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Transmittal Sheet

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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Developmental Disabilities Services

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Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: Community and Employment Supports (CES) 1915 (c) Waiver, CES Provider Manual and Certification Standards for CES Providers

Intended Effective Date
(Check One)

- ☐ Emergency (ACA 25-15-204)
- ☑ 10 Days After Filing (ACA 25-15-204)
- ☐ Other _____ (Must be more than 10 days after filing date.)

	Date
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Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Becky Murphy — becky.murphy@dhs.arkansas.gov

Contact Person — E-mail Address — Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Rose M Naff
Signature

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Director
Title

9-19-17
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – DDS Community and Employment Supports (CES)**

EFFECTIVE DATE: **October 1, 2017**

SUBJECT: **Provider Manual Update Transmittal DDSCES-New-17**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
		ALL	10-1-17

Explanation of Updates

A new DDS Community and Employment Supports (CES) policy manual is available for all DDS Community and Employment Supports (CES) providers.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

SECTION II - DDS COMMUNITY AND EMPLOYMENT SUPPORTS (CES)

CONTENTS

200.000 DDS COMMUNITY AND EMPLOYMENT SUPPORTS (CES) WAIVER GENERAL INFORMATION

201.000 Arkansas Medicaid Program Participation Requirements for DDS CES Waiver Program 10-1-17

All Division of Developmental Disabilities Services (DDS) Community and Employment Supports (CES) waiver providers must meet the provider participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

All willing and qualified providers have the opportunity to enroll as a waiver provider. DDS provides continuous open enrollment for waiver service providers. Potential providers should contact DDS Quality Assurance staff for information on the CES certification standards. Once a provider is certified by DDS, the provider must contact the DMS Provider Enrollment Unit to enroll as a Medicaid provider.

Certified and enrolled providers are allowed to specify the maximum number of persons they can serve, the county they can serve, the services they can provide and the service levels they can offer based on staff availability. Waiver beneficiaries have the freedom of choice of service providers. Once a provider is chosen by a beneficiary and meets the designations made by the provider, the provider cannot refuse to provide services unless the provider cannot assure the health and safety of the beneficiary. It is incumbent upon the provider to prove the individual cannot be served by the provider. The burden of proof also requires written identification of the cause for the failure to provide health and safety supported by documentation that attests to that condition.

Before a provider can decrease the maximum number of beneficiaries they will serve, drop an existing county they serve, a service, or service level, the provider must identify any beneficiary currently being served who would be affected. The provider will be required to continue providing services to any beneficiary who would be affected by the changes until such time as DDS can secure a new provider and services are in place under the new provider. If a provider elects to change the existing county served or the maximum number of participants served, the change cannot be made if it will adversely impact any beneficiary currently receiving services from the provider. The provider's maximum number of beneficiaries served may only be reduced through ceasing provision of services in a designated county or counties, freezing the number of persons they serve at the current number and reducing the number through attrition, or ceasing provision of services to those beneficiaries they have most recently begun serving. DDS will

freeze new referrals when a provider requests to make changes in the above items but will not approve the changes for existing beneficiaries until such time as the transition to a new provider has occurred. Further, when less than an entire county is deleted from coverage, the provider must articulate in writing a business reason for making the change and demonstrate that the selection process is not capricious or arbitrary, does not result in discrimination and does not unfairly distinguish between levels of care. The process cannot be used to eliminate difficult families or beneficiaries. Other than business reasons for closing entire counties or programs, beneficiaries can only be discontinued if the provider cannot assure health and safety.

Option: Based on individual choice, a provider may continue to serve a beneficiary without serving others in the county when the individual served relocates their place of residence.

201.100 Providers of DDS CES Waiver Services in Arkansas and Bordering States Trade Area Cities 10-1-17

DDS CES waiver services are limited to Arkansas and bordering state trade area cities. The DDS must certify providers located in a bordering state trade area city as CES waiver providers before services may be provided for Arkansas Medicaid beneficiaries.

Bordering state trade area cities are Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee and Texarkana, Texas.

201.200 Organized Health Care Delivery System Provider 10-1-17

The DDS CES waiver allows a provider who is licensed and certified as a DDS CES care coordination entity or a DDS CES supportive living services provider to enroll in the Arkansas Medicaid Program as a DDS CES organized health care delivery system (OHCDS) provider.

The option of OHCDS is available to any current or future provider through a written agreement between DDS and the provider entity. The agreement requires each OHCDS provider to guarantee that any sub-contractor will abide by all Medicaid regulations and provides that the OHCDS provider assumes all liability for contract noncompliance. The OHCDS provider must also have a written contract that sets forth specifications and assurances that work will be completed timely, satisfactorily to the beneficiary being served and with quality maintained. The OHCDS provider is responsible for ensuring that services were delivered and proper documentation, including a signed customer satisfaction statement, has been submitted prior to billing.

As long as the OHCDS provider delivers at least one waiver service directly utilizing its own employees, an OHCDS provider may provide any other DDS CES waiver service via a sub-contract with an entity qualified to furnish the service. The subcontract must ensure financial accountability and that services were delivered, properly documented and billed. The primary use of OHCDS is consultation, adaptive equipment, environmental modifications, supplemental support and specialized medical supplies.

The OHCDS provider furnishes the services as the beneficiary's provider of choice as described in that beneficiary's person-centered service plan.

202.000 Documentation Requirements 10-1-17

DDS CES waiver providers must keep and properly maintain written records. Along with the required enrollment documentation, which is detailed in Section 141.000, the following records must be included in the beneficiary's case files maintained by the provider.

202.100 Documentation in Beneficiary's Case Files 10-1-17

DDS CES waiver providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

A. A copy of the beneficiary's person-centered service plan, including any amendments thereto.

B. The specific services rendered.

C. The date and actual time the services were rendered.

D. The name of the individual who provided the service.

E. The relationship of the service to the treatment regimen of the beneficiary's person-centered service plan.

F. Updates describing the beneficiary's progress or lack thereof. Updates should be maintained on a daily basis or at each contact with or on behalf of the beneficiary. Progress notes must be signed and dated by the provider of the service.

G. Certification statements, narratives and proofs that support the cost-effectiveness and medical necessity of the service to be provided.

Additional documentation and information may be required dependent upon the service to be provided.

202.200 HCBS Settings Requirements 10-1-17

Home and Community-Based Services (HCBS) Settings

All providers must meet the following Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR 441.301(c) (4)-(5).

Settings that are HCBS must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

A. Chosen by the individual from among setting options including non-disability-specific settings (as well as an independent setting) and an option for a private unit in a residential setting.

1. Choice must be included in the person-centered service plan.
2. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.

B. Ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.

C. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

D. Facilitates individual choice regarding services and supports and who provides them.

F. In a provider-owned or -controlled residential setting (e.g., Group Homes), in addition to the qualities specified above, the following conditions must be met:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord/tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.
2. Each individual has privacy in their sleeping or living unit:
   a. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
   b. Beneficiaries sharing units have a choice of roommates in that setting.
   c. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
3. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
4. Beneficiaries are able to have visitors of their choosing at any time.
5. The setting is physically accessible to the individual.
6. Any modification of the additional conditions specified in items 1 through 4 above must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
   a. Identify a specific and individualized assessed need.
   b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
   c. Document less intrusive methods of meeting the need that have been tried but did not work.
   d. Include a clear description of the condition that is directly proportionate to the specific assessed need.
   e. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
   f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
   g. Include the informed consent of the individual.
   h. Include an assurance that interventions and supports will cause no harm to the individual.

210.000 PROGRAM COVERAGE

211.000 Scope 10-1-17

The Medicaid program offers certain home and community-based services (HCBS) as an alternative to institutionalization. These services are available for eligible beneficiaries with a developmental disability who would otherwise require an intermediate care facility for the intellectually disabled/developmentally disabled (ICF/ID/DD)level of care. This waiver does not provide education or therapy services.

The purpose of the CES waiver is to support beneficiaries of all ages who have a developmental disability, meet the institutional level of care, and require waiver support services to live in the community and thus prevent institutionalization.

The goal is to create a flexible array of services that will allow people to reach their maximum potential in decision-making, employment and community integration; thus giving their lives the meaning and value they choose.

The objectives are as follows:

A. To transition eligible persons who choose the waiver option from residential facilities into the community

B. To provide priority services to persons who meet criteria for the third tier of service (requiring supports 24 hours a day, seven (7) days a week)

C. To enhance and maintain community living for all persons participating in the waiver program

DDS is responsible for day-to-day operation of the waiver. All waiver services are accessed through DDS Adult Services, DDS Children's Services or the ICF/ID/DD services intake and referral staff.

All CES waiver services must be prior authorized by DDS and based on an independent assessment and functional evaluations. All services must be delivered based on the approved person-centered service plan.

Waiver services will not be furnished to persons while they are inpatients of a hospital, nursing facility (NF), or ICF/ID/DD unless payment to the hospital, NF, or ICF/ID/DD is being made through private pay or private insurance.

A person may be placed in abeyance in three-month increments (with status report every month) for up to 12 months when the following conditions are met:

A. The need for absence must be for the purposes of treatment in a licensed or certified program or facility for the purposes of behavior stabilization, physical or mental health treatment.

B. The loss of home or loss of the primary non-paid caregiver.

C. The request must be in writing with supporting evidence included.

D. The request must be prior approved by DDS.

E. A minimum of one visit or one contact each month is required.

NOTE: The DDS Specialist is responsible for conducting or assuring the conducting of the contacts or monitoring visits with applicable documentation filed in the case record.

F. All requests for abeyance are to be faxed to the DDS Waiver Program Director for Adult and Waiver Services. Monthly status reports are required to be submitted to the DDS Waiver Program Director as long as the person is in abeyance. Each request for continuance must be submitted in writing and supported by evidence of treatment status or progress. Requests for continuance must be made prior to the expiration of the abeyance period.

In order for beneficiaries to continue to be eligible for waiver services while they are in abeyance the following two requirements must be met:

A. It must be demonstrated that a beneficiary needs case management and at least one other service as documented in their person-centered service plan.

B. Beneficiaries must receive monthly monitoring of waiver services.

As stated in the Medical Services Manual, Section 1348, an individual living in a public institution is not eligible for Medicaid.

A. Public institutions include county jails, state and federal penitentiaries, juvenile detention centers, and other correctional or holding facilities.

B. Wilderness camps and boot camps are considered a public institution if a governmental unit has any degree of administrative control.

C. Inmate status will continue until the indictment against the individual is dismissed or until he or she is released from custody either as “not guilty” or for some other reason (bail, parole, pardon, suspended sentence, home release program, probation, etc.)

Thus, a person who is living in a public institution as defined above would be deemed ineligible for Medicaid and thus the waiver program.

211.100 Selection Process for Entrance to the Waiver 10-1-17

Selection for entrance into the waiver is as follows:

A. In order of waiver application eligibility determination date for persons determined to have successfully applied for the waiver, but whom through administrative error, were or are inadvertently omitted from the waiver wait list.

B. In order of waiver application eligibility determination date of persons for whom waiver services are necessary to permit discharge from an institution, i.e., ICF/IID residents, nursing facility residents, and Arkansas State Hospital patients; or admission to Supported Living Arrangements (group homes and apartments).

C. In order of date the Department of Human Services (DHS) custodian chose waiver services for eligible person in the custody of DHS Division of Children and Family Services or DHS Adult Protective Services.

D. In order of waiver application eligibility determination date for all other persons.

Selection for priority consideration is in the order identified above. When more than one category of priority is identified in a ranking, the order of release shall be by date of eligibility determination within each category. Releases occur only when there is a vacant waiver slot.

211.200 Risk Assessment 10-1-17

A. DDS will not authorize or continue waiver services under the following conditions:

1. The health and safety of the beneficiary, the beneficiary’s caregivers, workers or others are not assured.
2. The beneficiary or legally responsible person has refused or refuses to participate in the plan of care development or to permit implementation of the plan of care or any part thereof that is deemed necessary to assure health and safety.
3. The beneficiary or legally responsible person refuses to permit the on-site entry of: care coordinator to conduct required visits, caregivers to provide scheduled care, DDS, DMS, DHS or CMS officials acting in their role as oversight authority for compliance or audit purposes.
4. The beneficiary applying for, or receiving, waiver services requires 24-hour nursing care on a continuous basis as prescribed by a physician.
5. The beneficiary participating in the waiver program is incarcerated or is an inmate in a state or local correctional facility.

6. The person is deemed ineligible based on a DDS Psychological Team assessment or reassessment for meeting ICF/IID level of care.
7. The beneficiary is deemed ineligible based on not meeting or not complying with requirements for determining continued Medicaid income eligibility.
8. The beneficiary does not undergo an independent assessment by a third-party vendor.

B. Safeguards concerning the use of restraints or seclusion:

1. Physical restraints (use of a staff member's body to prevent injury to the beneficiary or another person) are allowed in cases of emergency. An emergency exists for any of the following conditions:
   a. The beneficiary has not responded to de-escalation techniques and continues to escalate behavior
   b. The beneficiary is a danger to self or others
   c. The safety of the beneficiary and those nearby cannot be assured through positive reinforcers.

An individual must be continuously under direct observation of staff members during any use of restraints.

If the use of personal restraints occurs more than three (3) times per month, use should be discussed by the interdisciplinary team and addressed in the plan of care. When emergency procedures are implemented, person-centered service plan revisions including, but not limited to, psychological counseling, review of medications with possible medication change or a change in environmental stressors that are noted to precede escalation of behavior may be implemented.

1. Use of mechanical or chemical restraint is not allowed. Seclusion is not allowed.
2. DDS standards require that providers will not allow maltreatment or corporal punishment (the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior) of individuals. Providers' policies and procedures must state that corporal punishment is prohibited.

C. Safeguards concerning the use of restrictive intervention:

1. Restrictive interventions may be used.
2. DDS standards require the use of a behavior management plan for all beneficiaries whose behavior may warrant intervention. The behavior management plan must specify what will constitute the use of restrictive interventions, the length of time to be used, who will authorize the use of restrictive intervention and the methods for monitoring the beneficiary.

   When the behavior plan is implemented, all use of restrictive interventions must be documented in the beneficiary's case record and should include the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.
3. Restrictive interventions include
   a. Absence from a specific social activity
   b. Temporary loss of a personal possession
   c. Time out or separation
4. Restrictive interventions cannot include
   a. Aversion techniques
   b. Restrictions to an individual's rights, including the right to physically leave
   c. Mechanical or chemical restraints

d. Seclusion

These interventions might be implemented to deal with aggressive or disruptive behaviors related to the activity or possession. Staff, families and the beneficiary are trained by the provider to recognize and report unauthorized use of restrictive interventions.

Before absence from a specific social activity or temporary loss of personal possession is implemented, the beneficiary is first counseled about the consequences of the behavior and the choices they can make.

1. All personnel who are involved in the use of restrictive interventions must receive training in behavior management techniques as well as training in abuse and neglect laws, rules and regulations and policies. The personnel must be qualified to perform, develop, implement and monitor or provide direction intervention as applicable.
2. Use of restrictive interventions requires submission of an incident report that must be submitted no later than the end of the second business day following the incident. The DDS Quality Assurance staff investigates each incident and monitors use of restrictive interventions for possible overuse or inappropriate use. DDS Quality Assurance staff will notify entities involved with the complaint or service concern the results of their review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Failure to complete corrective action measures may result in the provider being placed on provisional status or revocation of certification.

D. Behavior Management Plans

Before use of restraints or restrictive interventions, providers must develop a written behavior management plan to ensure the rights of beneficiaries. The plan must include a provision for alternative methods to avoid the use of restraints and seclusions.

The behavior management plan must

1. Be written or supervised by a qualified professional who is at minimum a Qualified Developmental Disabilities Professional (QDDP)
2. Be designed so that the rights of the individual are protected
3. Preclude procedures that are punishing, physically painful, emotionally frightening involve deprivation, or put the individual at medical risk
4. Identify the behavior to be decreased
5. Identify the behavior to be increased
6. Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior
7. Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person
8. Identify the event that likely occurs right before a behavior of concern
9. Identify what staff should do if the event occurs
10. Identify what staff should do if the behavior to be increased or decreased occurs, and
11. Involve the fewest interventions or strategies as possible

The behavior management plan must also specify the length of time the restraint or restrictive intervention is to be used, who will authorize the use of restraint or seclusion and the methods for monitoring the beneficiary.

Behavior management plans cannot include procedures that are punishing, physically painful, emotionally frightening, depriving, or that put the beneficiary at medical risk.

E. Reports of Use of Restraints or Restrictive Interventions

All use of restraint must be documented in the beneficiary's case record, including the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.

1. The use of restraint or unauthorized seclusion must be reported to the DDS Quality Assurance section via an incident report form that must be submitted no later than the end of the second business day following the incident. The DDS Quality Assurance staff investigates each incident and monitors use of restraints for possible overuse or inappropriate use of restraints or seclusion. DDS Quality Assurance staff will notify entities involved with the complaint or service concern the results of their review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Failure to complete corrective action measures may result in the provider being placed on provisional status or revocation of certification.
2. Each person working within the provider agency must complete Introduction to Behavior Management, Abuse and Neglect and any other training as deemed necessary as a result of deficiencies or corrective actions.

212.000 Description of Services 10-1-17

DDS CES services provide the support necessary for a beneficiary to live in the community. Without these services, the beneficiary would require institutionalization.

Services provided under this program are as follows:

A. Supportive Living

B. Respite Services

C. Supported Employment

D. Adaptive Equipment

E. Environmental Modifications

F. Specialized Medical Supplies

G. Supplemental Support Service

H. Care Coordination Services

I. Consultation Services

J. Crisis Intervention Services

K. Community Transition Services

213.000 Supportive Living 10-1-17

Supportive living is an array of individually tailored services and activities provided to enable eligible beneficiaries to reside successfully in their own homes, with their family, or in an alternative living residence or setting. Alternative living residences include apartments, leased or owned homes, or provider group homes. Supportive living services must be provided in an integrated community setting. The services are designed to assist beneficiaries in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in the home- and community-based setting. Services are flexible to allow for unforeseen changes needed in schedules and times of service delivery. Services are approved as maximum days that can be adjusted within the annual plan year to meet changing needs.

The total number of days cannot be increased or decreased without a revision. Care and supervision for which payment will be made are those activities that directly relate to active treatment goals and objectives.

A. Residential Habilitation Supports

Supports to assist the beneficiary to acquire, retain or improve skills in a wide variety of areas that directly affect their ability to reside as independently as possible in the community. The supports that may be provided to a beneficiary include:

1. Decision making, including the identification of and response to dangerously threatening situations, making decisions and choices affecting the person's life and initiating changes in living arrangement or life activities.
2. Money management, including training, assistance or both in handling personal finances, making purchases and meeting personal financial obligations.
3. Daily living skills, including habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medications (to the extent permitted under state law) and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid and emergency procedures.
4. Socialization, including training, assistance or both, in participation in general community activities, and establishing relationships with peers. Activity training includes assisting the person to continue to participate on an ongoing basis.
5. Community integration experiences, including activities intended to instruct the beneficiary in daily living and community living skills in an integrated setting. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. Community experiences include activities and supports to accomplish individual goals or learning areas including recreation and specific training or leisure activities. Each activity is then adapted according to the beneficiary's individual needs.
6. Non-medical transportation to or from community integration experiences is an integral part of this service and is included in the daily rate computation. DDS will assure duplicate billing between waiver services and other Medicaid state plan services will not occur. The habilitation objectives to be served by such training must be documented in the beneficiary's service plan. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized.

   Exclusions: Transportation to and from medical, dental and professional appointments inclusive of therapists. Non-medical transportation does not include transportation for other household members.
7. Mobility, including training, assistance or both aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel or movement within the community.
8. Communication, including training in vocabulary building, use of augmentative communication devices and receptive and expressive language.
9. Behavior shaping and management, including training, assistance or both in appropriate expressions of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors.
10. Reinforcement of therapeutic services, including conducting exercises or reinforcing physical, occupational, speech and other therapeutic programs.
11. Health maintenance activities may be provided by a supportive living worker. All health maintenance activities, except injections and IV's, can be done in the home by

a designated care aide, such as a supportive living worker. With the exception of injectable medication administration, tasks that beneficiaries would otherwise do for themselves, or have a family member do, can be performed by a paid designated care aide at their direction, as long as the criteria specified in the Arkansas Nurse Practices Consumer Directed Care Act has been met. Health maintenance activities are available in the Arkansas Medicaid State Plan as self-directed services. State plan services must be exhausted before accessing waiver funding for health maintenance activities.

