance”), I am submitting the below comments, questions and concerns with regard to the proposed Licensure Manual for Community Support System Providers. (“CSSP manual”). As you know, the Alliance consists of over fifteen BH and/or DD providers located throughout the State. The below comments are a compilation of input from those providers.

103(p) – ITP:

Who has the responsibility for writing the ITP and for how long is it effective.

Response: Under CSSP, we do not mandate the credentials for the person responsible for writing the ITP. At a minimum, the ITP must be reviewed annually or more frequently if services are modified. We will add language stating minimum annual requirement.

Comment: 103(z) 2(A) - Restraint:

Is there a more specific definition of “briefly?”

Response: no, we mimicked the federal definition who also uses “briefly.”

Comment: 203. How long does the license last? What is the recertification process?

Response: There is no end date to the license. See 203(d).

Comment: 302.(a)1. “A CSSP must appropriately supervise all beneficiaries based on each beneficiary’s needs.” Is there a specific assessment required to determine those needs?

Response: There is no specific assessment.

Comment: 302(a)2. “A CSSP must have enough employees on-site to supervise beneficiaries in a CSSP location.”

Is there a specific setting to which this applies? Does it apply to an outpatient provider setting? What is the specific client to staff ratio?

Response: It is determined by the beneficiary’s ITP.

Comment: 302(d)1. Is there a frequency required when running backgrounds, maltreatments, etc?

Response: This must be completed in accordance with state statute.

Comment: 302(e)2. “Employees must have at least one of the following”: “Two years of experience working with individuals with developmental disabilities”:

Shouldn’t the experience be inclusive of working with all of the populations being served? It should include experience with behavioral health and/or intellectual disabilities? Also 2 (two) years should be recommended. Often,, 2 years is not possible when trying to find coverage for this population.

Response: The version out for public comment does include BH OR IID under this section.

Comment: 302.(f)1 and (f)2. Employee staffing: This requires clarification. Does this cover supervision, case consultation or something akin to a nurse before a shift change? Or is this like a progress note for BH?

Response: no, this is not a progress note. These requirements pertain to who is working and the shift they are working.

Comment: Section 308(d)1 – Would we have to buy software or an additional module from Credible to be able to maintain financial records for our beneficiaries?

Response: That is a business decision. We require that the records are maintained, and appropriate accounting practices are followed.

Comment: 502.(c)2 – Does this require that the beneficiary, upon discharge, be provided with a copy of his/her entire record at provider expense? Can you define service records? Additionally, providing all documentation causes concerns in the BH world because typically we do not release records that could be detrimental to the clients well being.

Response: We will clarify to add that the beneficiary should be provided a treatment summary, the current ITP, current medication log is applicable and other records as requested by the beneficiary in compliance with clinical discretion as allowed by law and your accrediting agency.

Comment: 502(d) – This is a massive issue. In the DD world, it makes more sense that the provider is responsible for the health, safety and welfare of the beneficiary until transitioning to a new service provider. This does not work in the outpatient BH world. Clients are non-compliant, they get off their meds, they overtake their meds and we fire them, they use illicit drugs, etc. We cannot force them to have services and once we discharge the client we should not be held liable. We need more parameters around exits and transitions. Accreditation agencies have transition requirements that we could mimic.

Response: We will clarify language to state: All transition services were offered and proof of refusal to participate in transition by the beneficiary or if the beneficiary lacks capacity, by the beneficiary’s guardian. With all accreditations, we expect those requirements to be met as well.

Comment: 601 Individualized Treatment Plans

A1 – “Each beneficiary must have an ITP that covers each HCBS service that it provided.” – At what time must an ITP need to be completed and how often does the ITP need to be updated or reviewed?

Response: As far as completed, if the beneficiary is in a PASSE, it is likely the treatment plan will be requested for service payment and PCSP development/modifications. In 601(b)(9) requires a schedule for when the ITP will be updated.

Comment: B6 – “The minimum employee-to-staff ratio...” - What is the employee-to-staff ratio? Is this required for outpatient services or just residential? Is the ratio different depending on the service being provided? This is not language used in BH. Maybe this can be answered in Q/A.

Response: This is based upon the beneficiary’s ITP.

Comment: B7 – “...including if applicable the name and physical address of the place of service.” – Does this mean that the ITP has to have each location that the service maybe provided? What if a service is provided at a place not listed (for example the client transfers to a different school or moves)?

Response: This question was answered above.

Comment: B9 – “The schedule for completing re-evaluations of the beneficiaries’ condition and updating the ITP.” – Is this a set time frame or at the providers discretion? Individual basis, agency time frame or is the time frame being established otherwise?

Response: This question was answered above.