B. Companion and Activities Therapy

Companion and activities therapy services provide reinforcement of habilitative training. This reinforcement is accomplished by using animals as modalities to motivate beneficiaries to meet functional goals. Through the utilization of an animal's presence, enhancement and incentives are provided to beneficiaries to practice and accomplish such functional goals as

1. Language skills
2. Increased range of motion
3. Socialization by developing the interpersonal relationships skills of interaction, cooperation and trust and the development of self-respect, self-esteem, responsibility, confidence and assertiveness

Exclusions: This service does not include the cost of veterinary or other care, food, shelter or ancillary equipment that may be needed by the animal that is providing reinforcement.

C. Direct Care Supervision

The direct care supervisor employed by the supportive living provider is responsible for assuring the delivery of all supportive living direct-care services including the following activities:

1. Coordinating all direct service workers who provide care through the direct service provider
2. Serving as liaison between the beneficiary, parents, legal representatives, care coordination entity and DDS officials
3. Coordinating schedules for both waiver and generic service categories
4. Providing direct planning input and preparing all direct service provider segments of any initial plan of care and annual continued stay review
5. Assuring the integrity of all direct care service Medicaid waiver billing
6. Arranging for staffing of all alternative living settings
7. Assuring transportation as identified in beneficiary's person-centered service plan specific to supportive living services
8. Assuring timely collaboration with the care coordination entity to obtain comprehensive behavior and assessment reports, continued person-centered case plans with revisions as needs change and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determination
9. Reviewing the person's records and environments in which services are provided by accessing appropriate professional sources to determine whether the person is receiving appropriate support in the management of medication. Minimum components are as follows:
    a. The direct care supervisor has an on-going responsibility for monitoring beneficiary medication regimens. While the provider may not staff a person on a 24/7 schedule, the provider is responsible around the clock to ensure that the

person-centered service plan identifies and addresses all the needs with other supports as necessary to assure the health and welfare of the beneficiary.

b. Staff, at all times, are aware of the medications being used by the beneficiary.
c. Staff are knowledgeable of potential side effects of the medications being used by the beneficiary through the prescribing physician, nurse and pharmacist at the time medications are ordered.
d. All medications consumed are prescribed or approved by the beneficiary's physician or other health care practitioner.
e. The beneficiary or legally responsible person is informed by the prescribing physician about the nature and effect of medication being consumed and consents to the consumption of those medications prior to consumption.
f. Staff are implementing the service provider's policies and procedures as to medication management, appropriate to the beneficiary's needs as monitored by the direct care supervisor in accordance with acceptable personnel policies and practices and by the care coordinator at least monthly.
g. If psychotropic medications are being used for behavior, the direct care supervisor and care coordinator are responsible to assure appropriate positive behavior programming is present and in use with programming reviews at least monthly.
h. The consumption of medications is monitored at least monthly by the direct care supervisor to ensure that they are accurately consumed as prescribed.
i. Toxicology screenings are conducted on a frequency determined by the prescribing physician with care coordinator oversight.
j. Any administration of medication or other nursing tasks or activities are performed in accordance with the Nurse Practice and Consumer Directed Care Acts and are monitored by the direct care supervisor in accordance with acceptable personnel practices and by the care coordinator at least monthly.
k. Medications are regularly reviewed to monitor their effectiveness, to address the reason for which they were prescribed and for possible side effects.
l. Medication errors are effectively detected by the direct care supervisor by review of the medication log and with appropriate response up to and inclusive of incident reporting and reporting to the Nursing Board.
m. Frequency of monitoring is based on the physician's prescription for administration of medication.
n. The physician approving the service level of support and the person-centered service plan is responsible for monitoring and determining contraindications when multiple medications are prescribed. A minimum review is at the annual continued stay review of the person-centered service plan for approval and recertification.

Direct care staff are required to complete daily activity logs for activities that occur during the work timeframe with such activities linked to the person-centered service plan objectives. The direct care supervisor is required to monitor the work of the direct care staff and to sign off on timesheets maintained to document work performed. All monitoring activities, reviews and reports must be documented and available upon request from authorized DDS or DMS staff.

NOTE: Failure to satisfactorily document activities according to DMS requirements may result in non-payment or recoupment of payment of services.

Beneficiaries may access both supportive living and respite on the same date as long as the two services are distinct, do not overlap and the daily rate maximum is correctly prorated as to the portion of the day that each respective service was actually provided. DDS monitors this provision through retrospective annual review with providers responsible

for maintaining adequate time records and activity case notes or activity logs that support the service deliveries. A maximum daily rate is established in accordance with budget neutrality wherein both supportive living and respite cannot exceed the daily maximum.

Controls in place to assure payments are made only for services rendered include requirement by assigned staff to complete daily activity logs for activities that occurred during the work timeframe with such activities linked to the person-centered case plan objectives; supervision of staff by the direct care supervisor with sign-off on timesheets maintained weekly; audits and reviews conducted by DDS Quality Assurance annually and at random; DDS Waiver Services annual retrospective reviews, random attendance at planning meetings and visits to the home; DMS random audits; and oversight by the chosen and assigned care coordinator. Retainer payments may be made to providers of habilitation while the waiver beneficiary is hospitalized or absent from his/her home.

213.100 Supportive Living Arrangements (Provider owned group homes or apartments) 10-1-17

Persons residing in supportive living arrangements are eligible for the same services and service level as any other waiver participant. Staff working in such arrangements must have hours of compensation prorated according to the number of individuals, waiver and non-waiver, residing in the supportive living arrangement. Additional one-on-one staffing may be provided when the need is justified. Supportive living arrangements include:

A. Existing group homes serving groups of no more than 14 unrelated adults (age 18 and older) with developmental disabilities in the residential setting.

B. Existing DDS licensed supportive living apartments serving up to 4 unrelated adults (age 18 and older) with developmental disabilities in each self-contained apartment unit up to the total number of licensed units in the complex.

C. Adults served in their family home, in their own home or in an integrated apartment complex or in an alternative living setting with no more than 4 unrelated adults with developmental disabilities in the home.

D. Children served in their family home or in an alternative family with no more than 4 unrelated children with developmental disabilities in the home.

Exception: Only those supportive living apartments and group homes licensed by the DDS prior to July 1, 1995, are approved to serve more than 4 adults. No expansions will be approved beyond the July 1, 1995, total capacity (waiver and non-waiver).

213.200 Supportive Living Exclusions 10-1-17

Only hired caregivers may be reimbursed for supportive living services provided.

The payments for these services exclude the costs of room and board, including general maintenance, upkeep or improvement to the beneficiary's own home or that of his or her family.

Routine care and supervision for which payment will not be made are defined as those activities that are necessary to assure a person's well-being but are not activities that directly relate to active treatment goals and objectives.

It is the responsibility of the provider to assure compliance with state and federal Department of Labor wage and hour laws.

Software will be approved only when required to operate the accessories included for environmental control or to provide text-to-speech capability.

Note: Adaptive equipment must be an item that is modified to fit the needs of the beneficiary. Items such as toys, gym equipment, sports equipment, etc. are excluded as not meeting the service definition.

Conditions: The care and maintenance of adaptive equipment, vehicle modifications, and personal emergency response systems are entrusted to the beneficiary or legally responsible person for whom the aids are purchased. Negligence (defined as failure to properly care for or perform routine maintenance of) shall mean that the service will be denied for a minimum of two plan years. Any unauthorized use or selling of aids by the beneficiary or legally responsible person shall mean the aids will not be replaced using waiver funding.

Exclusions:

A. Swimming pools (in-ground or above-ground) and hot tubs are not allowable as either an environmental modification or adaptive equipment.

B. Therapeutic tools similar to those therapists employ during the course of therapy are not included.

C. Educational aids are not included.

D. Computers will not be purchased to improve socialization or educational skills.

E. Computer supplies.

F. Computer desks or other furniture items are not covered.

G. Medicaid-purchased equipment cannot be donated if the equipment being donated is needed by another waiver beneficiary residing in the residence.

213.300 Benefit Limits for Supportive Living 10-1-17

The maximum daily rate for the supportive living array, which includes both supportive living and respite services is based upon the tier of support identified in the beneficiary's person-centered service plan after completion of the independent assessment. This daily rate includes provider-indirect costs for each component of service. DDS must prior authorize daily rates for all tiers of support.

Tier 3: Maximum Daily Rate is $391.95 with a maximum of $143, 061.75 annually.

Tier 2: Maximum Daily Rate is $184.80 with a maximum of $67,452.00 annually.

All units must be billed in accordance with the beneficiary's person-centered service plan. Extensions of benefits will be provided when extended benefits are determined to be medically necessary and do not exceed the maximum daily rate.

See Section 260.000 for billing information.

See Section 224.000 for payment guidelines of relatives or legal guardians.

214.000 Respite Services 10-1-17

Respite services are provided on a short-term basis to beneficiaries unable to care for themselves due to the absence of or need for relief of non-paid primary caregivers. Room and board may not be claimed when respite is provided in the beneficiary's home or a private place of residence. Room and board is not a covered service except when provided as part of respite furnished in a facility that is approved by the State.

Receipt of respite services does not necessarily preclude a beneficiary from receiving other services on the same day. For example, a beneficiary may receive day services, such as supported employment, on the same day as respite services.

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite may not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.

Respite services may be provided through a combination of basic child care and support services required to meet the needs of a child.

Respite may be provided in the following locations:

A. Beneficiary's home or private place of residence

B. The private residence of a respite care provider

C. Foster home

D. Group home.

E. Licensed respite facility

F. Other community residential facility approved by the state, not a private residence

G. Licensed or accredited residential mental health facility

214.100 Benefit Limits for Respite Services 10-1-17

The maximum daily rate for the supportive living array, which includes both supportive living and respite services, collectively or individually is based upon the tier of support identified in the beneficiary's person-centered service plan, after completion of the independent assessment. This daily rate includes provider indirect costs for each component of service. DDS must prior authorize daily rates for all tiers of support.

Tier 3 – maximum daily rate is $391.95 with a maximum annual rate of $143,061.75.

Tier 2 – maximum daily rate is $184.80 with a maximum annual rate of $67,452.00.

All units must be billed in accordance with the beneficiary's person-centered service plan. Extensions of benefits will be provided when extended benefits are determined to be medically necessary.

See Section 260.000 for billing information.

215.000 Supported Employment 10-1-17

Supported employment is a tailored array of services that offers ongoing support to beneficiaries with the most significant disabilities to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for individuals for whom competitive employment has not traditionally occurred, or has been interrupted or intermittent as a result of a significant disability, and who need ongoing supports to maintain their employment.

The supported employment service array includes:

A. Discovery Career Planning: Information is gathered about a beneficiary's interests, strengths, skills, the types of supports that are the most effective and the types of environments and activities where the participant is at his or her best. These services should result in the development of the Individual Career Profile which includes specific recommendations regarding the beneficiary's employment support needs, preferences, abilities and characteristics of optimal work environment. The following activities may be a component of Discovery/Career Planning: review of the beneficiary's work history, interest and skills; job exploration; job shadowing; informational interviewing, including mock interview; job and task analysis activities; situational assessments to assess the

beneficiary's interest and aptitude in a particular type of job; employment preparation (i.e. resume development); benefits counseling; business plan development for self-employment; and volunteerism.

B. Employment Path: Beneficiary receiving these services must have goals related to employment in integrated community settings in their person-center service plan. Activities must be designed and developed to support the employment goals outlined in the person-centered service plan. Such activities should develop and teach soft skills utilized in integrated employment including, but not limited to, following directions, attending to tasks, problem-solving skills and strategies, mobility training, effective and appropriate communication (verbal and nonverbal) and time management.

   Employment Path is a time-limited service and requires prior authorization for the first 12 months. One reauthorization of up to twelve months is possible, but only if the beneficiary is also receiving job development services that indicate the beneficiary is actively seeking employment.

C. Employment Supports.

   1. Job Development: Individualized services that are specific in nature to obtaining a certain employment opportunity. The initial outcome of Job Development is the Job Development Plan. The Job Development Plan must be created and incorporated with the individual Career Profile no later than 30 days after Job Development services begin. The Job Development Plan must, at a minimum, specify:
      a. Short- and long-term employment goals
      b. Target wages
      c. Task hours
      d. Special conditions that apply to the worksite for the beneficiary
      e. Jobs that will be developed or tasks that will be customized through negotiations with potential employers
      f. Initial list of employer contacts
      g. Plan for how many employers will be contacted each week
      h. Conditions for use of on-site job coaching
   2. Job Coaching: On-site activities that may be provided to a beneficiary once employment is obtained. Activities provided under this service may include, but are not limited to, completing job duty and task analysis; assisting the beneficiary to learn to do the job by the least intrusive method available; developing compensatory strategies if needed to cue beneficiary to complete the job; analyzing the work environment during initial training/learning of the job and making determinations regarding modifications or assistive technology. Services are authorized for twelve months. A fading plan must be developed for Job Coaching services that show how the goals of this service will be achieved in 12 months. Additional authorizations of Job Coaching with no additional fading gains will require additional documentation of level of need for service.

      Job Coaching may also be utilized when the beneficiary chooses self-employment. Activities such as assisting the beneficiary to identify potential business opportunities, develop a business plan, as well as develop and launch a business are included. Waiver funds may not be used to defray expenses associated with starting or operating a business, such as capital expenses, advertising, hiring or training of employees.
   3. Extended Services: The expected outcome of extended services is sustained paid employment at or above minimum wage with associated benefits and the opportunity for advancement in a job that meets the beneficiary's personal and career planning goals. Employment supports: Extended Services allows for the continued monitoring

of employment outcomes through regular contact with the beneficiary and the employer. A minimum of one contact per quarter with the employer is required.

215.100 Supported Employment Exclusions 10-1-17

Supported employment requires related activities to be identified and included in outcomes with an accompanying work plan submitted as documentation of need for service.

Payment for employment services excludes:

A. Incentive payments made to an employer of waiver beneficiaries to encourage or subsidize an employer's participation in the program.

B. Payments that are passed through to waiver beneficiaries.

C. Payments for training that are not directly related to the waiver beneficiary's employment.

D. Reimbursement if the beneficiary is not able to perform the essential functions of the job. The functions of a job coach are to "coach," not to do the work for the person.

E. CES waiver supported employment services when the same services are otherwise funded under the Rehabilitation Act of 1973 or Public Law 94-142. This means that such services must be exhausted before waiver-supported employment services can be approved or reimbursement can be claimed.

F. Services provided in a sheltered workshop or other similar type of vocational service furnished in a specialized facility.

215.200 Documentation Requirements for Supported Employment 10-1-17

Supported employment providers must maintain documentation in each waiver beneficiary's file to demonstrate the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Individual with Disabilities Education Act (20 U.S.C. 1401 et. seq).

Documentation must include proof from the funded provider where services were exhausted.

For Discovery Career Planning, the provider must create and maintain an individual Career Profile-Discovery Staging Record to demonstrate compliance and delivery of service.

For Employment Path Services, the provider must maintain the person-centered service plan, the beneficiary's progress notes, and the Arkansas Rehabilitation Services Referral to demonstrate compliance and delivery of service.

For Job Development Plan Services, the provider must maintain the Job Development Plan and beneficiary's remuneration statement.

For Extended Services, the provider must maintain the Arkansas Rehabilitation Services letter of closure, beneficiary's remuneration statement (paycheck stub) and beneficiary's work schedule, if available, to demonstrate compliance with and delivery of this service.

See Section 202.200 for other information to be retained for beneficiary's file.

215.300 Benefit Limits for Supported Employment 10-1-17

Discovery/Career Planning: Allowed maximum is 50 hours per week over a six-week period to complete the activities and create the Individual Career Profile. There is an outcome payment upon submission of the Profile and required documentation.

Employment Path: Allowed maximum is 25 hours per week alone or combined with Employment Supports in small group. Only twelve months of service may be authorized with one reauthorization allowed if the beneficiary is receiving Job Development Services that indicate he

or she is actively seeking employment. A milestone payment is available if the beneficiary obtains individualized, competitive integrated employment or self-employment during the first 12-month authorization.

Employment Supports Job Development: This is outcome-based reimbursement, payable in stages to incentivize retention of the job. The total outcome payment is $3000.00. The payment schedule is as follows:

A. 60% at the end of the beneficiary's first pay period.

B. 25% when the beneficiary has completed four (4) weeks on the job.

C. 15% when the beneficiary has completed eight (8) weeks on the job.

Employment Supports—Job Coaching: Allowed maximum of 40 hours per week. Twelve months of services are authorized, and the provider must have a fading plan. The provider must document necessity of additional services to have additional services authorized without a fading plan.

Employment Supports—Extended Services: Allowed maximum of 20% of the beneficiary's weekly scheduled work hours.

See Section 260.000 for billing information.

216.000 Adaptive Equipment 10-1-17

The adaptive equipment service includes an item or a piece of equipment that is used to increase, maintain or improve functional capabilities of individuals to perform daily life tasks that would not be possible otherwise. The adaptive equipment service provides for the purchase, leasing, and as necessary, repair of adaptive, therapeutic and augmentative equipment that enables individuals to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Adaptive equipment needs for supportive employment are included. This service may include specialized equipment such as devices, controls or appliances that will enable the person to perceive, to control or to communicate with the environment in which they live.

Adaptive equipment includes "enabling technology," that empowers the beneficiary to gain independence through customizable technologies to allow them to safely perform activities of daily living without assistance, while still providing for monitoring and response for those beneficiaries, as needed. Enabling technology must be shown to meet a goal of the beneficiary's person-centered service plan , ensure beneficiary's health and safety, and provide for adequate monitoring and response for beneficiary's needs. Before enabling technology will be provided, it must be documented that an assessment was conducted and a plan was created to show how the enabling technology will meet those requirements.

Equipment may only be covered if not available to the beneficiary from any other source. Professional consultation must be accessed to ensure that the equipment will meet the needs of the beneficiary when the purchase will at a minimum exceed $500.00. Consultation must be conducted by a medical professional as determined by the beneficiary's condition for which the equipment is needed. All items must meet applicable standards of manufacture, design and installation.

All adaptive equipment must be solely for the waiver beneficiary. All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids with the lowest bid with comparable quality being awarded; however, DDS may require three bids for any requested purchase.

Computer equipment may be approved when it allows the beneficiary control of his or her environment, assists in gaining independence or when it can be demonstrated that it is

necessary to protect the health and safety of the beneficiary. The waiver does not cover supplies. Printers may be approved for non-verbal beneficiaries.

Communication boards are allowable devices. Computers may be approved for communication when there is substantial documentation that a computer will meet the needs of the beneficiary more appropriately than a communication board.

Software will be approved only when required to operate the accessories included for environmental control or to provide text-to-speech capability.

Conditions: The care and maintenance of adaptive equipment, vehicle modifications, and personal emergency response systems are entrusted to the beneficiary or legally responsible person for whom the aids are purchased. Negligence (defined as failure to properly care for or perform routine maintenance of) shall mean that the service will be denied for a minimum of two (2) plan years. Any abuse or unauthorized selling of aids by the beneficiary or legally responsible person shall mean the aids will not be replaced using waiver funding.

Exclusions:

A. Swimming pools (in-ground or above-ground) and hot tubs are not allowable as either an environmental modification or adaptive equipment.

B. Computer supplies.

C. Computer desk or other furniture items are not covered.

D. Medicaid-purchased equipment cannot be donated if the equipment being donated is needed by another waiver beneficiary residing in the residence.

216.100 Adaptive Equipment: Vehicle Modifications 10-1-17

Vehicle modifications are adaptations to an automobile or van to accommodate the special needs of the beneficiary. Vehicle adaptations are specified by the service plan as necessary to enable the beneficiary to integrate more fully into the community and to ensure the health, welfare and safety of the beneficiary.

Payment for permanent modification of a vehicle is based on the cost of parts and labor, which must be quoted and paid separately from the purchase price of the vehicle to which the modifications are or will be made.

Transfer of any part of the purchase price of a vehicle, including preparation and delivery, to the price of a modification is a fraudulent activity. All suspected fraudulent activity will be reported to the Office of Medicaid Inspector General for investigation.

Reimbursement for a permanent modification cannot be used or considered as down payment for a vehicle.

Lifts that require vehicle modification and the modifications themselves are, for purposes of approval and reimbursement, one project and cannot be separated by plan-of-care years in order to obtain up to the maximum amount allowed.

Exclusions:

A. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the beneficiary

B. Purchase, down payment, monthly car payment, or lease cost of a vehicle;

C. Regularly scheduled upkeep and maintenance of a vehicle and the modification to the vehicle.

216.200 Adaptive Equipment: Personal Emergency Response System (PERS) 10-1-17

A PERS may be approved when it can be demonstrated as necessary to protect the health and safety of the beneficiary. A PERS is a stationary or portable electronic device that is used in the beneficiary's place of residence that allows the beneficiary to secure help in an emergency. The system must be connected to a response center staffed by trained professionals who respond upon activation of the PERS. The beneficiary may also wear a portable "help" button to allow for mobility. PERS services are limited to beneficiaries who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision. Included in this service are assessment, purchase, installation, testing, and monthly rental fees. A PERS shall include cost of installation and testing as well as monthly monitoring performed by the response center.

216.300 Benefit Limits for Adaptive Equipment 10-1-17

The maximum annual expenditure for adaptive equipment, including vehicle modifications and PERS, and environmental modifications is $7,687.50 per person.

The maximum allowed can be increased upon showing a medical necessity, with the difference in the total required amount and the allowed maximum ($7,687.50) being deducted from the supportive living maximum allowance.

216.400 Required Documentation for Adaptive Equipment 10-1-17

When the adaptive equipment modification will be over $1,000.00, the provider must document that it obtained at least three bids, and that the lowest bid with comparable quality was awarded, DDS may require three bids for any requested purchase.

217.000 Environmental Modifications 10-1-17

Environmental modifications are made to or at the waiver beneficiary's home, required by the person-centered service plan and are necessary to ensure the health, welfare and safety of the beneficiary or that enable the beneficiary to function with greater independence and without which the beneficiary would require institutionalization.

Environmental modification may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, installation of specialized electric and plumbing systems to accommodate medical equipment, installation of sidewalks or pads to accommodate ambulatory impairments, and home property fencing when medically necessary to assure non-elopement, wandering or straying of persons who have dementia, Alzheimer's disease or other causes of memory loss or confusion as to location, or decreased mental capacity or aberrant behaviors.

Expenses for the installation of the environmental modification and any repairs made necessary by the installation process are allowable. Portable or detachable modifications that can be relocated with the beneficiary and that have a written consent from the property owner or legal representative will be considered. Requests for modification must include an original photo of the site where modifications will be done; to-scale sketch plans of the proposed modification project; identification of other specifications relative to materials, time for project completion and expected outcomes; labor and materials breakdown and assurance of compliance with any local building codes. Final inspection for the quality of the modification and compliance with specifications and local codes is the responsibility of the waiver care coordinator. Payment to the contractor is to be withheld until the work meets specifications including a signed customer satisfaction statement.

All services must be provided as directed by the beneficiary's person-centered service plan and in accordance with all applicable state or local building codes.

Environmental modifications must be made within the existing square footage of the residence and cannot add to the square footage of the building.

Modifications are considered and approved as single, all-encompassing projects and, as such, cannot be split whereby a part of the project is submitted in one service plan year and another part submitted in the next service plan year. Any such activity is prohibited. All modifications must be completed within the plan-of-care year in which the modifications are approved.

All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids, with the lowest bid with comparable quality being awarded. However, DDS may require three bids for any requested modification.

Environmental modifications may only be funded through the waiver if not available to the beneficiary from any other source. If the beneficiary may receive environmental modifications through the Medicaid State Plan, a denial by Utilization Review will be required prior to approval for funding through the waiver.

217.100 Environmental Modifications Exclusions 10-1-17

Modifications or improvements made to or at the beneficiary's home which are of general utility and are not of direct medical or remedial benefit to the beneficiary (e.g., carpeting, roof repair, central air conditioning, etc.) are excluded as covered services. Also excluded are modifications or improvements that are of aesthetic value such as designer wallpaper, marble counter tops, ceramic tile, etc.

Outside fencing is limited to one fence per lifetime. Total perimeter fencing is excluded.

Expenses for remodeling or landscaping which are cosmetic, designed to hide the existence of the modification, or result from erosion are not allowable.

Environmental modifications that are permanent fixtures will not be approved for rental property without prior written authorization and a release of current or future liability by the residential property owner.

Environmental modifications may not be used to adapt living arrangements that are owned or leased by providers of waiver services.

Swimming pools (both in- and out-of-ground) and hot tubs (spas) are not allowable.

The moving of modifications, such as fencing or ceiling tracks and adaptive equipment that may be permanently affixed to the structure or outside premises, is not allowable.

217.200 Benefit Limits for Environmental Modifications 10-1-17

A beneficiary's annual expenditure for environmental modifications and adaptive equipment cannot exceed $7,687.50 per person.

218.000 Specialized Medical Supplies 10-1-17

A physician must order or document the need for all specialized medical equipment. All items must be included in the person-centered service plan. Specialized medical equipment and supplies include:

A. Items necessary for life support or to address physical conditions along with the ancillary supplies and equipment necessary for the proper functioning of such items.

B. Durable and non-durable medical equipment not available under the Arkansas Medicaid State Plan that is necessary to address beneficiary functional limitations.

C. Necessary medical supplies not available under the Arkansas Medicaid State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design and installation. The most cost-effective item will be considered first.

Additional supply items are covered as a waiver service when they are considered essential and medically necessary for home and community care. Covered items include:

A. Nutritional supplements

B. Non-prescription medications. Alternative medicines not Federal Drug Administration-approved are excluded from coverage.

C. Prescription drugs, minus the cost of drugs covered by Medicare Part D, when extended benefits are available under the Arkansas Medicaid State Plan.

When the items are included in Arkansas Medicaid State Plan services, a denial of extension of benefits by DMS Utilization Review will be required prior to approval for waiver funding by DDS.

218.100 Benefit Limits for Specialized Medical Supplies 10-1-17

The maximum annual allowance for specialized medical supplies, supplemental supports and community transition services is $3690.00.

When a non-prescription or prescription medication is necessary to maintain or avoid health deterioration, the $3,690.00 limit may be increased with the difference in the specialized medical supplies maximum allowance and the required amount deducted from the supportive living maximum daily allowance. All such requests must be prior approved by the DDS Assistant Director of Waiver Services.

See Section 260.000 for billing information.

219.000 Supplemental Support Service 10-1-17

The supplemental support service helps improve or enable the continuance of community living. Supplemental support service will be based on demonstrated needs as identified in a beneficiary's person-centered service plan as unforeseen problems arise that, unless remedied, could cause disruptions in the beneficiary's services, placement, or place him or her at risk of institutionalization. Waiver funds will be used as the payer of last resort.

219.100 Reserved 10-1-17

219.200 Supplemental Support Service Benefit Limits 10-1-17

This service can be accessed only as a last resort. Lack of other available resources must be proven.

The maximum annual allowance for supplemental support, community transition services, and specialized medical supplies is $3,690.00.

220.000 Care coordination Services 10-1-17

Care coordination is ensuring that specialty services are coordinated and appropriately delivered by specialty providers. Care Coordination will be provided to waiver beneficiaries until they are attributed to a PASSE. Care Coordination is not available to beneficiaries who have been

attributed to a PASSE. These beneficiaries will receive care coordination through the PASSE entity.

Care Coordination includes the following activities:

A. Health education and coaching;

B. Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;

C. Assistance with social determinants of health, 3 such as access to healthy food and exercise;

D. Promotion of activities focused on the health of a patient and the community, including without limitation outreach, quality improvement, and patient panel management;

E. Coordination of Community-based management of medication therapy.

The care coordinator is responsible for the total plan of care for each beneficiary assigned to him or her. This includes, but is not limited to, the following:

A. Behavioral Health Treatment Plan;

B. Person-Centered Service Plan;

C. Primary Care Physician Care Plan;

D. Individualized Education Program;

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

F. Nutrition Plan;

G. Housing Plan;

H. Any existing Work Plan;

I. Justice system-related plan;

J. Child welfare plan; or

K. Medication management plan.

The care coordinator is responsible for obtaining copies of all treatment and service plans related to an individual beneficiary and coordinating services between those plans. The goal is to prevent duplication of services, ensure timely access to all needed services, and identify any service gaps for the beneficiary. The ultimate goal of the care coordinator is to assist the beneficiary in remaining in the most appropriate and least restrictive setting for that beneficiary.

Other services provided by the care coordinator include:

A. Coordinating and arranging all CES waiver services and other state plan services;

B. Identifying and accessing needed medical, social, educational and other publicly funded services (regardless of funding source);

C. Identifying and accessing informal community supports needed by eligible beneficiaries and their families.

D. Monitoring and reviewing services provided to the beneficiary to ensure all plan services are being provided and to ensure the health and safety of the beneficiary;

E. Facilitating crisis intervention;

F. Providing guidance and support to meet generic needs;

G. Conducting appropriate needs assessments and referral for resources;

H. Monitoring services provided to ensure quality of care and case reviews which focus on the beneficiary's progress in meeting goals and objectives established on existing case plans;

I. Providing assistance relative to obtaining waiver Medicaid eligibility and ICF/IID level of care eligibility determinations;

J. Ensuring submission of timely (advanced) and comprehensive behavior and assessment reports, continued PCSPs, revisions as needs change and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;

K. Arranging for access to advocacy services as requested by beneficiary.

L. Providing assistance upon receipt of DDS or DHS notices or denials, including assistance with the reconsideration and appeal process.

The care coordinator will also be responsible for assisting the beneficiary with transitioning between service settings, for example with transition from the residential treatment setting to community based care.

Care coordination services must be available to attributed beneficiaries 24 hours a day through a hotline or web-based application.

If a beneficiary has already been assigned to or selected a PCP or PCMH, that PCP or PCMH will be responsible for coordinating the beneficiary's medical care. If the beneficiary does not have a PCP selected, care coordinator must assist the beneficiary with selecting a PCP or provide a referral to a PCP.

A care coordinator cannot have more than 50 beneficiaries on its caseload at any one time. The care coordinator must make a monthly face-to-face contact with each beneficiary assigned. The care coordinator must also obtain all treatment plans for the beneficiary and obtain all medical records for the beneficiary in order to adequately coordinate services, identify health needs, and provide health coaching and health education.

If the beneficiary is seen in an emergency room or urgent care clinic or is admitted to an acute inpatient psychiatric facility, the care coordinator must follow up with the beneficiary within seven (7) days of discharge from the facility. The follow up visit is to ensure that all discharge instructions are being followed and any follow-up appointments have been scheduled. Care coordination services must be available to attributed beneficiaries 24 hours a day.

Care Coordination will be provided up to a maximum of a 90 day transition period for all persons who seek to voluntarily withdraw from waiver services unless the individual does not want to continue to receive the service. The transition period will allow for follow up to assure that the person is referred to other available services and to assure that the person's needs can be met through optional services. It also serves to assure that the person understands the effects and outcomes of withdrawal and to ascertain if the person was coerced or otherwise was unduly influenced to withdraw. During this 90 day timeframe, the person remains enrolled in the waiver, the case remains open, and waiver services will continue to be available until the beneficiary finalizes their intent to withdraw.

The State of Arkansas adheres to CMS regulation as it relates to conflict-free case management. Care Coordination services may not include the provision of direct services to the beneficiary that are typically or otherwise covered as service under CES Waiver of State Plan. The organization may not provide care coordination services to any person to whom they provide any direct services without adhering to the following firewalls and protections:

A. The individual who performs the annual needs based assessment may not be a provider of services on the person centered service plan and may not provide direct care;

B. Participant should be encouraged to advocate or have an advocate present during all planning meetings; and

C. Provides will administratively separate care coordination functions and staff and direct care functions and staff.

Care Coordination services are available at two tiers of support. They are:

Tier 2 – The individual meets the institutional level of care criteria but does not currently require 24 hours a day of paid support and services to maintain his or her current placement.

Tier 3 – The individual meets the institutional level of care criteria and does require 24 hours a day of paid support and services to maintain his or her current placement.

The minimum requirement for service contacts is a monthly face-to-face contact. After the initial contact, the monthly contact can be made via videoconferencing.

Abeyance: It is sometimes necessary to place a case in abeyance to allow the case to remain open while the beneficiary is temporarily placed in a licensed or certified treatment program for the purpose of behavior, physical, or health treatment or stabilization. Monthly contacts shall continue when a beneficiary is in abeyance.

See Section 260.000 for billing information.

220.010 Person-Centered Service Plan Development 10-1-17

Person-Centered Service Plan Development is a service provided through supportive living that consists of the development of the PSCP. The Person-Centered Service Plan is a treatment plan developed and driven by the beneficiary and/or parent or guardian to deliver specific services to enhance and maintain community living, support the person in all major life activities, determine the person's choices about their life, assist the person in carrying out those choices, access employment services, and assist the person with integrating into the life and activities of his or her community. The Person-Centered Service Plan Developer is responsible for developing and implementing the PCSP.

Person-Centered Service Plan Development may be billed when the beneficiary enters the Waiver and must be reviewed at least annually or more frequently if there is documentation of a significant change of condition that requires an update in the beneficiary's treatment plan.

Yearly maximum of 1 per year (prior authorization for additional PCSP development can be requested).There will be a maximum rate of $90.00 per Plan development.

220.100 Transitional Care Coordination 10-1-17

Care coordination services may be available during the last 180 consecutive days of a Medicaid eligible person’s institutional stay to allow care coordination activities to be performed related to transitioning the person to the community. The person must be approved and in the waiver program for care coordination to be billed.

220.200 Benefit Limits for Care Coordination 10-1-17

The maximum reimbursement limit per beneficiary is $173.33 per month.

Abeyance will be approved in three-month increments when the beneficiary will be out of service for at least one month. Abeyance cannot exceed one year.

221.000 Consultation Services 10-1-17

Consultation services are clinical and therapeutic services that assist waiver beneficiaries, parents, guardians, legally responsible individuals, and service providers in carrying out the beneficiary's person-centered service plan.

A. Consultation activities may be provided by professionals who are licensed as:

1. Psychologists
2. Psychological examiners
3. Mastered social workers
4. Professional counselors
5. Speech pathologists
6. Occupational therapists
7. Physical therapists
8. Registered nurses
9. Certified parent educators or provider trainers
10. Certified communication and environmental control specialists
11. Dietitians
12. Rehabilitation counselors
13. Recreational therapists
14. Qualified Developmental Disabilities Professionals (QDDP)
15. Positive Behavioral Supports (PBS) Specialists
16. Behavior Analysts

These services are indirect in nature. The parent educator or provider trainer is authorized to provide the activities identified below in items 2, 3, 4, 5, 7, and 13. The provider agency will be responsible for maintaining the necessary information to document staff qualifications. Staff who meet the certification criteria necessary for other consultation functions may also provide these activities. Selected staff or contract individuals may not provide training in other categories unless they possess the specific qualifications required to perform the other consultation activities. Use of this service for provider training cannot be used to supplant provider trainer responsibilities included in provider indirect costs.

B. Activities involved in consultation services include:

1. Providing updated psychological and adaptive behavior assessments
2. Screening, assessing and developing therapeutic treatment plans
3. Assisting in the design and integration of individual objectives as part of the overall individualized service planning process as applicable to the consultation specialty
4. Training of direct services staff or family members in carrying out special community living services strategies identified in the person-centered service plan as applicable to the consultation specialty
5. Providing information and assistance to the individuals responsible for developing the beneficiary's person-centered service plan as applicable to the consultation specialty
6. Participating on the interdisciplinary team, when appropriate to the consultant's specialty

7. Consulting with and providing information and technical assistance with other service providers or with direct service staff and/or family members in carrying out a beneficiary's person-centered service plan specific to the consultant's specialty
8. Assisting direct services staff or family members in making necessary program adjustments in accordance with the beneficiary's person-centered service plan as applicable to the consultation specialty
9. Determining the appropriateness and selection of adaptive equipment to include communication devices, computers and software consistent with the consultant's specialty
10 Training and/or assisting beneficiaries, direct services staff or family members in the set-up and use of communication devices, computers and software consistent with the consultant's specialty
11. Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment and modification of the positive behavior support plan consistent with the consultant's specialty
12. Training of direct services staff and/or family members by a professional consultant in:
    a. Activities to maintain specific behavioral management programs applicable to the beneficiary
    b. Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the beneficiary
    c. The provision of medical procedures not previously prescribed but now necessary to sustain the beneficiary in the community
13. Training or assisting by advocacy to beneficiaries and family members on how to self-advocate
14. Rehabilitation counseling for the purposes of supported employment supports that do not supplant the Federal Rehabilitation Act of 1973 and PL 94-142 and the supports provided through Arkansas Rehabilitation Services
15. Training and assisting beneficiaries, direct services staff or family members in proper nutrition and special dietary needs

221.100 Benefit Limits for Consultation Services 10-1-17

The maximum amount payable for consultation services, per person is $1,320.00 annually. It is reimbursable at no more than $136.40 per hour.

See Section 260.000 for billing information.

222.000 Crisis Intervention Services 10-1-17

Crisis intervention services are defined as services delivered in the beneficiary's place of residence or other local community site by a mobile intervention team or professional.

Intervention services must be available 24 hours a day, 365 days a year and must be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geographic area conducive to rapid intervention as defined by the provider responsible to deploy the team or professional. Services may be provided in a setting as determined by the nature of the crisis, i.e., residence where behavior is happening, neutral ground, local clinic or school setting, etc. The following criteria must be met:

A. The beneficiary is receiving waiver services.

B. The beneficiary needs non-physical intervention to maintain or re-establish behavior management or positive programming plan.

C. Intervention is on-site in the community.

The maximum rate of reimbursement for this service is $127.10 per hour. The annual maximum is $2,640.00.

Crisis intervention services are only provided as a waiver service to individuals who are age 21 and over. All medically necessary crisis intervention services for children under age 13 are covered as part of the Medicaid State Plan EPSDT benefit.

See Section 260.000 for billing information.

223.000 Community Transition Services 10-1-17

Community transition services are non-recurring set-up expenses for beneficiaries who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the beneficiary or his or her guardian is directly responsible for his or her own living expenses. Waiver funds can be accessed once it has been determined that the waiver is the payer of last resort.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

A. Security deposits that are required to obtain a lease on an apartment or home

B. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens

C. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water

D. Services necessary for the beneficiary's health and safety such as pest eradication and one-time cleaning prior to occupancy

E. Moving expenses

Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the person-centered service plan development process, clearly identified in the person-centered service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Duplication of environmental modifications will be prevented through DDS control of prior authorizations for approvals.

Costs for community transition services furnished to beneficiaries returning to the community from a Medicaid institutional setting through entrance to the waiver are considered to be incurred and billable when the person is determined to be eligible for the waiver services. The beneficiary must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason the beneficiary does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid.

Exclusions: Community transition services may not include payment for room and board, monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional or recreational purposes. Community transition services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Diversionary or recreational items such as televisions, cable TV access, VCRs or DVD players are not allowable.

223.100 Benefit Limits for Community Transition Services 10-1-17

The maximum annual allowance for supplemental support, community transition services, and specialized medical supplies is $3,690.00.

See Section 260.000 for billing information.

224.000 Payment to Relatives or Legal Guardians 10-1-17

Payment for waiver services will not be made to the adoptive or natural parent, step-parent or legal representative or legal guardian of a beneficiary less than 18 years old. Payments will not be made to a spouse or a legal representative for a beneficiary 18 years of age or older. The employment of eligible relatives (regardless of the waiver beneficiary's age) shall require prior approval from DDS authority.

Payment to relatives, other than parents of minor children, legal guardians, custodians of minors or adults, or the spouse of adults, must be prior approved by DDS to provide services. For purposes of exclusion, "parent" means natural or adoptive parents and step-parents. For any service provider, all DDS qualifications and standards must be met before the person can be approved as a paid service provider. Qualified relatives, other than as specified in the foregoing, can provide any service.

In no case will a parent or legal guardian be reimbursed for the provision of transportation for a minor.

Controls for services rendered: All care staff are required to document all services provided daily according to their work schedules, direct-care support service supervisors are responsible for day-to-day supervision and monitoring of the direct-care staff; care coordinators are responsible for periodically reviewing with the beneficiary any problems in care delivery and reporting any deficiencies to the Waiver DD Specialist and DDS Quality Assurance provider certification staff. DDS specialists conduct a 100% review of service utilization for each person-centered service plan at the time of each plan of care 12-month expiration date to identify any gaps in approved services with corrective action by the provider to be taken; DDS Quality Assurance conducts annual provider reviews; and DMS conducts both random Quality Assurance audits and audits specific to the financial integrity of services delivered.