Comment: ITP: Will there be 2 separate ITP - MTP required for the population – one for Counseling Level Services and one for CSSP? If so, how do our EMRs handle that? Why would the PASSE pay the same provider or different providers that? What licensure signs on the MTPs/ITPs? How do we distinguish services provided by the two provider types? Who orders the service modalities? What is the role of the licensed therapist or psychiatrist?

Response: This provider type requires an ITP. We are focused on services being delivered under the CSSP provider type. These are HCBS services so no prescription requirement under the standards (the PASSEs may have individual requirements). A therapist or psychiatrist can be utilized in accordance with the beneficiary’s ITP.

Comment: 602 Daily Service Log:

Can using an EMR / progress note be an acceptable alternative to a daily service log as long as it contains the same information?

Response: yes

Comment: B5 “The relationship of the HCBS to the treatment objectives...” – Does this mean a rationale and justification for the functional service?

Response: This question was answered above.

Comment: Section 605 - Who writes a behavior management plan and how is it different than the ITP?

Response: We do not dictate specific qualifications for who writes the ITP or the BMP.

Comment: There are policies and procedures that have to be written for DD services that we do not provide. We have to check with accreditation to see if we have to be certified in different program types under accreditation – as well as paying for these accreditations.

Response: Thank you for your comment. Please note that becoming this provider type does not require you to serve all members nor provide all services. Also, one PASSE has proposed a process for accreditation reimbursement or payment as a community investment. DHS approved that proposal.

Comment: What happens when someone in the DD world is dealing with a client that has psychosis? Who are they supposed to call? Are we saying that they could be our client for counseling level services and someone else’s client for CSSP? Who is responsible for the client and the liability factor?

Response: The provider is expected to provide the services in the ITP. What you explained above is exactly why we are moving to one provider type option. Currently, IDD clients are receiving services from a CES Waiver provider and struggle to get connected to an OBH provider for mental health treatment. Liability for the agency providing mental health treatment remains the same.

Comment: Transportation requirements: Will this apply to BH staff that only transports one client? Thank you for your consideration on these questions, comments, and requests. As always, we are happy to answer additional questions or discuss further.

Response: yes, and this question was also answered above.

Lindsey Radcliffe, CEO, Morning Star Behavioral Associates

Public hearing held remotely on October 16, 2020 at 10:00 a.m.

Comment: My two questions are regarding in Section (q)(2) and (3) on page 5 of the document where it discusses licensed professional and nonprofessionals. It's my understanding that the State of Arkansas does not have a licensure for board certified behavior analysts, and that you kept the national credential out of a -- you know, as moving forward.

But with that said, the way it is written, it does not allow any ABA services to be utilized in this very important part of the waiver. And I would argue that it is a vital service that will reduce taxpayer burden and also increase independence among individuals with disabilities. So I would humbly ask that you might consider putting BCBA in that language.

And then the second question I have for you is, under the definitions on page 2 Section 103(a), you describe adult rehabilitation, adult day rehabilitation. But there's only one description where it's found where this document covers a multitude of different populations. And I was wanting to understand a more detailed version, and how you guys were going to create specific rules for individuals depending upon their diagnosis. Because it would or would not be appropriate, depending upon the function of it.

Thank you.

Response: ABA is a service available to Medicaid beneficiaries under EPSDT and there is an Autism Waiver. For those reasons, autism services are duplicated under the CES Waiver. However, they are still available for clients on Medicaid. They just do not fall under CSSP. They have a particular Autism provider type.

Adult Rehab Day has a service description that can be found in the ABSCI manual and the PASSE manual. The service is not diagnosis driven.

Joel P. Landreneau, Crochet & Landreneau, PLLC, Attorneys At Law

Comment: Dear Sir/Madam:

Please accept these comments regarding the promulgation of the CSSP certification manual in your public comment on behalf of the Arkansas Behavioral Health Private Providers' Association. We are grateful to have the opportunity to address this publication.

Adverse action definition: if action pursuant to Section 803 is an appealable adverse action by a CSSP, does that mean that a plan of correction imposed on a CSSP by DHS or one of its contractors is appealable, since it is listed in Section 803(b)(1) as one of the enumerated enforcement actions? **Yes.**

Medical Staffing: No medical director is required to oversee HCBS service planning, as is currently the case with companies licensed as Behavioral Health Agencies. In behavioral health, the treatment plan is the prescription for services overseen by a physician. There is no similar requirement in CSSP regulations that governs who is in charge of ensuring that the treatment plan is carried out. **This is not a medical model. It is a home and community based model.**