230.000 Eligibility Assessment 10-1-17

The intake and assessment process for the DDS CES Waiver Program includes:

A. Determination of categorical eligibility

B. Institutional level-of-care determination

C. Comprehensive diagnosis and evaluation, including an independent assessment for functional need

D. Development of a person-centered service plan

E. Cost comparison to determine cost-effectiveness

F. Notification of a choice between home and community-based services and institutional services.

230.100 Categorical Eligibility Determination 10-1-17

Current eligibility for the Arkansas Medicaid Program must be verified as part of the intake and assessment process for admission into the CES Waiver Program. Medicaid eligibility is

determined by the Division of Developmental Disabilities Services or by the Social Security Administration for SSI Medicaid eligibles.

Failure to obtain any required eligibility determination, whether initial or subsequent (time-bound) reassessments, will result in the beneficiary's case being closed. Once closure has occurred, and the appeals processes are exhausted, the affected person will have to make a new request for services through the waiver program intake process.

For supportive living arrangements, the Medicaid eligibility date is retroactive to the date the Medicaid application is received at the DDS Medicaid Unit or no more than three (3) months prior to the receipt of the Medicaid application, whichever is less.

230.200 Level of Care Determination 10-1-17

Based on intellectual and behavioral assessment submitted by the provider, the ICF/IID level of care determination is performed by the Division of Developmental Disabilities. The ICF/IID level of care criteria provides an objective and consistent method for evaluating the need for institutional placement in the absence of community alternatives. The level of care determination must be completed and the beneficiary determined to

A. Require the level of care provided in an ICF/IID.

B. Need institutionalization in an ICF/IID in the near future (in a month or less) but for the provision of waiver services.

Recertification, based on intellectual and behavioral assessments submitted by the provider at appropriate age milestones, will be performed by DDS to determine the beneficiary's continuing need for an ICF/IID level of care.

The annual level of care determination is made by a QDDP.

230.210 Tiers of Support 10-1-17

Coverage is provided within two tiers of support. The two tiers are as follows:

Tier 3: The individual meets the institutional level of care criteria and does require 24 hours a day of paid support and services to maintain his or her current placement.

Tier 2: The individual meets the institutional level of care criteria but does not currently require 24 hours a day of paid support and services to maintain his or her current placement.

Tiers will be determined through an independent assessment conducted by a third-party vendor that will assess the beneficiary in three (3) areas. Refer to the Independent Assessments and Developments Screens provider manual for a complete listing of areas addressed.

The independent assessment must be used in conjunction with the application packets and other applicable functional assessments to create the person-centered service plan.

230.300 Comprehensive Diagnosis and Evaluation 10-1-17

A comprehensive diagnosis and evaluation (D&E) must be administered in order to determine that applicants are persons with a developmental disability and meet institutional level of care prior to receiving CES waiver services from DDS.

The comprehensive diagnosis and evaluation includes a series of examinations and observations performed or validated and approved by professionals leading to conclusions and findings.

The examinations and/or assessments include, but are not limited to:

A. A thorough medical examination and other evaluations deemed necessary by the physician

B. A psychological assessment

C. A social history/sociological examination

D. An educational assessment, if applicable

E. An appraisal of adaptive behavior

F. All other examinations, assessments and evaluations necessary to describe the beneficiary's needs

G. Areas of Need form

Failure to submit the reassessments in advance of eligibility expiration date will result in the denial of care coordination reimbursement for the period the determination is overdue. Failure to obtain any required eligibility determination, whether initial or subsequent time-bound reassessments, may result in the beneficiary's case being closed.

When a beneficiary's case has been closed, the affected person must make a new request for services through the waiver program intake process in order for services to continue. This will be considered a new application to the waiver program.

230.400 Person-Centered Service Plan 10-1-17

During the initial sixty (60) days of DDS CES waiver services, a beneficiary receives services based on a DDS pre-approved interim person-centered service plan that provides for care coordination at the prevailing rate, up to sixty (60) days; and supportive living services for direct-care supervision up to sixty (60) days. It may include transitional funding when the person is transitioning from an institution to the community. Persons residing in a Medicaid-reimbursed facility may receive care coordination the last 180 consecutive days of the institutional stay.

NOTE: The fully-developed person-centered service plan may be submitted, approved and implemented prior to the expiration of the initial person-centered service plan. The initial plan period is simply the maximum time frame for developing, submitting, obtaining approval from DDS and implementing the person-centered service plan. An extension may be granted when there is supporting documentation justifying the delay.

Prior to expiration of the interim service plan, each beneficiary eligible for CES waiver services must have an individualized, specific, written person-centered service plan developed by a multi-agency team, including a person-centered service plan developer, and approved by the DDS authority. The members of the team will determine services to be provided, frequency of service provision, number of units of service and cost for those services while ensuring that the beneficiary's desired outcomes, needs and preferences are addressed. Team members and a physician, via the DDS 703 form, certify the beneficiary's condition (level of care) and appropriateness of services initially and at the annual continued-stay review. The person-centered service plan development is conducted once every 12 months in accordance with the continued-stay review date or as changes in the beneficiary's condition require a revision to the person-centered service plan.

The person-centered service plan must be designed with consideration given to the independent assessment results and to assure that services provided will be:

A. Specific to the beneficiary's unique circumstances and potential for personal growth.

B. Provided in the least restrictive environment possible.

C. Developed within a process assuring participation of those concerned with the beneficiary's welfare. Participants of the multi-agency team included the beneficiary's chosen care coordinator, the beneficiary or legal representative and additional persons whom the

beneficiary chooses to invite to the planning meeting, as long as all rules pertaining to confidentiality and conflict of interest are met. If invited, the DDS Waiver Specialist attends the planning meetings randomly, in an effort to assure an annual 10% attendance ratio. Mandatory attendance by the care coordinator is required to ensure the written person-centered service plan meets the requirements of regulations, the desires of the beneficiary or legal representative, is submitted timely, and is approved by DDS prior to service delivery.

D. Monitored and adjusted to reflect changes in the beneficiary's needs. A person-centered service plan revision may be requested at any time the beneficiary's needs change.

E. Provided within a system that safeguards the beneficiary's rights.

F. Documented carefully, with assurance that appropriate records will be maintained.

G. Will assure the beneficiary's and others' health and safety. The person-centered service plan development process identifies risks and makes sure that they are addressed through backup plans and risk management agreements, including how and who will be responsible for ongoing monitoring of risk level and risk management strategies, and how staff will be trained regarding those risks. A complete description of backup arrangements must be included in the person-centered service plan. All strategies must be designed to respect the needs and preferences of the beneficiary. All risk management strategies must be analyzed by the team at least quarterly as part of the PCSP review.

H. Consider cost-efficient options that foster independence, such as shared staffing and other adaptions. When such options are not utilized in the PCSP for a Tier 3 participant, it must be documented that the participant's health and safety require one-on-one staffing, 24 hours a day.

The Person-Centered Service Plan Developer will be responsible for the development and implementation of the PSCP.

230.410 Person-Centered Service Plan Required Documentation 10-1-17

A. General Information

Identification information must include:

1. Beneficiary's full name and address
2. Beneficiary's Medicaid number
3. Guardian or Power of Attorney with an address (when applicable)
4. Number of individuals with ID/IID residing in home of waiver beneficiary and type of residence
5. Physician Level of Care Certification
6. Names, titles and signatures of the multi-agency team members responsible for the development of the beneficiary's person-centered service plan
7. Results of the independent assessment and any other functional assessments used to develop the person-centered service plan

B. Budget Sheet, Worksheets and Provider Information

Information must include:

1. Identification of the type of waiver services to be provided
2. Name of the provider delivering the service
3. Total amount by service

4. Total plan amount authorized
5. Beginning and ending date for each service
6. Supported Living Array worksheet listing units and total cost by service and level of support
7. Adaptive Equipment, Environmental Modifications, Specialized Medical Supplies, Supplemental Support, and Community Transition worksheets listing units and total cost by service
8. Provider Information sheet showing care coordination provider, care coordinator, supportive living provider, and direct care supervisor

C. Narrative justification for the revision to the initial plan of care must, at a minimum, justify the need for requested services. Narrative justification for annual continued-stay reviews must address utilization of services used or unused within the past year, justify new services requested and address risk assessment.

D. The person-centered service plan must include:

1. Identification of individual objectives
2. Frequency of review of the objectives
3. List of medical and other services, including waiver and non-waiver services necessary to obtain expected objectives
4. Expected outcomes including any service barriers

E. Product and service cost-effectiveness certification statement, with supporting documentation certifying that products, goods and services to be purchased meet applicable codes and standards and are cost-competitive for comparable quality.

240.000 PRIOR AUTHORIZATION 10-1-17

CES waiver services require prior authorization by the Division of Developmental Disabilities Services. **In the absence of prior authorization, reimbursement will be denied and will not be approved retroactively.**

241.000 Approval Authority 10-1-17

For the purpose of person-centered service plan approvals, DDS is the Medicaid authority.

A. The DDS prior authorization process requires that all Tier 3-support service plans, problematic service plans, or plans not clearly based on documented need must have approval by DDS Plan of Care Review Team.

1. Problematic is based on individual circumstances, a change in condition, or a new service request as determined by the DDS Waiver Specialist or by request of the care coordinator.
2. The DDS Person-Centered Service Plan Review Team consists of the DDS Waiver Program director or designee, DDS Waiver Area Managers, DDS Psychology Team member and other expert professionals such as nurses, physicians or therapists. The DDS Waiver Specialist is responsible for presenting the case to the team. The waiver beneficiary or legal representative is permitted to attend the meeting and present supporting evidence why the services requested should be approved, as long as all rules pertaining to confidentiality and conflict of interest are met.
3. The DDS Waiver Specialist must conduct an in-home visit for all Tier 3 service plans and may conduct an in-home visit for problematic service plans or plans that are not based on documented need. Failure of the beneficiary or legal representative to

permit DDS from conducting the in-home visit may result in the denial of service request and may result in case closure.

B. Tier 2 service plans will be subject to a local-level approval process.

C. All waiver services must be needed to prevent institutionalization.

D. All beneficiaries receiving medications must also receive appropriate support in the management of medication(s). The use of psychotropic medications for behavior will require the development, implementation and monitoring of a written positive behavior plan.

E. Service requests that will supplant Department of Education responsibilities WILL NOT be approved. This includes voluntary decisions to withdraw from, or never enter, the Department of Education public school system. The waiver does not provide educational services, including educational materials, equipment, supplies or aids.

F. All person-centered service plans are subject to review by a qualified physician and random audit scrutiny by DDS Specialists, DDS Area Managers, DDS Licensure staff or DMS Quality Assurance staff. In addition, the following activities will occur:

1. Review of provider standards and actions that provide for the assurance of a beneficiary's health and welfare
2. Monitoring of compliance with standards for any state licensure or certification requirement for persons furnishing services provided under this waiver
3. Assurance that the requirements are met on the date that the service is furnished
4. Quality assurance reviews by DDS staff include announced and unannounced quarterly on-site home visits.
5. Random review equal to a percent as prescribed by DDS Licensure Unit's certification policy.

G. All service requests are subject to review by DDS and may necessitate the gathering and submission of additional justification, information and clarification before prior approval is made. In this event, it is the primary responsibility of the care coordination provider, with cooperation from the procurement source, to satisfy the request(s) within the prescribed time frames.

H. It is the responsibility of the care coordination services provider with cooperation from the direct services providers to ensure that all requests for services are submitted in a timely manner to allow for DDS prior authorization activities prior to the expiration of existing plans or expected implementation of revisions.

I. Initially, a beneficiary receives up to sixty (60) days of DDS CES waiver services based on a DDS pre-approved interim service plan. The pre-approved interim plan will include care coordination and supportive living service for direct care supervision and may include community transition services when the person is transitioning from an institution to the community. For transitional care coordination, the sixty (60)-day interim plan begins with the date of discharge.

1. At any time during the initial sixty (60) days or transitional care coordination period, the PCSP Developer will complete the planning process and submit a detailed person-centered service plan that identifies all needed, medically necessary services for the remainder of the plan of care year. Once approval is obtained, these services may be implemented.
2. Waiver services will not be reimbursed for any date of service that occurs prior to the date the beneficiary's person-centered service plan is approved, the date the beneficiary is determined to be ICF/IID-eligible, or the date the beneficiary is deemed Medicaid waiver-eligible, whichever date is last.

3. All changes of service or tier revisions must have prior authorization. Services that are not prior authorized will not be reimbursed.

J. Emergency approvals may be obtained via telephone, facsimile or e-mail, with retroactive reimbursement permitted as long as the notice of emergency, with request for service change, is received by DDS within 24 hours from the time the emergency situation was known. All electronically transmitted requests for emergency services must be followed with written notification and requests must be supported with documented proof of emergency. Failure to properly document proof of emergency shall result in approval being rescinded.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 10-1-17

The reimbursement rates for DDS CES waiver services will be according to the lesser of the billed amount or the Title XIX (Medicaid) maximum for each procedure.

The maximum supportive living daily rate is inclusive of administration costs that cannot in any event exceed 20% of the total supportive living array for a beneficiary.

If fringe benefits exceed 25%, documentation must be submitted with a person-centered service plan and budget request. Fringe benefits cannot exceed 32%.

The administration and fringe costs are subject to audit and must be documented to support the rate charged.

252.000 Rate Appeal Process 10-1-17

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program or provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she wishes, for a full explanation of the factors involved and the Program decision. Following review, the Assistant Director will notify the provider of the action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the program and/or provider conference.

When the provider disagrees with the decision made by the Assistant Director of the Division of Medical Services, the provider may appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department Human Services (DHS) management staff, who will serve as chairperson.

The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director of the Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the questions and a recommendation will be submitted to the Director of the Division of Medical Services.

260.000 BILLING PROCEDURES

261.000 Introduction to Billing 10-1-17

DDS CES waiver providers use the CMS-1500 claim form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim should contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

262.000 DDS CES Waiver Procedure Codes 10-1-17

The following procedure codes and any associated modifier(s) must be billed for DDS CES Waiver Services. Prior authorization is required for all services.

Procedure Code	M1	M2	PA	Description	Unit of Service	National POS Codes
H2016			Y	Supportive Living	1 Day	12, 99, 14
H2023			Y	Supported Employment	15 Minutes	99
S5151			Y	Respite Services	1 Day	12, 99, 14, 54
T2020	UA		Y	Supplemental Support Services	1 Package	12, 99, 14
T2022			Y	Care coordination Services	1 Month	12, 99, 14
T2025			Y	Consultation Services	1 Hour	12, 99, 14
T2028			Y	Specialized Medical Equipment	1 Package	12, 99,14
T2020	UA	U1	Y	Community Transition Services	1 Package	99, 14, 54
T2022	U2		Y	Transitional Care coordination	1 Month	99, 14, 54
T2034	U1	UA	Y	Crisis Intervention Services	1 Hour	99,12
K0108			Y	CES environmental modifications	1 Package	12
S5160			Y	Adaptive equipment, personal emergency response system (PERS), installation and testing,	1 Package	12, 14
S5161			Y	Adaptive equipment, personal emergency response system (PERS), service fee, per month, excludes installation and testing	1 Package	12, 14
S5162			Y	Adaptive equipment, personal emergency response system (PERS), purchase only	1 Package	12, 14
S5165	U1		Y	CES adaptive equipment, per service	1 Package	12, 14

262.100 National Place of Service (POS) Codes 10-1-17

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Codes
Patient's Home	12
Other	99
Group Home	14
ICF/IID	54

262.200 Billing Instructions - Paper Only 10-1-17

DHS' fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.

Bill Medicaid for professional services with form CMS-1500. **View a sample form CMS-1500.** Field Code Changed

Carefully follow these instructions to help the fiscal agent efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the fiscal agent's claims department. **View or print fiscal agent claims department contact information.** Field Code Changed

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

262.210 Completion of CMS-1500 Claim Form 10-1-17

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's date of birth as given on the Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary resides.

Field Name and Number		Instructions for Completion
	STATE	Two-letter postal code for the state in which the beneficiary resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's telephone number or the number of a reliable message/contact/emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured beneficiary.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.

Field Name and Number	Instructions for Completion
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.

Field Name and Number	Instructions for Completion
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for DDS Community and Employment Supports (CES) Waiver services. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's inpatient hospitalization, enter the beneficiary's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.

Field Name and Number		Instructions for Completion
24A.	DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B.	PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.100 for codes.
C.	EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D.	PROCEDURES, SERVICES, OR SUPPLIES	
	CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Section 262.000.
	MODIFIER	Modifier(s) if applicable.
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any beneficiary of the provider’s services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
	NPI	Not required.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider’s Medicaid file. If it changes, please contact Provider Enrollment.

Field Name and Number	Instructions for Completion
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do **not** include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

262.300 Special Billing Procedures 10-1-17

Not applicable to this program.

Arkansas Department of Human Services

Division of Developmental Disabilities Services

DDS COMMUNITY AND EMPLOYMENT SUPPORTS (CES) WAIVER MINIMUM CERTIFICATION STANDARDS

EFFECTIVE OCTOBER 1ST, 2017

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100 ORGANIZATIONAL/MANAGEMENT REQUIREMENTS AND SOLICITATION

101. Organizational Requirements

1. Standards are not comprehensive: These DDS Community and Employment Supports Waiver Minimum Certification Standards ("**Certification Standards**") establish those Provider policies, activities, and areas where DDS Quality Assurance will monitor Provider compliance.

   However, these Certification Standards do not contain a comprehensive listing of all laws, statutes, guidelines, or other rules and regulations with which a Provider must comply. Depending on the services or programs a Provider chooses to offer and participate in, there may be other federal, state and local statutes, acts, and regulations with which a Provider must comply, including, but not limited to, the following:

   - Health Insurance Portability and Accountability Act
   - Freedom of Information Act
   - Individuals with Disabilities Education Act
   - American with Disabilities Act
   - Federal Privacy Act
   - Developmental Disabilities Assistance & Bill of Rights Act.

   DDS Quality Assurance has the right to sanction Provider non-compliance with any laws, statutes, guidelines, or other regulations not found in the Certification Standards applicable to a Provider.

2. Provider Governing Documents Available for DDS Inspection: All governing documents, policies, procedures, or other equivalent operating documents of a Provider shall at all times be readily available for DDS inspection and review upon request.

3. Legal Existence and Good Standing: A Provider shall at all times be duly organized, validly existing and in good standing as a legal entity under the laws of the State of Arkansas, with the power and authority under the appropriate federal, state or local statues to own and operate its business as presently conducted.

4. Provider Name and Control Changes:

   a. *Name Changes*: Any change to the legal name of a Provider or the name under which a Provider conducts business in the State of Arkansas must be reported to DDS Quality Assurance within seven (7) days.

b. *Control Changes*: Any change in the control of a Provider must be reported to DDS within seven (7) days. A "change in control" shall mean a change in the Executive Director or other titled position that is considered the highest position of authority for the Provider.

5. Governing Body Requirement: Each Provider's governing body shall include at least one individual with developmental disabilities as an ex officio member (see Ark. Code Ann. § 20-48-705).

6. Provider Inability to Continue as Going Concern: If DDS receives information that would reasonably cause it to doubt a Provider's ability to continue as a going concern, DDS Quality Assurance has the right to demand that the Provider present evidence that the Provider is still able to safely provide services in full compliance with these Certification Standards. Examples of actions or events that might trigger this concern include, but are not limited to, IRS liens, threats to revoke non-profit status, and the inability to pay employees, subcontractors, or others.

102. Management Requirements

1. DDS QA Point of Contact: Each Provider must appoint a single member of management as the point of contact for all DDS Quality Assurance matters. This manager must have authority over all Provider employees, and would have sole responsibility for ensuring that DDS Quality Assurance's requests, concerns, and inquiries are investigated and carried out.

2. Executive Director. Each Provider must appoint an Executive Director, or other titled officer position, that is vested with the authority and responsibility of overseeing all day-to-day Provider operations.

103. Organized Health Care Delivery System

DDS has established an optional Organized Health Care Delivery System election as per 42 C.F.R. 447.10(b) for Providers. A Provider must deliver to DDS, in writing, a guarantee that the Provider will ensure the services of each subcontractor will comply with all Medicaid regulations and the Certification Standards. The Provider assumes all liability for subcontractor non-compliance. The Provider must deliver at least one HCBS Waiver service utilizing its own employees. DDS Quality Assurance's annual review will determine compliance with the Certification Standards.

The Provider is required to have a duly executed subcontract in place that specifies the services to be rendered and assures that services will be completed by the subcontractor in a timely manner and be satisfactory to the beneficiary. The Provider is also responsible for the financial accountability of any subcontractor by ensuring that subcontractor services were delivered and proper documentation was submitted.

104. Solicitation

Solicitation of a beneficiary by a Provider is strictly prohibited, and a Provider that is found to be engaging in solicitation of a beneficiary will be subject to enforcement remedies. "Solicitation" means when a Provider (through its employees, owners, independent contractors, family members, or other agents) attempts to influence a beneficiary (or his or her family/guardian). Examples of prohibited solicitation include, but are not limited to, the following:

1.) Contacting a beneficiary or their family currently receiving services from another Provider to induce them to choose/switch Providers;

2.) Offering cash or gift incentives to a beneficiary or their family to induce them to choose/switch Providers;

3.) Offering free goods and/or services not available to other similarly stationed beneficiaries or their families to induce them to choose/switch Providers;

4.) Refusing to provide access to entitlement services for which the beneficiary is eligible if the beneficiary or their legal guardian selects another Provider for services;

5.) Making negative comments to a beneficiary or their family regarding the quality of services performed by another Provider;

6.) Promising to provide CES home and community based waiver services or other services in excess of those necessary to induce a beneficiary or their legal guardian to choose the Provider;

7.) Directly or indirectly giving a beneficiary or their family the false impression that the Provider is the only Provider that can perform the services desired by the beneficiary or their family; and

8.) Engaging in any activity that DDS Quality Assurance reasonably determines was intended to be "solicitation" as defined herein.

Marketing by a Provider is distinguishable from solicitation and is considered an allowable practice. Examples of acceptable marketing practices include, but are not limited to: (i) advertising using traditional media; (ii) distributing brochures and other informational materials regarding the services offered by a Provider; (iii) conducting tours of a Provider to interested beneficiaries; (iv) mentioning other services offered by the Provider in which a beneficiary might have an interest; and (v) hosting informational gatherings during which the services offered by a Provider are honestly described. All marketing must be factual and honestly presented, or a Provider could be subject to enforcement remedies.

200 HIRING PROCEDURES & PERSONNEL RECORD MAINTENANCE

201. Hiring Procedures and Required Personnel Records

A. Prior to Employment

The Provider must obtain and verify each of the following from an applicant prior to employment:

1. A completed job application that includes all the applicant's required current and up-to date credentials.
2. A signed criminal conviction statement.
3. All required criminal background checks, as outlined in DDS Policy #1087 (A.C.A. § 20-38-101 et. seq. and §20-48-812, or any applicable successor statutes). DDS requires criminal background checks for the applicant, their spouse, and any children or other adult over the age of eighteen (18) if a beneficiary is to be permitted to stay overnight in an applicant's residence.
4. A signed declaration of truth of statement.
5. Completed reference checks.
6. A successfully passed drug screen.
7. If the applicant is applying for a position where transportation is required, a current and valid driver's license or a commercial driver's license (CDL), as appropriate.

B. Post-Employment

The Provider shall obtain and verify within thirty (30) days of an applicant's employment:

1. A completed Adult Maltreatment Central Registry check (see A.C.A. § 12-12-1716, or any successor statutes), or a second submission request if a response has not been received. An Adult Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adult over the age of eighteen (18) that resides in a residence where a beneficiary is approved and permitted to stay overnight.

2. A completed Child Maltreatment Central Registry check (A.C.A. § 12-18-901 et. seq., or any successor statutes), or a second submission request if a response has not been received. A Child Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adult over the age of eighteen (18) that resides in a residence where a beneficiary is approved and permitted to stay overnight.

3. A successfully passed criminal background check for the employee, their spouse, and any children or other adult over the age of eighteen (18) residing in a residence where a beneficiary is approved and permitted to stay overnight.

The Provider shall maintain the above documentation in the employee's personnel file for at least one (1) year following termination of employment.

C. Required Follow-up Checks

The child maltreatment registry checks required upon hiring in Section 201 must be repeated for each employee at least once every two (2) years. The criminal background and adult maltreatment registry checks required upon hiring in Section 201 must be repeated for each employee at least once every five (5) years. Failure to pass any required follow-up check at any time requires that the employee immediately cease unsupervised contact with beneficiaries.

D. New Information after Employment

If DDS or the Provider receives additional information after hiring that creates a reasonable belief that an employee has had a change in status in connection with one of the requirements in Section 201 (A) or (B) above (i.e. a license has been revoked/expired, an employee would no longer pass a criminal background and/or registry check, etc.), then the Provider must verify that the employee still meets all requirements for employment.

E. Exception

Any applicant who submits evidence of holding a current professional license is exempt from the criminal background, adult maltreatment and child maltreatment check requirements of this Section.

202. Job Description Requirements

The Provider shall create written job descriptions for each position offered that describe the duties, responsibilities, and qualifications for such staff position. In addition, the job description shall include the physical and educational qualifications and licenses/certifications required for each position. All employees that require a professional license must maintain current credentials.

203. Sub-Contractors/Volunteer/Interns

Each Provider must ensure that sub-contractors, students, interns, volunteers, and trainees or any other person who has regular, routine contact with beneficiaries are in compliance with all the requirements applicable to an "employee" that are contained in this Section 200. The classification of a worker as something other than an "employee" will not negate the responsibilities of the Provider under this Section 200.

300 INCIDENT REPORTING

301. Reportable Incidents

Providers must submit an incident report to DDS Quality Assurance using the automated form DHS 1910 via secure e-mail upon the occurrence of any one of the following events:

1. Death of beneficiary.

2. The use of any restrictive intervention, including seclusion, or physical, chemical, or mechanical restraint on a beneficiary.

3. Suspected maltreatment or abuse of a beneficiary.

4. Any injury to a beneficiary that:

    - Requires the attention of an Emergency Medical Technician, a paramedic, or physician
    - May cause death
    - May result in a substantial permanent impairment
    - Requires hospitalization

5. Threatened or attempted suicide by a beneficiary.

6. The arrest of a beneficiary, or commission of any crime by a beneficiary.

7. Any situation in which the whereabouts of a beneficiary is unknown for more than two (2) hours (i.e. elopement and/or wandering), or where services are interrupted for more than two (2) hours.

8. Any event where a staff member threatens a beneficiary.

9. Unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary.

10. Medication errors made by staff that cause or have the potential to cause serious injury or illness to a beneficiary, including, but not limited to, loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time, by the wrong route, and the administration of the wrong medication.

11. Any violation of a beneficiary's rights that jeopardizes the health, safety, or quality of life of the beneficiary.

12. Any incident involving property destruction by a beneficiary.

13. Vehicular accidents involving a beneficiary.

14. Biohazard incidents involving a beneficiary.

15. An arrest or conviction of a staff member providing direct care services.

16. Any use or possession of a non-prescribed medication or an illicit substance by a beneficiary.

17. Any other event that might have resulted in harm to a beneficiary or could have reasonably endangered the health, safety, or welfare of the beneficiary.

In addition to submitting incident reports for the reportable incidents described above to DDS Quality Assurance using the automated form DHS 1910 via secure e-mail, Providers are to also forward a copy of each incident report to the appropriate DDS Regional Area Group email address. This requirement also applies to any required follow-up incident reports described in Section 303. The DDS Regional Area Group email addresses are as follows:

DHS.DDS.Central@arkansas.gov
DHS.DDS.NorthCentral@arkansas.gov
DHS.DDS.Northeast@arkansas.gov
DHS.DDS.Northwest@arkansas.gov
DHS.DDS.Southeast@arkansas.gov
DHS.DDS.Southwest@arkansas.gov

Providers should contact DDS Waiver Services with any questions regarding the appropriate DDS Regional Area Group email.

302. Reporting Timeframes

A. Immediate Reporting

Providers must report the following incidents to the DDS Quality Assurance emergency number ((501) 765-9018) within one (1) hour of occurrence, regardless of hour:

- Suicide
- Death from adult abuse
- Death from child maltreatment
- Serious injury

B. Incidents Involving Potential Publicity

Incidents, regardless of category, that a Provider should reasonably know might be of interest to the public and/or media must be immediately reported to DDS Quality Assurance in central office if

during business hours, and to the DDS Quality Assurance emergency number ((501) 765-9018), if after business hours.

C. All Other Incident Reports

Except as otherwise provided above in subsection A and B, all reportable incidents must be reported to DDS Quality Assurance using the automated form DHS 1910 via secure e-mail no later than two (2) days following the incident. Any incident that occurs on a Friday is still considered timely if reported by the Monday immediately following.

303. Required Incident Report Contents

A. Initial Incident Report: Each initial incident report filed by a Provider must contain the following information:

1. Date of the incident
2. Detailed description of the accident/injury
3. Time of the incident
4. Location of incident
5. Persons involved in the incident
6. Other agencies contacted regarding incident, and the name of the individual in the agency that was contacted
7. Whether the guardian was notified of the incident and time of notification,
8. Whether the police were involved, and if so, a detailed description of their involvement
9. Any action taken by Provider or staff of Provider, both at the time of the incident and subsequent to the incident
10. Any expected follow-up
11. Name of person that prepared the report

When applicable, the Provider shall notify the parent or legal guardian of the beneficiary any time an incident report is submitted.

B. Follow-up Incident Reports: Information that is not available at the time of the initial incident report filing must be submitted in follow-up or final incident reports. These reports should be submitted in the same manner as soon as the additional information becomes available.

- The initial report should be resubmitted with the "follow-up" or "final" report areas checked and dated in the appropriate space on the incident report form.

- The current date should precede the new information in the text/narrative sections to differentiate follow-up information from the information originally submitted.

- A new form DHS-1910 should be submitted for follow-up and final reports only when there is insufficient space on the original form. Whenever a new form is submitted, the date of the original written report must be included for cross-referencing.

304. Mandated Reporters

The Arkansas Child Maltreatment Act and the Arkansas Adult Maltreatment Act deem all staff of Providers to be mandated reporters of any suspected adult or child abuse, neglect, exploitation, and maltreatment. Failure on the part of a Provider to properly report suspected abuse, neglect, exploitation, and maltreatment to the appropriate hotline is a violation of these Certification Standards.

400 BENEFICIARY AND LEGAL GUARDIAN RIGHTS

401. Beneficiary/Guardian Rights Policy

Each Provider must implement policies that enumerate in clear and understandable language each beneficiary's rights and the rights of the legal guardian of each beneficiary. The Provider must take reasonable steps to ensure beneficiaries and their legal guardians are: (i) informed of their rights; (ii) provided copies of the policies enumerating their rights prior to the initiation of services and at any other time upon request; and (iii) that the information is transmitted in a manner that the beneficiary and their legal guardian are able to read and understand.

402. Beneficiary Rights

Each Provider must, at a minimum, ensure the following beneficiary rights:

1. The right to be free from:

    - physical or psychological abuse or neglect
    - retaliation
    - coercion
    - humiliation
    - financial exploitation

    The Provider must ensure that the application of corporal punishment to beneficiaries is prohibited. "Corporal punishment" refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.

2. The freedom to control their own financial resources.

3. The freedom to receive, purchase, possess, and use individual personal property. Any restriction on this right must be supported by an assessed need and justified in the beneficiary's person centered service plan ("**PCSP**").

4. The freedom to actively and meaningfully make decisions affecting their life and access pertinent information in a timely manner to facilitate such decision making.

    - If a beneficiary is age eighteen (18) or older, he/she is considered competent unless there is a court appointed legal guardian. Competent adults must always sign their own consents, releases, or other documentation requiring a signature.

    - A beneficiary who has a court appointed legal guardian retains all legal and civil rights except those which have been expressly limited by the court in the court

order, or which have been specifically granted to the legal guardian pursuant to the court order.

- Adult individuals who are legally competent shall have the right to decide whether their family will be involved in planning and implementing the PCSP.

5. The right to privacy. Any restriction on this right must be supported by an assessed need and justified in the PCSP.

6. The right to choice of roommate when sharing a bedroom.

7. The freedom to associate and communicate publicly or privately with any person or group of people of the beneficiary's choice at any time. Any restriction on this right must be supported by an assessed need and justified in the PCSP.

8. The freedom to have visitors of their choosing at any time.

9. The freedom of religion.

10. The right to be free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment.

11. The opportunity to seek employment and work in competitive, integrated settings to the same degree as those not receiving home and community based services through Medicaid.

12. Freedom from being required to work without compensation.

    - There is a limited exception when residing in a Provider owned/controlled setting if the required work is related to the upkeep of the beneficiary's own living space, or the common living area and grounds that the beneficiary shares with others.

13. The right to be treated with dignity and respect.

14. The right to receive due process.

    - Providers must ensure beneficiaries have access to legal entities for appropriate and adequate representation, advocacy support services, and must adhere to research and ethics guidelines (45 CFR § 46.101 et. seq.).

    - Provider rules may not contain provisions that result in the unfair, arbitrary, or unreasonable treatment of a beneficiary.

15. The right to contest and appeal Provider decisions affecting the beneficiary.

16. The right to request and receive an investigation in connection with an alleged infringement of a beneficiary's rights.

    - The Provider must maintain the documentation relating to all investigations of alleged beneficiary rights violations, and the actions taken to intervene in such situations. The Provider will ensure that the beneficiary has been notified of their right to appeal according to DDS Policy #1076.

17. The freedom to access their own records, including information regarding how their funds are accessed and utilized and what services were billed for on the beneficiary's behalf. Additionally, all beneficiaries and legal guardians must be informed of how to access the beneficiary's service records and the Provider must ensure that appropriate equipment is available for them to obtain such access.

    - Beneficiaries may not be prohibited from having access to their own service records, unless a specific state law indicates otherwise.

18. The right to live in a manner that optimizes, but does not regiment, beneficiary initiative, autonomy, and independence in making life choices, including but not limited to:

    - Choice of Provider
    - Service delivery
    - Release of information
    - Composition of the service delivery team
    - Involvement in research projects, if applicable
    - Daily activities
    - Physical environment
    - With whom to interact

19. Other legal and constitutional rights.

403. Informing Beneficiary and/or Legal Guardian of their Rights

The beneficiary and/or legal guardian shall be informed of their rights. The Provider shall maintain documentation in the beneficiary's service record showing that the following information has been provided to the beneficiary or legal guardian in writing:

1. All service options available to the beneficiary, including those not presently provided by the Provider and any available non-disability specific settings.

2. A copy of the appeal procedure for decisions made by the Provider.

3. A list of available external advocacy services.

4. A document informing the beneficiary or legal guardian of their right to appeal any service decision to DDS, along with a copy of DDS Policy #1076 regarding appeal procedures.

5. The care coordinator's name and contact information.

6. The name and phone number of the DDS Waiver Manager for the area.

7. A document describing any positive behavior programming practices (including, but not limited to, restraints) used by the Provider.

404. Grievances and Appeals

1. The Provider must institute and maintain policies that provide beneficiaries the right to file formal complaints/grievances and appeals.

2. The Provider must make complaint procedures and, if applicable, forms, readily available to all beneficiaries and their legal guardians. The complaint and appeals procedures must be in writing and understandable to the beneficiaries and legal guardians.

3. Complaint and appeal procedures shall be explained to personnel, beneficiaries, and legal guardians in a format that is easily understandable and meets their needs. This explanation may include, but is not limited to, a video, audiotape, a handbook, and interpreters.

405. Financial Safeguards

This Section applies if the Provider serves as a representative payee of a beneficiary, is involved in managing the funds of the beneficiary, receives benefits on behalf of the beneficiary, or temporarily safeguards funds or personal property for the beneficiary. Every supportive living Provider must comply with this Section.

A. Financial Safeguards and Procedures

The Provider must demonstrate, to the reasonable satisfaction of DDS, that there is a system in place to protect the financial interests of all beneficiaries. Provider personnel that have any involvement with beneficiary funds and the beneficiary or their legal guardian must receive a copy of the Provider's Financial Safeguards Policies and Procedures.

1. The Provider is responsible for ensuring that each beneficiary's funds are used solely for the benefit of the beneficiary.

2. The Provider must ensure that the beneficiary is able to receive the benefit of those items/services for which they are paying. By way of illustration, if a beneficiary is paying for internet, the beneficiary should have a device with which to access the internet; if the beneficiary pays for a cell phone plan, then the beneficiary should have a functioning cell phone.

B. Access to Financial Records

Beneficiaries and their legal guardians must have access to financial records concerning the beneficiary's account/funds at all times.

C. Financial Safeguards Policy and Procedures

The Provider must implement policies that define:

1. How beneficiaries will provide informed consent for the expenditure of their funds.

2. How beneficiaries will access their financial records.

3. How beneficiary accounts/funds will be segregated and maintained for accounting purposes.

4. The safeguards and procedures in place to ensure that beneficiary funds are used only for designated and appropriate purposes.

5. How interest will be credited to the accounts of the beneficiaries, if applicable.

6. A mechanism that provides evidence that beneficiary funds were expended in the manner authorized.

D. Consent Requirements

The Provider shall obtain consent from the beneficiary or their legal guardian prior to implementing the following:

1. Limiting the amount of funds a beneficiary may expend or invest in a specific instance.

2. Designating the amount a beneficiary may expend or invest for a specific purpose.

3. Establishing time frames where a beneficiary is required to or prohibited from expending or investing their funds.

4. Delegating responsibility for expending or investing a beneficiary's funds.

E. Additional Group Residential Setting Requirements

1. **Budget Requirement**: In group living residential settings, Providers must establish an individual budget for each beneficiary. At a minimum, each budget must include a detailed breakdown of monthly personal income (SSI, family contributions, job income, etc.) and monthly personal expenses (rent, utilities, food, clothing, extra-curricular activities etc.). Providers will be monitored to ensure that the budget is being implemented properly. It is the Provider's responsibility to revise the budget with the help of the beneficiary or legal guardian if the budget does not accurately reflect the actual income and/or expenditures of the beneficiary.

2. **Record Maintenance**. It is the responsibility of the Provider to maintain records and receipts that provide verifiable evidence that each beneficiary's funds are being used solely for the benefit of the beneficiary, and are not being used for the benefit of another beneficiary residing in the same setting. Examples of such documentation might include, but are not limited to, grocery receipts, bank statements, and paid invoices.

3. Prohibition on Disproportionate Rental Payments: A beneficiary's personal resources may not be taken into account when determining how much they are required to pay in rent. In group residential settings all beneficiaries must be charged the same amount in rent each month unless there is verifiable and reasonable justification.

406. Waiver Eligibility Disqualification

DDS will not authorize or continue waiver services under the following conditions:

1. When the health and safety of the beneficiary, the beneficiary's staff, or others cannot be assured.

2. When the beneficiary or legal guardian has refused or refuses to participate in the PCSP development or to permit implementation of the PCSP or any part thereof that is deemed necessary to assure health and safety.

3. When the beneficiary or legal guardian refuses to permit the on-site entry of:

    - The care coordinator or PCSP Developer to conduct scheduled/required visits,
    - Direct care staff to provide scheduled care, and
    - DHS or CMS officials acting in their role as oversight authority for compliance or audit purposes.

4. When the beneficiary applying for or receiving waiver services requires twenty-four (24) hour nursing care on a continuous basis as prescribed by a physician.

5. When the beneficiary is incarcerated or an inmate in a state or local correctional facility.

6. When the beneficiary is deemed ineligible based on a DDS Psychological Team assessment or reassessment finding that the beneficiary does not meet ICF/IID level of care.

7. When the beneficiary is ineligible based on not meeting or not complying with Medicaid eligibility requirements.

500 SERVICE PROVISION

501. Person Centered Service Plan

All CES waiver services are delivered pursuant to a person centered service plan ("**PCSP**"), which is based on the Independent Assessment and other needs assessments. The PCSP must have measurable goals and specific objectives, measure progress through data collection, and be developed, overseen, and updated through consultation with a PCSP team that must include the beneficiary.

A. Beneficiary Participation and Approval Required

The beneficiary (and, if applicable, their legal guardian) must be an active participant in the PCSP planning and revision process. The Provider must ensure that the PCSP development, planning, and update process is driven to the maximum extent possible by the beneficiary/legal guardian. Providers shall deliver services based on the choices of the beneficiary/legal guardian.

The written PCSP must be finalized and agreed to with the informed consent of the beneficiary/legal guardian in writing and signed by all individuals and Providers responsible for its implementation (see § 42 CFR 441.725 B).

B. Interim Service Plan

When a beneficiary accesses CES Waiver services for the first time, the beneficiary is issued an interim service plan ("**ISP**") for up to sixty (60) days, until the PCSP can be developed and implemented. The ISP may include care coordination and supportive living for direct case supervision. DDS staff will track the expiration dates of ISPs and ensure that a PCSP is complete before the interim plan expires.