This is serious concern. As we understand it, as behavioral health agencies, we will be able to provide services to Tier I clients, as well as to Tier II and Tier III clients. However, unless we get the CSSP certification, our service provision to Tiers II and III will be governed by the BHA certification manual, which imposes a much more detailed list of requirements that are not found in the CSSP manual. Lack of a medical director is but one of these differences. If adopted in its present form, ILP's will be able to serve Tier I clients with their current ILP certification, and ILP's will be able to serve Tiers II and III under the CSSP manual without having to meet the higher standards expressed in the BHA certification manual. **ILPs can provide therapy services under CSSP enhanced services if they meet the requirements outlined in the CSSP standards. Any group that meets the requirements can become a CSSP.**

The concern is that this will put ILP's at a competitive advantage vis-à-vis BHA's, because BHA's will still have to retain their BHA to serve Tier I, and as a result will have to be governed by its higher requirements. Is this the case? Could a BHA opt to be certified as CSSP and see Tier I clients through that certification, foregoing the BHA certification? We do not read the draft to allow that. The result of this is that BHA's will

be governed by the stricter standards set forth in the BHA manual, while ILP's will only have to meet the ILP requirements to see Tier I's. **The question regarding Tier I clients and certifications was answered above.**

At a minimum, some of the differences between the BHA manual and the CSSP manual should be narrowed, or else the CSSP manual is a direct threat to BHA's who have to meet higher standards than ILP's to see the same clients.

Response: Answered after each question above.

Comment: There are other such differences as well:

Service radius: BHA's are subject to a radius of 50 miles. There will be no such limitation to ILP's licensed as CSSP's.

Contemporaneous documentation requirement: There are standards in the CSSP manual which address what has to be documented, but nothing that states when the documentation must be created. The documentation requirement for BHA certification is quite stringent (end of the next business day after service delivery) and BHA's often struggle to meet this requirement. Again, as BHA's will have to continue to be certified under the BHA manual to see Tier I's, this means that BHA's will have to meet a requirement that ILP's licensed as CSSP's do not have to meet.

Training for QBHP's: BHA certification lists detailed topics that must be included in training of paraprofessionals providing home and community-based services. ILP's licensed under the CSSP manual have a noticeably shorter list of topics (Section 303(b)(2)) they must include in training.

Other staffing: There is no analog to the BHA-required staffing requirements for Medical Records Librarian, Grievance Officer, Quality Control manager, and the like. There is no process for use of multidisciplinary teams to review quality control. These are functions that address quality of service delivery, and are burdensome comply with. ILP's licensed as CSSP's will only be subject to whatever is required by their accreditation agency, which, if desirable, ought to be the rule for BHA's as well.

Restraint/Seclusion: There seems to be no physician's approval required to initiate restraint, as is the case with PRTF's. Who has authority to initiate any particular use of restraint/seclusion? The draft does say that restraints must comply with the beneficiary's behavior management plan, but who approves that? Also, Section 701(a)(5) requires incident reporting of an "unauthorized use of restraint or seclusion." Again, who can authorize?

Response: This is a completely different provider type that can provide a select group of HCBS to both IDD and BH Tier II and III. It is not intended to supplant other provider types. This is a business decision.

Comment: Incident Reporting: do verbal threats of suicide, without any overt act to carry out the threat, constitute a reportable event?

Response: The incident reporting in the CSSP is pulled from the federal waivers and is consistent with the practices put in place with the launch of the PASSE program in March of 2019. We didn't change it.

Comment: Section 804: what are the circumstances that would justify a "moratorium" wherein DPSQA could prohibit a CSSP from accepting new beneficiaries? Is this an enforcement provision meant for dealing with noncompliance with rules, or are there any other reasons that DPSQA may do this?

Thank you for the opportunity to offer our views on this publication.

Sincerely,

Response: Section 801(b)(3) and (c) outline the circumstances when this could occur.

Suzanne L. Tipton
Chief Compliance and Legal Officer

Comment: Empower Healthcare Solutions comments and suggestions:

For the most part the Rules for the Division of Medical Services Licensure Manual for Community Support System Providers is comprehensive and thorough. There are a few recommendations that follow that would help clarify the information within the document.

The only outstanding issue is payment. There are not any details linking the information to billing Medicaid or the PASSEs. There should be at least a reference to codes or where that information can be obtained.

“Approved accrediting organization” means the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission, the Council on Accreditation (COA), and the Council on Quality and Leadership (CQL).

Are these the only accreditation bodies that can be used?

Response: We are currently working through Medicaid manuals to remove codes and only publish on the fee schedule. This will allow us to keep our codes more current. We have been working with the PASSEs on any needed coding changes for this provider type. Yes, those are the approved agencies.

Comment: If an accreditation is lost what is the process to cure the deficiency? Is there a time period that can be defined for re-accreditation?