C. Initial PCSP Development Meeting

1. **Independent Assessment**: Every beneficiary must undergo an Independent Assessment performed by the designated DDS third party vendor prior to developing a PCSP for the beneficiary. The PCSP Developer must have the results of the Independent Assessment at the initial PCSP development meeting.

    - A beneficiary must receive an Independent Assessment through the designated DDS third party vendor at least once every three (3) years.

2. **Information Gathering**: Prior to the initial PCSP development meeting, in addition to the Independent Assessment, the PCSP Developer should secure for review as part of the meeting additional information which would be beneficial to the initial PCSP development process, including, but not necessarily limited to:

    - The results of any evaluations that are specific to the needs of the beneficiary

- The results of any psychological testing during eligibility determination
- The results of any adaptive behavior assessments conducted to establish eligibility

3. **Scheduling and Attendees**: The PCSP Developer is responsible for scheduling, coordinating, and managing the PCSP development meeting, including inviting other participants, making sure that the location and the participants are acceptable to the beneficiary. Ideally this PCSP development team would consist of some combination of the beneficiary and/or their legal guardian, the beneficiary's parents or other family supports, the assigned DDS Waiver representative, professionals that conducted assessments/evaluation of beneficiary, and others who might provide support to the beneficiary.

    - If the beneficiary or their legal guardian objects to the presence of any individual at the PCSP development meeting, then the individual is not permitted to attend the PCSP development meeting.

D. PCSP Requirements

Generally, the PCSP must reflect the services and supports that are important for the beneficiary to meet the needs identified in the Independent Assessment and other needs assessments, as well as what is important to the beneficiary with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the beneficiary, the written PCSP must:

1. Identify the setting in which the beneficiary chooses to reside.

2. Reflect the beneficiary's strengths, preferences, interests, and needs.

3. Reflect the beneficiary's clinical and support needs as identified through the Independent Assessment and other needs assessments.

4. Include individually identified goals and desired outcomes for the beneficiary.

5. Reflect the services and supports (both paid and unpaid) that will assist the beneficiary to achieve identified goals, and the providers of those services and supports, including natural supports.

6. Reflect the risk factors identified through the Independent Assessment and the measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be understandable to the beneficiary, and the individuals important in supporting him or her. At a minimum, the PCSP must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

8. Identify the care coordination Provider and the individual care coordinator responsible for monitoring the PCSP.

9. Be finalized and agreed to, with the informed consent of the beneficiary in writing, and signed by all individuals and Providers responsible for the PCSP's implementation.

10. Be distributed to the beneficiary and other individuals/Providers involved in the development and implementation of the PCSP.

11. Prevent the provision of unnecessary or inappropriate services and supports.

12. Document any modifications to the PCSP that are contrary to the home and community based settings requirements (See Section 1607 for documentation requirements).

D. PCSP Reviews and Updates

1. **Annual Update**: The PCSP Developer must review and update the PCSP with the beneficiary (and anyone else the beneficiary desires to attend) at least annually. The annual PCSP update process should be very similar to the initial PCSP development process. The beneficiary selects the participants on the PCSP update team. The care coordinator secures the available and appropriate data, information, assessments, and evaluations and presents it to the PCSP Developer and PCSP update team. The PCSP Developer will then develop an updated PCSP that meets all the requirements in Section C above. The discussions and activities involved at each annual update meeting must be documented and maintained by the PCSP Developer in the beneficiary's service file. The writing should document the beneficiary's input and participation in all aspects of the review.

    2. Updates to a PCSP can occur more often than once a year, but additional updates require DDS prior authorization.

2. **Beneficiary Requested Updates**: A beneficiary must be allowed to request an update of their PCSP at any time.

502. Behavior Management Plan

A. When Behavior Management Plans Are Required

The care coordinator must develop and monitor implementation of an appropriate behavior management plan incorporating positive behavior support strategies when:

1. Three (3) or more distinct challenging behaviors occur in a three (3) month period; or[1]

[1] "*Challenging Behaviors*" behaviors defined as problematic or maladaptive by others who observe the behaviors or by the person displaying the behaviors. They are actions that:

- Come into conflict with what is generally accepted in the individual's community,
- Often isolate the person from their community, or
- Are barriers to the person living or remaining in the community, and

2. Beneficiaries are prescribed psychotropic medications for behavior; or

3. Any other time the Provider, DDS Quality Assurance, or the DDS Psychological Team believes a beneficiary's behavior warrants intervention.

A Provider of direct care services must provide training to all staff who implement a behavior management plan. Training requirements include Introduction to Behavior Management, Abuse and Neglect and any other training as necessary.

B. Behavior Management Plans Generally

All behavior management plans must:

1. Prohibit behavior modification techniques that are punishing in nature, physically painful, emotionally frightening, depriving, or that put the beneficiary at medical risk.

2. Specify what behaviors, if any, require the use of restraints, the length of time to be used, person responsible for the authorization and the use of restraints (see Section 503 below), and the methods for monitoring the beneficiary and staff.

3. Prohibit the use of medications for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition, or for the purpose of chemical restraint.

4. Prohibit the use of mechanical restraints for the purpose of limiting or controlling challenging behavior. "Mechanical restraint" means any physical apparatus or equipment that cannot be easily removed by the beneficiary, restricts the free movement or normal functioning of beneficiary, or restricts normal access to a portion or portions of the beneficiary's body.

C. Behavior Management Plan Development

Behavior management plans must be written and monitored by a qualified professional who is, at a minimum, a Qualified Developmental Disabilities Professional ("QDDP"). The care coordination Provider (with input from the supportive living Provider) will develop a beneficiary's behavior management plan. All behavior management plans must:

1. Identify the behavior/s to be decreased.

2. Identify the behavior/s to be increased.

- Vary in seriousness and intensity.

3. Identify what things should be provided or avoided in the beneficiary's environment on a daily basis to decrease the likelihood of the identified behavior/s.

4. Identify the methods that staff should use to manage behavior/s.

5. Identify the event/s that appear to trigger the behavior/s.

6. Identify what staff should do if the triggering event/s occur.

7. Identify what staff should do if the behavior/s to be increased or decreased occur.

8. Should involve the fewest interventions or strategies possible.

9. Be designed so that the rights of the individual are protected.

10. Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or put the individual at medical risk.

D. Re-Evaluation of Behavior Management Plan

All behavior management plans must be re-evaluated at least quarterly. Behavior management plans must also be re-evaluated if:

1. Distinct behaviors occur three (3) or more times within a three (3) month period, which could all take place in one day; or

2. Any time that DDS determines that re-evaluation of the behavior management plan is appropriate under the circumstances.

Each Provider is responsible for maintaining written documentation sufficient to prove that any required re-evaluation was properly requested and conducted.

E. Data Collection for Behavior Management Plan

Each Provider delivering direct care services must collect data on the behavior management plan so that the effectiveness can be evaluated. A Provider delivering direct care services is required to:

1. Develop a simple, efficient, and manageable method of logging and collecting data regarding the implementation of the behavior management plan.

2. Data collection must include the frequency, length of time of each use, the duration of use over time and the impact of the use of interventions, if applicable.

3. Review the data regularly, and send the beneficiary to the behavior management plan developer (or other assigned QDDP) for re-evaluation if the strategies are not achieving the desired results.

503. Restraints & Restrictive Intervention

A. Behavior Management Plan Required

A Provider is prohibited from using any restraints or restrictive interventions on a beneficiary unless the beneficiary has a developed and implemented behavior management plan which incorporates alternative strategies to avoid the use of restraints and restrictive interventions, and includes the use of positive behavior support strategies as an integral part of the behavior management plan (See Section 502 "Behavior Management Plans"). There is a limited exception to this requirement when the use of an emergency restraint is necessary (See Section 503 (E) "Emergency Restraint")

B. Definitions of Restraints and Interventions

1. "**Physical restraint**" or "**personal restraint**": the application of physical force without the use of any device (manually holding all or part of the body), for the purpose of restraining the free movement of a beneficiary's body. This does not include briefly holding, without undue force, a beneficiary in order to calm them, or holding a beneficiary's hand to escort them safely from one area to another.

2. "**Physical Intervention**": the use of a manual technique intended to interrupt or stop a behavior from occurring.

3. "**Restrictive intervention**": procedures that restrict or limit a beneficiary's freedom of movement, restricts access to their property, prevents them from doing something they want to do, requires them to do something they do not want to do, or removes something they own or have earned. The definition would include the use of "time-out," in which a beneficiary is temporarily, for a specified period of time, removed from positive reinforcement or denied opportunity to obtain positive reinforcement for the purpose of providing the beneficiary with the opportunity to regain self-control. Under no circumstances may a beneficiary be physically prevented from leaving.

4. "**Mechanical restraint**": any physical apparatus or equipment used to limit or control a challenging behavior. This would include any apparatus or equipment that cannot be easily removed by the beneficiary, restricts the beneficiary's free movement or normal functioning, or restricts normal access to a portion or portions of the beneficiary's body.

    - ***Under no circumstances are mechanical restraints permitted to be used on a beneficiary***.

5. "**Chemical restraint**": the use of medication for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition.

    - ***Under no circumstances are chemical restraints permitted to be used on a beneficiary***.

6. "**Seclusion**": the involuntary confinement of a beneficiary alone in a room or an area from which the beneficiary is physically prevented from having contact with others or leaving.

    - ***Under no circumstances is seclusion permitted to be used on a beneficiary***.

C. Use of Restraints and Interventions

Permitted restraints and interventions may be used only when a challenging behavior exhibited by the beneficiary threatens the health or safety of the beneficiary or others. The use of restraints or interventions must be supported by a specific assessed need as justified in the beneficiary's PCSP, and only performed as provided in the beneficiary's behavior management plan.

1. **Required Prior Counseling**: Before a "time out," an absence from a specific social activity, or a temporary loss of personal possession is implemented, the beneficiary must first be counseled about the consequences of the behavior and the choices they can make.

2. **Direct Observation**: A beneficiary must be continuously under direct visual and auditory observation by staff members during any use of restraints or interventions.

3. **Specialized Restraint and Intervention Training**: All personnel who are involved in the use of restraints or interventions must receive training on and be qualified to perform, implement, and monitor the particular restraint or intervention as applicable. Additionally, personnel should receive training in in behavior management techniques, and abuse and neglect laws, rules, regulations and policies.

4. **Restraint and Intervention Identification**: The Provider is required to advise all staff, families, and beneficiaries on how to recognize and report the unauthorized use of a restraint or restrictive intervention.

D. Required Restraint and/or Intervention PCSP Information

Any PCSP and behavior management plan permitting the use of restraints or interventions must include the following information:

1. Identify the specific and individualized assessed need for the use of the restraint or intervention.

2. Document the positive interventions and supports used prior to any modifications to the PCSP that permits use of restraint or interventions.

3. Document the less intrusive methods of behavior modification that were attempted but did not work.

4. Include a clear description of the condition that is directly proportionate to the specific assessed need.

5. Include regular collection and review of data to measure the ongoing effectiveness of the modification to the PCSP that permitted the use of a restraint or intervention.

6. Include established time limits for periodic reviews to determine if the use of restraint or intervention is still necessary or can be terminated.

7. Include the informed consent of the beneficiary or legal guardian.

8. Include an assurance that the use of the restraint or intervention will cause no harm to the beneficiary.

E. Emergency Restraint

Personal restraints (use of staff member's body to prevent injury to the beneficiary or another person) are allowed in cases of emergency, even if a behavior management plan incorporating the use of restraints has not been developed and implemented. An "emergency" exists in the following situations:

1. The beneficiary has not responded to de-escalation or other positive behavior support strategies and the behavior continues to escalate.

2. The beneficiary is a danger to themselves or others.

3. The safety of the beneficiary and those nearby cannot be assured through positive behavior support strategies.

The care coordinator must request an interdisciplinary team meeting to revise the PCSP and implement a behavior management plan when there are more than three (3) emergency restraint incidents within a three (3) month period. It is an emergency restraint "incident" if each of the following occurred:

- A behavior was exhibited
- A restraint procedure was used
- The beneficiary was no longer thought to be dangerous
- The restraint procedure was discontinued

F. Reporting each Incident where Restraint or Intervention was Used

An incident report must be completed and submitted to DDS Quality Assurance in accordance with Section 300 herein no later than the end of the second business day following the date any restraint or restrictive intervention is administered. If the use of a restraint or restrictive intervention occurs more than three (3) times in any thirty (30) day period, permitted use of restraints and interventions must be

discussed by the PCSP development team, addressed in the PCSP, and implemented pursuant to an appropriate behavior management plan.

Any use of restraint or intervention, whether permitted or prohibited, also must be documented in the beneficiary's daily service log, maintained it their service record, and must include the following information:

1. The behavior initiating the use of restraint or intervention.
2. The length of time the restraint or intervention was administered.
3. The name of the personnel that authorized the use of the restraint or intervention.
4. The names of all individuals involved and outcomes of the use of the restraint or intervention.

504. Medication Management Plan and Medication Logs

The Provider delivering care coordination must develop a medication management plan for any beneficiary with prescribed medications. Providers delivering direct care services must maintain an accurate and up-to-date medication log for all beneficiaries to whom the Provider is responsible for administering medications, whether prescribed, pro re nata ("**PRN**"), or over-the-counter. A Provider must maintain written evidence of any beneficiary or legal guardian electing to administer all prescribed medications themselves.

A. Medication Management Plan

The care coordination Provider (with input from the supportive living Provider) must develop a medication management plan for all beneficiaries with prescribed medication/s. A medical prescription for medications, services, and level of care must be obtained annually. When medication is used to treat a specifically diagnosed mental illness, the prescribed medication must be managed by a psychiatrist who periodically provides information regarding the effectiveness of, and any side effects experienced from the medication. The prescription and management may be by a physician, if a psychiatrist is not available. Medications may NOT be used to modify behavior in the absence of a specifically diagnosed mental illness, or for the purpose of chemical restraint.

1. Each medication management plan must include:

    - How each medication will be administered (i.e. times, doses, delivery, etc.) and charted.
    - A list of potential side effects caused by any medication/s.
    - A description of the reason each medication has been prescribed and the related symptoms.
    - The beneficiary/legal guardian's consent to the administration of the medication/s.
    - How each medication must be administered and by whom, in order to comply with the Nurse Practice Act and the Consumer Directed Care Act. This would include a list which medications may be administered by which staff.

2. For all prescribed psychotropic medications due to behaviors, the care coordination Provider shall develop and implement a behavior management plan and update as necessary (See Section 502).

3. Providers are required to provide training to direct care staff which details the specifics of the beneficiary's medical management plan, including possible side effects.

4. Direct care staff members are required to be re-trained on the medication management plan and behavior management plan (if applicable) any time medications are updated.

B. Medication Logs

1. **Prescription Medications**: Providers delivering direct care services must maintain medications logs detailing the administration of prescribed medications to the beneficiary. The prescribed medication logs must be readily available for DDS review, and document the following for each administration of a prescribed medication:

- Name and dosage of the medication administered.
- Route the medication was administered.
- Date and time the medication was administered (recorded at the time of medication administration).
- Initials of the staff administering or assisting with the administration of the medication.
- Any side effects or adverse reactions to the medication.
- Any errors in administering the medication.

2. **PRN and Over-the-Counter Medications**: Providers delivering direct care services must also maintain logs concerning the administration of PRN and over-the-counter medications. The logs for the administration of prescription PRN and over-the-counter medications must document the following:

- How often the medication is used.
- Date and time each medication was administered (recorded at the time of medication administration).
- The circumstances in which the medication is used.
- The symptom for which the medication was used.
- The effectiveness of the medication.

3. **Medication Administration Error Reporting/Charting**: Any medication administration errors occurring or discovered must be recorded in the medication log and immediately reported to a supervisor. "Medication administration errors" include, but are not limited to, the loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time or by the wrong route, the administration of the wrong medication, and the discovery of an unlocked medication lock box that is supposed to be locked at all times.
    - An incident report must be filed with DDS Quality Assurance in accordance with Section 300 for any medication administration error that caused or had the potential to cause serious injury or illness to a beneficiary.

4. **Required Oversight Documentation**: Each Provider delivering direct care services must ensure that supervisory level staff (commonly titled Direct Care Supervisor) review on at least a monthly basis all beneficiary medication logs to determine if:

    - All medications were administered accurately as prescribed.
    - The medication is effectively addressing the reason for which it was prescribed.
    - Any side effects are noted, reported, and being managed appropriately.

505. Daily Service Activity Logs

Daily service activity logs must be maintained by all Providers delivering direct care services in order to provide specific information relating to the individually identified goals and desired outcomes for the beneficiary, so that the care coordinator, PCSP Developer, and PCSP development team can measure and record the progress on each of the beneficiary's identified goals and desired outcomes. There is no required format for a daily service activity log; however, the daily service activity logs must document the following:

1. The name and sign-in/sign-out times for each direct care staff member.

2. The specific services furnished.

3. The date and actual beginning and ending time of day the services were performed.

4. Name(s) of the staff/person(s) providing the service(s).

5. The relationship of the services to the goals and objectives described in the beneficiary's individualized PCSP.

6. Daily progress notes/narrative signed and dated by the staff delivering the service(s), describing each beneficiary's progress or lack thereof with respect to each of his or her individualized goals and objectives. This would include any behavior management plan data required to be maintained pursuant to Section 502(E) above.

506. Beneficiary Service Records

A. Required Service Record Documentation

Each Provider delivering care coordination services or direct care services to a beneficiary must establish a service record for the beneficiary. At a minimum, the service record file must contain:

1. Independent Assessment
2. A copy of the PCSP
3. Behavior management plan with proper beneficiary/legal guardian approval, if applicable
4. Daily service activity logs
5. Care coordinator monthly contact reports
6. Completed forms as required by DDS, including, but not limited to, Form DHS-704, ACS/CES-703, and ACS/CES-102
7. Fully approved medication management plan and Medication logs, or signed election to self-administer medication (see Section 504), if applicable
8. Fully executed copy of lease, residency agreement, or other form of written agreement that provides protections that address eviction processes and appeals comparable to those provided under a landlord-tenant law
9. Any documentation providing additional individuals with access to a beneficiary's service record
10. Documentation required in Section 403
11. Guardianship Order, if applicable
12. Any specific documentation required by a particular CES Waiver service used by the beneficiary

B. Face Sheets

A summary document ("Face sheet") must be maintained at the front of a beneficiary's service record file, which must document the following:

1. Full name of beneficiary
2. Address, county of residence, telephone number and email address, if applicable
3. Marital status, if applicable
4. Race and gender
5. Birth date
6. Social Security number
7. Medicaid Number
8. Legal status
9. Legal guardian's name and address and relationship, if applicable
10. Name, address, telephone number and relationship of person to contact in emergency
11. Health insurance benefits and policy number
12. Primary language
13. Admission date

14. Statement of primary/secondary disability
15. Physician's name, address, and telephone number
16. Current medications with dosage and frequency, if applicable
17. All known allergies or indicate none, if applicable

Face sheets must be updated as needed and after each PCSP update. Any update to a Face Sheet must be signed and dated by the person entering the update.

C. Beneficiary Records Maintenance & Storage Retention Requirements

1. **Confidentiality**: A Provider shall maintain complete service records/files and treat all information related to beneficiaries as confidential. Access to beneficiary service files must be limited to only those staff members who have a need to know the information contained in the records of the beneficiary. The only individuals that may access a beneficiary's files and records are:

    - The beneficiary
    - The legal guardian of the beneficiary, if applicable
    - Professional staff providing direct care or care coordination services to the beneficiary
    - Authorized Provider administrative staff
    - Any other individual authorized by the beneficiary or their legal guardian

    Adult beneficiaries who are legally competent shall have the right to decide whether their family will be involved in planning and implementing their PCSP, and a signed release or document shall be present in their service record either granting permission for family involvement or declining family involvement.

2. **HIPAA Regulations**: Each Provider shall ensure that information that is used for reporting or billing shall be shared according to confidentiality guidelines that recognize applicable regulatory requirements such as the Health Insurance Portability and Accountability Act ("**HIPAA**").

3. **Electronic and Paper Records/File Maintenance**: Electronic service records are acceptable. Paper and electronic service records must be uniformly organized and easily accessible. A list of the order of the service record information shall either be present in each beneficiary's service record or provided to DDS upon request. The documents in active service records should be organized in a systematic fashion. An indexing and filing system must be maintained for all service records.

4. **Storage Location**: The location of the files/service records, and the information contained therein, must be controlled from a central location.