Response: Loss of accreditation will subject the provider to remedies up to revocation of the license. If the license is revoked, the provider could apply again once accreditation was restored.

Comment: It appears that the initial application requires criminal background and Child and Adult Maltreatment Registry checks. How frequently will the CSSP be required to do these checks?

Response: Please comply with state law.

Comment: 303 Employee Training

There isn't mention of HIPAA or confidentiality training. Is it assumed to be covered in one of the other requirements? Should there not be an attestation? HIPAA and the Privacy Act of 1974 are mentioned in 311 mentions as being in compliance but should also be reflected in the employee training section.

(d)(2) Beneficiary specific training...what evidence is required that demonstrates this is done.

Response: As a Medicaid provider you are responsible for maintaining HIPAA and Privacy Act of 1974 requirements. Documentation of the training provided and of attendance in any format.

Comment: Subchapter 4, 401. General Requirements

(b)(6) Have at least one (1) toilet and one (1) sink for every twelve (12) beneficiaries, with running hot and cold water, toilet tissue, liquid soap, and paper towels or air dryers;

This doesn't appear adequate for male and female use and should be at least two in separate areas.

Response: This is a minimum requirement and individual providers can set up bathrooms as they see fit.

Comment: (b)(8) There should be smoke detectors in each room not just each area.

Response: This is a minimum requirement and individual providers can install smoke detectors as they see fit.

Comment: (b)(9) First aid kits should be placed in areas for ease of access and easily identified.

Response: It is up to each provider to determine the placement to meet this standard.

Comment:402 (a)(6) Need to also differentiate male and female showers.

Response: A ratio of showers to beneficiaries is set and it is up to each provider to designate how these are assigned based on gender, age, or other criteria.

Comment: Subchapter 6. Programs and Services.

601. Individualized Treatment Plans

(b)(1) The beneficiary's treatment objectives needs to have more detail since the daily progress requires how the objectives are being met. This documentation is critical to support medical necessity on an ongoing bases.

(b)(3) Does "medical necessity" mean a doctor's order?

Response: The amount of detail outlined in treatment objectives is left to the treatment provider. Medical necessity may be established by a doctor's order, but it can also be established as a part of the plan of care and initial assessment results compiled by those treating and evaluating the beneficiary.

Comment: (b)(6) minimum employee to beneficiary ratios required for the beneficiary for safety? Activities? Or something else? To be documented in the ITP? This isn't clear.

Response: This is a flexible ratio allowing individualization of services based on each beneficiary's need.

Comment: 603. Arrivals, Departures, and Transportation.

(d)(1)(A) Need more details about maintenance of vehicles. Able to demonstrate maintenance was provided every X number of miles according to the vehicle manufacturer requirements. Particularly brakes.

Response: It is expected that each provider will follow guidelines for the particular vehicle they use for transporting beneficiaries to assure safe operations.

Comment: 608. Service Requirements.

This section should be addressed as activities to meet objectives and have documentation requirements linked to the objectives.

Response: Each individual provider is allowed and encouraged to develop objectives and document activities in as much detail as they feel is appropriate.

Comment: (b) For community reintegration, a CSSP must:

Provide educational services to all beneficiaries either at the CSSP location or at a local school if that is appropriate and compliant with Arkansas Department of Education requirements;

Provide at least twenty (20) hours of home- and community-based services for each beneficiary per week, with at least five (5) hours provided by community support staff on an individual basis and not in a group setting;

Provide at least one (1) medical service encounter for each beneficiary per month;

Provide at least three (3) professional service encounters for each beneficiary per week, including at least one (1) professional service encounters on an individual basis and not in a group setting; and

Provide enrichment activities for each beneficiary based on each beneficiary's treatment objectives and needs.

This section should be addressed as activities to meet objectives and have documentation requirements linked to the objectives.

Response: Each individual provider is allowed and encouraged to develop objectives and document activities in as much detail as they feel is appropriate.

Comment: For therapeutic communities, a CSSP must:

Provide at least twenty (20) hours of adult rehabilitation day treatment for each beneficiary per week, which may include time from medical and professional service encounters;

Provide at least fifteen (15) hours of additional home- and community-based services for each beneficiary per week, which may include time from medical and professional service encounters and time from adult rehabilitation day treatment in excess of the twenty (20) hours required in subdivision (c)(1);

Provide at least one (1) medical service encounter for each beneficiary per month;

Provide at least three (3) professional service encounters for each beneficiary per week, including at least one (1) professional service encounters on an individual basis and not in a group setting; and

Provide enrichment activities for each beneficiary based on each beneficiary's treatment objectives and needs.

Response: Thank you for your feedback.