5. **Direct Care Staff Access**: The Provider shall ensure all direct care and care coordination staff has adequate access to the beneficiary's file/service record including, current PCSP and other pertinent information necessary to ensure the beneficiary's health, welfare, and safety (i.e., name and telephone number of physician(s), emergency contact information, insurance information, etc.).

6. **Record/File Retention**: Each Provider must retain all files/services records for five (5) years from the date of service or until all audit questions or review issues, appeals hearings, investigations or administrative or judicial litigation to which the files/services records may relate are finally concluded, whichever period is later. Failure to furnish medical records upon request may result in sanctions being imposed. Federal legislation further requires that any accounting of private healthcare information ("PHI") or HIPAA polices or complaints must be retained for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

7. **Access Sheets**: Access sheets shall be located in the front of the service record to maintain confidentiality according to 5 U.S.C. § 552a. If there is a signed release for a list of authorized persons to review the service record, only those not listed will need to sign the access sheet with date, title, reason for reviewing, and signature. If there is not a signed release for authorized persons to review, all persons must sign the access sheet whenever the service record is reviewed or any material is placed in the service record.

D. DDS Access to Beneficiary Files/Service Records

DDS shall have access to all beneficiary files/service records maintained by the Provider at any time upon demand.

507. Refusal to Serve

Providers shall not refuse services to any beneficiary unless the Provider cannot ensure the beneficiary's health, safety, or welfare. When a Provider is unable to serve a beneficiary, the Provider must notify the DDS Waiver Specialist within two (2) working days in order for choice to be offered to the beneficiary.

1. If a Provider is unable to ensure a beneficiary's health, safety, or welfare because qualified personnel are unavailable to deliver services to the beneficiary, the Provider should be able to demonstrate efforts to employ and retain qualified personnel and the results of those efforts. The documentation submitted by Provider should demonstrate:

    - Recruitment efforts
    - Retention efforts
    - Identification of any trends in personnel turnover

2. If the Provider is unable to ensure a beneficiary's health, safety, or welfare because adequate housing is not available, the Provider should develop and propose to the beneficiary alternative housing arrangements and locations within the beneficiary's resources. If the beneficiary is unable or unwilling to accept any of the proposed alternative housing arrangements or locations, the Provider shall document that the beneficiary has refused available resources and shall immediately notify the DDS Waiver Specialist.

3. The intent of this Section 507 is to prevent and prohibit Providers from implementing a selective admission policy based on the perceived "difficulty" of serving a beneficiary. Whether a Provider is refusing to serve based on legitimate beneficiary health, safety, or welfare concerns shall be determined in the sole discretion of DDS. DDS approval for refusal of services shall depend on the documented efforts made by the Provider to find housing and a determination of whether staffing can be provided by increasing the hourly rate of pay.

508. Transitioning Beneficiary

1. Corroboration and Responsibility: If it is necessary to transition a beneficiary to another Provider due to beneficiary choice, inability to serve, transition to an intermediate care facility, or any other reason, the current service Provider must fully cooperate with the care coordinator and any new service Provider in order to ensure a smooth transition process and the continuous delivery of services. The current service Provider shall remain responsible for the health, safety, and welfare of the beneficiary until the transition to the new service Provider is complete.

2. Turnover of Paperwork/Records: The current Provider must provide copies of the beneficiary's files, service records, data, and other paperwork without delay. If all copies of requested paperwork have not been provided to the care coordinator, DDS Waiver Specialist or the new Provider within thirty (30) days of the request, it is presumed to be unreasonable delay in violation of these Certification Standards.

3. Provider as Representative Payee: If the current Provider is serving as the transitioning beneficiary's representative payee (i.e. responsible for the beneficiary's finances), then within seven (7) days of the beneficiary's decision to transition the current Provider must submit the necessary paperwork to the Social Security Administration or any other necessary agency or financial institution. The current Provider is responsible for retaining written documentation evidencing that the necessary paperwork was submitted within the timeframe.

4. DDS Time-Extension: It is presumed any transition not completed within forty-five (45) calendar days from the date of the beneficiary's decision to transition is the result of undue delay by the current Provider. Notwithstanding the foregoing, a current Provider may submit written justification for any transition lasting longer than forty-five (45) calendar days to the beneficiary's DDS Waiver Specialist. DDS will determine if an extension is appropriate.

600 PROVIDER QUALIFICATIONS: SUPPORTIVE LIVING SERVICES

601. Supportive Living Responsibilities

1. Coordinating all supportive living staff that provide direct care to the beneficiary through the Provider;

2. Serving as a liaison between the beneficiary, parents, legal representatives, care coordinator and DDS representatives;

3. Coordinating schedules for both waiver and generic service categories;

4. Participating in planning and preparing the delivery of all supportive living services included in the initial PCSP and any annual or other PCSP update;

5. Assuring the integrity of all Medicaid waiver billing for all supportive living services delivered by Provider;

6. Arranging for the staffing of all alternative living settings;

7. Cooperating with the care coordinator and PCSP development team in developing a beneficiary's behavior management plan (see Section 502), if necessary, and then implementing, administering and collecting data relating to the behavior management plan;

8. Ensuring any necessary transportation is arranged for all supportive living services identified in the beneficiary's PCSP;

9. Collaborating with the care coordinator in a timely manner to obtain any Independent Assessment, comprehensive behavior and assessment reports, PCSP updates, and information and documents required for ICF/ID level of care and waiver Medicaid eligibility determination;

10. Reviewing the medication logs and daily service activity logs of the beneficiary to ensure the beneficiary is receiving appropriate services, medications and support in accordance with the PCSP and any medication management plan.

While the Provider may not staff a beneficiary on a 24/7 schedule, the Provider is responsible to ensure that sufficient staff is maintained to guarantee the health, safety, and welfare of each beneficiary, and to meet the established outcomes of the beneficiary as stated in their PCSP. Sufficiently trained staff shall be on duty at all times. Provisions shall be made for relief of supportive living staff during vacations, other relief periods and unplanned absences. Providers must have

backup plans in place to address contingencies if scheduled staff are unable, fail, or refuse to provide supportive living services.

602. Minimum Qualifications

Direct Care Staff

The Provider is responsible for the interviewing, hiring, firing, training, and scheduling of direct care staff providing supportive living services. Providers must ensure that all staff providing direct care services have one of the following:

- A high school diploma or GED;
- One (1) year of relevant, supervised work experience with a public health, human services or other community service agency; **OR**
- Two (2) years' verifiable successful experience working with individuals with developmental disabilities.

603. Medication Administration and Logs

1. Medication Administration

   Supportive living Providers must ensure that the beneficiary's medication management plan (See Section 504) incorporates measures which describe how direct care staff will administer or assist with the administration of medications. The Provider must ensure the medication management plan describes how the medication/s must be administered and by whom, in order to comply with the Nurse Practice Act and the Consumer Directed Care Act.

2. Medication Logs

   The supportive living Provider has an on-going responsibility for monitoring beneficiary medication regimens. Providers must ensure that supportive living staff are at all times aware of the medications used by the beneficiary, and are knowledgeable of potential side effects. See Section 504(B) above for the specific medication log requirements.

604. Daily Service Activity Logs

Providers must maintain daily service activity logs for each beneficiary. See Section 505 above for the specific requirements.

605. Training Requirements

1. First Aid Training: Within thirty (30) days of hiring, all supportive living staff, and any other staff of a supportive living Provider that may be required to provide emergency direct care services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

    - The course must provide a certificate of completion that can be maintained in the supportive living staff's personnel file.

    - Any services provided by a supportive living staff person prior to receiving the above described First Aid Training can only be performed in a training role, under the supervision of another supportive living staff person that has already had the required First Aid Training.

    - Training Certification must be maintained and kept up to date throughout the time any supporting living staff is providing services.

2. Beneficiary Specific Training: Prior to beginning service delivery, supportive living staff must receive the amount of individualized, beneficiary-specific training that is necessary to be able to effectively and safely provide the supportive living services required pursuant to the beneficiary's PCSP, including, but not limited to:

    - general training on beneficiary's PCSP
    - behavior management techniques/programming;
    - medication administration and management;
    - setting-specific emergency and evacuation procedures
    - appropriate and productive community integration activities; and
    - training specific to certain medical needs.

    Documentation evidencing that the necessary types and amount of beneficiary-specific training were completed must be maintained in the personnel file of the supportive living staff member at all times. This type of individualized, beneficiary-specific training shall be required each time a beneficiary's PCSP is updated, amended, or renewed.

3. Other Required Training: supportive living staff must receive appropriate training on the following topics at least once every two (2) calendar years:

    - HIPAA Policies and Procedures
    - Procedures for Incident Reporting

- Emergency and Evacuation Procedures
- Introduction to Behavior Management
- Arkansas Guardianship statutes
- Arkansas Abuse of Adult statutes
- Arkansas Child Maltreatment Act
- Nurse Practice Act
- Appeals Procedure for Individuals Served by the Program
- Beneficiary Financial Safeguards
- Community Integration Training
- Procedures for Preventing and Reporting Maltreatment of Children and Adults
- Other topics where circumstances dictate that supportive living staff should receive training to ensure the health, safety, and welfare of the beneficiary.

Documentation evidencing that training on the topics has been completed must be maintained in the personnel file of the supportive living staff member at all times.

4. DDS QA Mandated Training: DDS Quality Assurance has the ability to require a supportive living provider to conduct/administer specified training to an individual, a group, or all supportive living staff working for the Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each supportive living service staff member at all times.

700 PROVIDER QUALIFICATIONS: CARE COORDINATION SERVICES

Starting in October 2017, care coordination will begin to be phased out as a CES Waiver service. In October 2017, DHS and DDS will implement a Provider-led Managed care model for case management/care coordination where an independent third party vendor will conduct an Independent Assessment of each beneficiary for a tier determination, as well as a needs and risks assessment. Upon receiving the results of the Independent Assessment, the beneficiary will be attributed to and enrolled in a Provider-led Share Savings Entity ("**PASSE**"). Once a beneficiary is enrolled in a PASSE, care coordination services will no longer be available to the beneficiary as a CES Waiver service. Care coordination services will be performed by the PASSE under a separate home and community based services waiver.

701. Conflict Free Case Management

A Provider delivering care coordination services to a beneficiary must follow the federal conflict free case management rules.

702. Care Coordinator Minimum Qualifications

A. Care coordination Providers must require each care coordinator to meet the following minimum qualification criteria:

1. Be a Registered Nurse (R.N.), a physician, or have a bachelor's degree in a social science or health-related field; **OR**

2. Have at least one (1) year of experience working with developmentally or intellectually disabled clients or behavioral health clients;

B. Person Centered Service Plan Developer

Providers must require any supportive living staff responsible for the development of a beneficiary's PCSP ("**PSCP Developer**") to meet one of the following minimum qualification criteria:

1. A Bachelor's degree in a human services related field.

2. Two (2) or more years college credit in the field of human services, and two (2) years' experience working with individuals with developmental disabilities.

3. Two (2) or more years' experience working with individuals with developmental disabilities, and two (2) additional years of mentoring/training under a case manager.

4. Four (4) or more years' experience working as a case manager in a related field

703. <u>Care Coordination Responsibilities</u>

Care coordination services include responsibility for guidance and support in all life activities including the following:

1. Coordinating and arranging for the provision of all CES Waiver services and other state plan services;

2. Identifying and accessing needed medical, social, educational, and other publicly funded sources (regardless of funding source);

3. Identifying and accessing informal community supports needed by beneficiaries and their families;

4. Providing the beneficiary with guidance and support for their generic needs;

5. Coordinating and monitoring the implementation of all services identified on the beneficiary's PCSP, whether such services are home and community based waiver services, state plan services or generic services;

6. Coordinating with and monitoring the beneficiary's supportive living and other direct care Providers to ensure quality of care and service delivery;

7. Monitoring the beneficiary to assure their health, safety, and welfare;

8. Facilitating crisis intervention for the beneficiary;

9. Securing, scheduling, and/or conducting the beneficiary's Independent Assessment, other appropriate needs assessments, evaluations, and referrals for resources when required/necessary;

10. Providing the beneficiary with assistance in connection with continuing waiver Medicaid eligibility and obtaining ICF/IID level of care eligibility determinations;

11. Monitoring the beneficiary to ensure that the services and supports meet the needs, goals, and objectives identified in PCSP, with regard to the beneficiary's preferences for the delivery of such services and supports, and ensuring that the PCSP is revised/updated if the current services and supports are ineffective or the beneficiary's preferences change;

12. Assuring submission of timely and comprehensive behavior and assessment reports, updated PCSP, revisions to PCSP, and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;

13. Informing the beneficiary of their rights, providing support and training to each beneficiary so that they may identify attempts at exploitation, and arranging for a beneficiary to have access to advocacy services when requested;

14. Upon receipt of DDS approvals and denials, ensuring that a copy of each approval and denial is provided to the beneficiary or their legal representative;

15. Providing support and assistance with appeals when a beneficiary receives an adverse decision and desires to appeal the decision;

16. Assisting the beneficiary with transitioning between service settings or service Providers;

17. Assisting the beneficiary with selecting a primary care physician ("**PCP**") or providing a referral to a person centered medical home ("**PCMH**"), if necessary.

704. PCSP Development Responsibilities

Provider is responsible for the development of a beneficiary's person centered service plan ("**PCSP**") and ensuring the delivery of all supportive living services including the following activities:

11. Developing/updating the beneficiary's PCSP in cooperation with the beneficiary or the beneficiary's legal representative, and any other individual/s the beneficiary/legal representative wishes to have participate on the PCSP development team.

    - The PSCP developer is responsible for scheduling, coordinating, and managing the PCSP development/update meetings, including inviting other participants, and making sure that the location and the participants are acceptable to the beneficiary.

    - If the beneficiary objects to the presence of any individual at a PCSP development/update meeting, then that individual is not permitted to attend the PCSP development meeting.;

12. Scheduling, coordinating, and managing the PCSP annual update and any other necessary updates, including inviting other participants, making sure that the location and the participants are acceptable to the beneficiary;

705. Caseload Limit

No individual providing care coordination services is permitted to have more than fifty (50) beneficiaries on their case load at any one time.

706. Mandatory Beneficiary Contact

1. Monthly Contact: The care coordinator must stay in regular contact with each beneficiary, and must have face-to-face contact with each beneficiary at least once a month. After the initial contact, these monthly contacts can be made via video-conferencing. During each contact the care coordinator should discuss issues related to services and supports the beneficiary is supposed to be receiving pursuant to their PCSP, including, but not limited to:

    - Whether or not the beneficiary feels that their needs are being met.
    - Whether the beneficiary is satisfied with their Provider/s.
    - Inform the beneficiary they are always free to change Providers.
    - Whether there are any beneficiary health, safety, or welfare concerns.

    The care coordinator must report any service gap of thirty (30) consecutive days to the DDS Wavier Specialist assigned to the beneficiary. The report must include the reason for the gap and identify remedial action to be taken. A copy of the report must be maintained in the beneficiary's service record file.

2. 24 Hour Availability: The Provider must ensure that care coordination services are available to a beneficiary twenty-four (24) hours a day through a hotline or web-based application.

3. Crisis Contact: If the beneficiary is seen in an emergency room, urgent care clinic, or is admitted to an acute inpatient psychiatric facility, the care coordinator must follow up with the beneficiary within seven (7) days of discharge from the facility. The visit is to ensure that all discharge instructions are being followed and any follow-up appointments have been scheduled.

4. Required Documentation: The care coordinator must document all monthly contacts with the beneficiary and maintain the documentation in the beneficiary's service record file. Documentation shall include:

    a) The date and time of the contact/meeting

    b) The location of the contact/meeting

    c) The individuals present during the contact/meeting

    d) A summary of the contact/meeting

    e) Any requests by the beneficiary for change in services or new services

    f) The documentation reciting the above required details must be signed by the care coordinator and the beneficiary.

707 Request to Change Provider

A beneficiary or their legal guardian may initiate a request to change Providers by contacting (written or verbally) their care coordinator. If a request to change Provider is received by the care coordinator, the care coordinator shall forward the request to the DDS Waiver Specialist within two (2) working days of its receipt. The current service Provider will remain responsible for delivery of services until such time as the transition to the new Provider is complete. When there is a request to change Providers, the care coordinator is responsible for overseeing and facilitating the transition process, including, but not limited to the following:

- Facilitating a transitional meeting with any direct care service Provider/s;
- Collecting the beneficiary's service record file and other available information for the transitional meeting;
- Determining the effective date for transfer of service responsibilities; and
- Ensuring that the beneficiary does not suffer a lapse in services due to the change in Providers.

708. Abeyance

A. Abeyance Generally

A beneficiary's waiver status is in "abeyance" when there is a cessation of implementation of the beneficiary's PCSP while the beneficiary is temporarily placed in a licensed or certified facility for the purposes of behavior, physical, or health treatment or stabilization. The beneficiary will remain eligible for and enrolled in the CES Waiver without harm during an abeyance period. The care coordinator is responsible for requesting for a beneficiary's status to be placed into abeyance by contacting the DDS Waiver Specialist. The request for abeyance must be in writing and include all supporting evidence. Approval of a request for abeyance is made by DDS, and will be made for an initial period of up to ninety (90) days.

A beneficiary "living" in a public institution is not eligible for Medicaid or CES Waiver services, and an abeyance request cannot be granted in such circumstances. Public institutions include county jails, state and federal penitentiaries, juvenile detention centers, and other correctional or holding facilities.

B. Abeyance Extensions

The abeyance period may be extended in ninety (90) day increments for up to one (1) year total. Each request for continuance must be submitted in writing and supported by evidence of treatment status or progress. Requests for continuance must be made prior to the expiration of the abeyance period.

C. Required Contact

A care coordinator must continue monitoring contact with a beneficiary whose case is in abeyance. The care coordinator must have a minimum of one (1) face-to-face visit or contact each month and

report the status to the applicable DDS Waiver Specialist. After the initial contact, these monthly contacts can be made via video-conferencing. Monthly status reports are required to be submitted to the DDS Waiver Specialist as long as the person is in abeyance.

709. Adaptive Equipment and Environmental Modifications

The care coordinator is responsible for handling adaptive equipment and environmental modification purchases for a beneficiary. Equipment may be purchased only when unable to be purchased through any other source, and all equipment must be solely for the use of the beneficiary.

1. Mandatory Consultation Threshold: When the purchase price of any single piece of equipment or single modification is $500 or greater, the care coordinator must seek an appropriate professional consultation to ensure that the equipment or modification to be purchased will meet the intended need of the beneficiary.

2. Mandatory Bidding Threshold: When any equipment or modification will be in excess of $1,000, the care coordinator must attempt to obtain at least three bids. The bids must be awarded to the lowest bid that meets the required quality level.

3. Final Inspection: Final inspection for the quality of the equipment or modification and compliance with specifications and local codes is the responsibility of the care coordinator. Payment to the supplier/contractor will be withheld until DDS receives a customer satisfaction statement signed by the care coordinator certifying that (i) the equipment/modification authorized has been delivered/completed, (ii) the beneficiary's property has been left in satisfactory condition, and (iii) any incidental damages have been repaired.

4. Required Documentation: The care coordinator must maintain in the beneficiary's service file written documentation evidencing that any required professional consultation and bidding was conducted as part of any adaptive equipment or environmental modification purchase. If a care coordinator is unable to secure three (3) bids, then the care coordinator must be able to document their efforts of the unsuccessful steps taken to secure the required three (3) bids.

7010. Training Requirements

1. First Aid Training: Within thirty (30) days of hiring, all care coordination staff, and any other staff of a care coordination provider that may be required to provide emergency services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

- The course must provide a certificate of completion that can be maintained in each care coordinator's personnel file.

- Training Certification must be maintained and kept up to date throughout the time any care coordinator is providing care coordination services.

2. Other Required Training: care coordinators must receive appropriate training on the following topics at least once every two (2) calendar years:

    - HIPAA Policies and Procedures
    - Procedures for Incident Reporting
    - Emergency and Evacuation Procedures
    - Introduction to Behavior Management
    - Arkansas Guardianship statutes
    - Arkansas Abuse of Adult statutes
    - Arkansas Child Maltreatment Act
    - Nurse Practice Act
    - Appeals Procedure for Individuals Served by the Program
    - Community Integration Training.
    - Procedures for Preventing and Reporting Maltreatment of Children and Adults
    - Other topics where circumstances dictate that care coordinators should receive training to ensure the health, safety, and welfare of the beneficiary served.

    Documentation evidencing that training on the topics listed above was completed must be maintained in the personnel file of each care coordinator at all times.

3. DDS QA Mandated Training: DDS Quality Assurance has the ability to require a care coordination Provider to conduct/administer specified training to an individual care coordinator, a group of care coordinators, or all care coordinators working for the Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each care coordinator at all times.

800 PROVIDER QUALIFICATIONS: ADAPTIVE EQUIPMENT (ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS)

801. Adaptive Equipment Units

1. The Provider must deliver professional, ongoing assistance when needed to evaluate and adjust any equipment delivered and/or to instruct the beneficiary or the beneficiary's caregiver in the use of equipment furnished.

2. The Provider must have the prior approval of DDS for any adaptive equipment items purchased and delivered. Equipment may only be covered if not available to the beneficiary from any other source.

802. Liability

1. The Provider must assume liability for equipment, supplies, warranties and must install, maintain, and/or replace any defective parts or items specified in those warranties. Replacement items or parts for adaptive equipment are not reimbursable as rental equipment.

2. The Provider must, in collaboration with the care coordinator, ascertain and recoup any third-party resource(s) available to the consumer prior to billing DDS or its designee. DDS or its designee will then pay any unpaid balance up to the lesser of the Provider's billed charge or the maximum allowable reimbursement.

803. Records of Adaptive Equipment

The Provider must submit the price for equipment and/or supplies to be purchased or rented within five (5) business days of the care coordinator's request for a bid. The Provider must maintain a record for each order. The documentation shall consist of:

1. The date the order was received and the name of the care coordinator placing the order.

2. The price quoted for the equipment and/or supplies.

3. The date the quote was submitted to the care coordinator.

The Provider must maintain a record for each beneficiary. The record must document the delivery, installation of the equipment purchased or rented, any education and/or instructions for the use of the equipment and/or supplies provided to the beneficiary, and must include documentation of delivery of item(s) to the beneficiary. The documentation shall consist of:

1. The beneficiary's signature, the signature of the beneficiary's caregiver or electronic verification of delivery.

2. The date on which the equipment and/or supplies were delivered.

900 PROVIDER QUALIFICATIONS: ENVIRONMENTAL MODIFICATION SERVICES

901. Required Credentials

Providers must be appropriately licensed and bonded in the State of Arkansas, as required, or have other appropriate credentials to perform jobs requiring specialized skills, including but not limited to:

- Electrical
- HVAC
- Plumbing
- General Contracting

All services must be completed as directed by the beneficiary's PCSP, and in accordance with all applicable state or local building codes. Environmental modifications must be made within the existing square footage of the residence.

902. Documentation

Providers must obtain and maintain the following documentation:

1. The written consent of the property owner to modify the property. When appropriate, the Provider must ensure that the owner understands that the property will be left in the modified state after the beneficiary vacates the premises.

2. An original photo of the site where modifications will be done.

3. A to-scale sketch plan of the proposed modification project.

4. Any necessary inspections, inspection reports, and permits required by federal, state and local laws either prior to commencing work or upon completion of each job to verify that the repair, modification or installation was completed. The Provider must obtain these inspections, inspection reports, and permits prior to billing for the completed job.

5. A signed and dated authorization from the beneficiary's care coordinator, or care coordinator's designee, for each job order prior to commencing work.

6. Written evidence that the Provider has informed the beneficiary and DDS or its designee of any health and/or safety risks expected during the job. The Provider is required to assist the beneficiary and care coordinator to coordinate dates and times of work to assure minimal risk of hazard to the beneficiary.

7. Obtain the beneficiary's or legal guardian's signature and the care coordinator's signature at job completion in order to certify that the work authorized has been completed, the beneficiary's property has been left in satisfactory condition, and any incidental damages have been repaired.

8. Maintain an itemized record of all expenses including materials and labor associated with the job order for a minimum of five (5) years.

903. Warranty

The Provider must furnish a warranty covering workmanship and materials with the final invoice submitted to DDS or the care coordinator. DDS will not pay any invoice that is not accompanied by a warranty.

904. Payor of Last Resort

Environmental modifications may only be purchased if not available to the beneficiary from any other source. The Provider must, in collaboration with the care coordinator, ascertain and recoup any third-party resource(s) available to the consumer prior to billing DDS or its designee. When environmental modifications are included as a Medicaid state plan service, a denial by utilization review will be required prior to approval for Waiver funding by DDS.

1000 PROVIDER QUALIFICATIONS: SPECIALIZED MEDICAL SUPPLIES

1001. Specialized Medical Supplies

A physician must order or document the need for all specialized medical supplies. Specialized medical supplies include:

- Items necessary for life support or to address physical conditions along with, ancillary supplies and equipment necessary for the proper functioning of such items;
- Such other durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to address participant functional limitations.
- Necessary medical items not available under the Medicaid State Plan.

Additional items are covered as a waiver service when they are considered essential for home and community care. Items covered include:

- Nutritional supplements
- Non-prescription medications (alternative medicines not FDA approved are excluded from coverage)
- Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under the State plan are exhausted.

1002. Provider Requirements

1. The Provider must assure professional, ongoing assistance when needed to evaluate and adjust medical supplies delivered and/or to instruct the beneficiary or the beneficiary's caregiver in the use of the medical supplies furnished.
2. The Provider must have the prior approval of DDS for any medical supply items purchased and delivered.
3. The Provider must assume liability for medical supplies and must replace any defective items.
4. The Provider must, in collaboration with the care coordinator, ascertain and recoup any third-party resource(s) available to the beneficiary prior to billing DDS or its designee.

DDS or its designee will then pay any unpaid balance up to the lesser of the Provider's billed charge or the maximum allowable reimbursement.

1003. <u>Documentation</u>

The Provider must submit the price for medical supplies to be purchased or rented within five (5) business days of the care coordinator's request. The Provider must maintain a record for each order. The documentation shall consist of:

1. The date the order was received and the name of the care coordinator placing the order.

2. The price quoted for the item.

3. The date the quote was submitted to the care coordinator.

The Provider must maintain a record for each beneficiary. The record must document the delivery, installation of the item(s) purchased or rented, any education and/or instructions for the use of the equipment and/or supplies provided to the beneficiary, and must include documentation of delivery of item(s) to the beneficiary. The documentation must include:

- The beneficiary's signature, the signature of the beneficiary's caregiver or electronic verification of delivery.

- The date on which the equipment and/or supplies were delivered.

1100 PROVIDER QUALIFICATIONS: CONSULTATION SERVICES

1101. Licensed Professionals

Providers will be responsible for maintaining the necessary information to document staff qualifications. Selected staff or contract individuals may not provide training unless they possess the specific qualifications required. Consultant services are indirect in nature.

1102. Qualifications

Providers must ensure that any individual providing consultation has current credentials which correspond to the specific area of consultation they provide. Providers must be able to provide evidence that the following professionals providing consultation services through the Provider hold a current license or certification by the following licensing or certification board or organization:

1. Psychologists: hold a current license from the Arkansas Psychology Board as a Psychologist

2. Psychological examiners: hold a current license from the Arkansas Psychology Board as a Psychological Examiner

3. Mastered social workers: hold a current license as an LMSW or ACSW by the Arkansas Social Work Licensing Board

4. Professional counselors: hold a current license as a counselor by the Arkansas Board of Examiners in Counseling

5. Speech pathologists: hold a current license in Speech Therapy by the Arkansas Board of Audiology and Speech Language Pathology

6. Occupational therapists: hold a current license in Occupational Therapy by the Arkansas State Medical Board.

7. Physical Therapy: hold a current license in Physical Therapy by the Arkansas Board of Physical Therapy.

8. Registered Nurses: hold a current license as a Registered Nurse by the Arkansas Board of Nursing.

9. Certified parent educators: meet the qualifications of a Qualified Developmental Disabilities Professional as defined in 42 C.F.R. Subsection 483.430(a)

10. Certified communication and environmental control adaptive equipment/aids providers: be currently enrolled as a provider of Durable Medical Equipment with the Arkansas Medicaid Program.

11. Qualified Developmental Disabilities Professional: meet the qualifications defined in 42 C.F.R. Subsection 483.430(a)

12. Dietician: hold a degree in nutrition.

13. Behavior Support Specialist: certified through our Center of Excellence University of Arkansas Partners for Inclusive Communities

14. Rehabilitation counselors: hold a masters degree in Rehabilitation Counseling.

15. Recreational Therapist: hold a degree in Recreational Therapy.

16. Behavior Analyst: hold a certification by the Behavior Analyst Certification Board as defined in A.C.A. § 23-99-418.

1103 Documentation

The Provider must maintain a record of every consultation service provided for each beneficiary. The documentation shall consist of:

1. The date the consult was provided and the name of the care coordinator requesting the consult.

2. The consultation service provided.

3. A detailed narrative regarding the content of each consulting session.

1200 PROVIDER QUALIFICATIONS: RESPITE SERVICES

1201. Minimum Qualifications

Providers must ensure that each staff member providing respite services has one of the following:

- A GED or high school diploma;
- One (1) year of relevant, supervised work experience with a public health, human services or other community service agency; **OR**
- Two (2) years' verifiable successful experience working with individuals with developmental disabilities

1202. Approved Settings

Respite may be provided in the following locations:

1. Beneficiary's home or private place of residence
2. Private residence of a Respite care Provider
3. Foster home
4. Medicaid certified intermediate care facility
5. Group home
6. Licensed respite facility
7. Licensed or accredited residential mental health facility
8. Licensed day care facility or other lawful child care setting

When respite is provided in a Medicaid certified ICF/ID, licensed respite facility, or licensed residential mental health facility, the time of the stay may not exceed thirty (30) consecutive days.

1203. Physical Environment

Providers must ensure the physical environments of facilities where respite services are provided are compatible with the services being provided and the needs of beneficiary and staff. The Provider shall provide an accessible and safe environment and be in compliance with U.S.C. § 12101 *et. seq*. "American with Disabilities Act of 1990." The environment must be appropriate and cannot jeopardize the health, safety, or welfare of beneficiaries.

1204. Training Requirements

A. First Aid Training

Within thirty (30) days of hiring, all respite staff, and any other employees that may be required to provide respite services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

- The course must provide a certificate of completion that can be maintained in the staff's personnel file.

- Any services provided by respite staff prior to receiving the above described First Aid Training can only be performed in a trainee role, under the supervision of another staff person that has already received the required First Aid Training.

- Training Certification must be maintained and kept up to date throughout the time any respite service Provider is providing services.

B. Beneficiary Specific Training

Prior to beginning service delivery, respite staff must receive the amount of individualized, beneficiary-specific training required to demonstrate the skills and techniques necessary to implement the individual Person-Centered Service Plan for each individual for whom they are responsible. Training must focus on skills and competencies directed toward the beneficiaries developmental, behavioral, and health needs. Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of beneficiaries. The Provider must ensure that the necessary amount of beneficiary-specific training was completed and written documentation evidencing training must be maintained in the staff member's personnel file at all times.

C. Other Required Training

Respite Services staff must receive appropriate training on the following topics at least once every two (2) calendar years:

- HIPAA Policies and Procedures
- Procedures for Incident Reporting
- Emergency and Evacuation Procedures
- Introduction to Behavior Management
- Arkansas Guardianship statutes
- Arkansas Abuse of Adult statutes

- Arkansas Child Maltreatment Act
- Nurse Practice Act
- Appeals Procedure for Individuals Served by the Program
- Community Integration Training.
- Procedures for Preventing and Reporting Maltreatment of Children and Adults
- Other topics where circumstances dictate that respite staff should receive training to ensure the health, safety, and welfare of the beneficiary served.

Documentation evidencing that training on the topics listed above was completed must be maintained in the staff member's personnel file at all times.

D. DDS QA Mandated Training

DDS Quality Assurance has the ability to require a respite services Provider to conduct/administer specified training to an individual, group, or all staff working for the Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each Respite Services staff member at all times.

1300 PROVIDER QUALIFICATIONS: CRISIS INTERVENTION SERVICES

1301. Provider Assurances

Providers must be able to initiate services on-site within two (2) hours of request. Documentation for crisis intervention services must, at a minimum, include the time of the request, the name of the individual making the request, the time of arrival on-site, a summary of the intervention services provided, any recommendations for changes in the behavior plan or recommendations in change in medications, the time intervention services were discontinued, the signature of the Provider, and the signature of the care coordinator/caregiver as appropriate.

1302. Qualifications

Each professional staff member providing crisis intervention services must hold a current license/certification through their respective state Board of licensing/certification as follows:

1. Psychologists: hold a current license from the Arkansas Psychology Board as a Psychologist

2. Psychological examiners: hold a current license from the Arkansas Psychology Board as a Psychological Examiner

3. Mastered social workers: hold a current license as an LMSW or ACSW by the Arkansas Social Work Licensing Board

4. Professional counselors: hold a current license as a counselor by the Arkansas Board of Examiners in Counseling

5. Qualified Developmental Disabilities Professional: meet the qualifications defined in 42 C.F.R. Subsection 483.430(a)

6. Behavior Support Specialist: certified through our Center of Excellence University of Arkansas Partners for Inclusive Communities

1303. Incident Reporting

Providers must adhere to Incident Report Standards found in Section 300 of this manual.

1400 PROVIDER QUALIFICATIONS: SUPPORTED EMPLOYMENT

Supported Employment is a tailored array of services that offers ongoing support to beneficiaries to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for beneficiaries for whom competitive employment has not traditionally occurred, and who need ongoing supports to maintain their employment.

1401. Supported Employment Supports

A. Discovery/Career Planning Services

1. **Services Included**: discovery/career planning services consist of the Provider gathering information about the beneficiary's interests, strengths, skills, the types of supports that are most effective, and the types of environments and activities where the beneficiary is at his or her best. The following activities may be a component of Discovery/Career planning services:

    - Review of the beneficiary's work history, interest, and skills
    - Job exploration
    - Job shadowing
    - Informational interviewing including mock interviews
    - Job and task analysis activities
    - Situational assessments to assess the beneficiary's interest in and aptitude for a particular type of job
    - Employment preparation (i.e. resume development)
    - Benefits counseling
    - Business plan development for self-employment
    - Volunteerism

2. **Individual Career Profile**: discovery/career planning services should result in the development of an Individual Career Profile for the beneficiary, which includes specific recommendations regarding the beneficiary's employment support needs, preferences, abilities, and characteristic of optimal work environment.

3. **Required Documentation**: the Provider must produce and maintain the following documents in the beneficiary's service record to demonstrate compliance in the delivery of discovery/career planning services:

    - Completed Individual Career Profile

- Record of progress notes/narratives detailing information gathering process and steps taken by Provider in developing the beneficiary's Individual Career Profile

B. Employment Path Services

1. **Services Included**: employment path service activities develop and teach soft skills utilized in integrated employment, which include, but are not limited to, following directions, attending to tasks, problem solving skills and strategies, mobility training, effective and appropriate communication, both verbal and nonverbal, and time management. The beneficiary's employment path service activities must be designed to support employment goals, and can replace non-work services.

2. **Part of PCSP**: beneficiaries receiving employment path services must have goals related to employment in integrated community settings in their person centered service plan ("**PCSP**").

3. **Limits**: employment path services are time-limited and require prior authorization for the first twelve (12) months. One re-authorization of up to an additional twelve (12) months is possible, but only if the beneficiary is also receiving job development services, which indicates the beneficiary is actively seeking employment.

4. **Required Documentation**: the Provider must produce and maintain the following documents in the beneficiary's service record to demonstrate compliance with delivery of employment path services:

    - Beneficiary's PCSP
    - Detailed progress notes/narratives
    - An Arkansas Rehabilitation Services ("**ARS**") referral letter for beneficiary

C. Employment Supports Services

Employment supports services consist of two (2) primary components: (i) job development and (ii) job coaching.

1. **Job Development**: individualized services that are specific in nature to obtaining a certain employment opportunity. The initial outcome of job development services is a Job Development Plan to be incorporated with the Individual Career Profile no later than thirty (30) days after job development services commence. The Job Development Plan must at a minimum specify:

    - The short and long term employment goals, target wages, task hours, and special conditions that apply to the worksite for that beneficiary.

- The jobs that will be developed and/or description of customized tasks that will be negotiated with potential employers.

- An initial list of employer contacts and plan for how many employers will be contacted each week.

- The conditions for use of on-site job coaching.

2. **Job Coaching**: on-site activities that may be provided to a beneficiary once employment is obtained. Activities provided under job coaching services may include, but are not limited to, the following:

    - Complete job duty and task analysis.
    - Assist the beneficiary in learning to do the job by the least intrusive method.
    - Develop compensatory strategies, if needed, to cue beneficiary to complete job.
    - Analyze work environment during initial training/learning of the job.
    - Make determinations regarding modifications or assistive technology.

    This service may also be utilized when the beneficiary chooses self-employment. Activities such as assisting the beneficiary to identify potential business opportunities, assisting in the development of business plan, as well as other activities in developing and launching a business. Medicaid Waiver funds may not be used to defray expenses associated with starting or operating a self-employment business such as capital expenses, advertising, hiring and training of employees.

3. **Required Documentation**: the Provider must produce and maintain the following documents in the beneficiary's service record to demonstrate compliance and delivery of employment support services:

    a) Job development

        1. Job Development Plan
        2. Beneficiary's remuneration statement

    b) *Job coaching*: the Provider must develop a fading Job Coaching Plan to be completed within twelve (12) months. Additional authorizations of Employment Supports Job Coaching with no additional fading gains will require additional documentation of level of need for service.

D. Employment Supports Extended Services

1. **Services Included**: The expected outcome of employment supports extended services is sustained paid employment at or above minimum wages with associated benefits and

opportunities for advancement in a job that meets the beneficiary's personal and career planning goals. This service allows for the continued monitoring of the employment outcome through maintenance of regular contact with the beneficiary and employer. Activities allowed under this service must include, but are not limited to, a minimum of one (1) contact per quarter with the employer.

2. **Required Documentation**: The Provider must maintain the following documents to demonstrate compliance and delivery of this service:

    - ARS letter of closure.
    - Beneficiary's remuneration statement.
    - Beneficiary's work schedule, if available.
    - Detailed documentation of the topics and issues discussed during all Beneficiary and employer meetings/contacts.

1402. Minimum Qualifications

Providers must be currently licensed as a vendor by ARS as a Community Rehabilitation Program. Supported employment services must be provided by certified job coaches under the Provider's ARS license. Continued certification is a qualification requirement for the period the Provider is certified to provide supported employment services. Providers must maintain documentation of certification on file.

1403. Required Training

1. First Aid Training: Within thirty (30) days of hiring, all supported employment staff shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

    - The course must provide a certificate of completion that can be maintained in the supported employment staff's personnel file.

    - Any services provided by a supported employment staff person prior to receiving the above described First Aid Training can only be performed in a training role, under the supervision of another supported employment staff person that has already completed the required First Aid Training.

    - Training Certification must be maintained and kept up to date throughout the time any supported employment staff person is providing supported employment services.

2. Beneficiary Specific Training: Prior to beginning service delivery, supported employment staff must receive the amount of individualized, beneficiary-specific training that is necessary to be able to effectively and safely provide the supported employment services required pursuant to the beneficiary's PCSP, Individual Career Profile, and/or Job Development Plan, including, but not limited to:

    - general training on beneficiary's PCSP
    - behavior management techniques/programming;
    - medication administration and management;
    - setting-specific emergency and evacuation procedures
    - appropriate and productive community integration activities; and
    - training specific to certain medical needs.

    Documentation evidencing that the necessary types and amount of beneficiary-specific training were completed must be maintained in the personnel file of the supported employment staff member at all times. This type of individualized, beneficiary-specific training shall be required each time a beneficiary's PCSP is updated, amended, or renewed.

3. Other Required Training: supported employment staff must receive appropriate training on the following topics at least once every two (2) calendar years:

    - HIPAA Policies and Procedures
    - Procedures for Incident Reporting
    - Emergency and Evacuation Procedures
    - Identifying Unsafe Environmental Factors
    - Introduction to Behavior Management
    - Arkansas Guardianship statutes
    - Arkansas Abuse of Adult statutes
    - Arkansas Child Maltreatment Act
    - Nurse Practice Act
    - Procedures for Preventing and Reporting Maltreatment of Children and Adults
    - Other topics where circumstances dictate that supported employment staff should receive training to ensure the health, safety, and welfare of the beneficiary served.

    Documentation evidencing that training on the topics listed above was completed must be maintained in the personnel file of the supported employment staff member at all times.

4. DDS QA Mandated Training: DDS Quality Assurance has the ability to require a supported employment provider to conduct/administer specified training to an individual, a group, or all supported employment staff working for Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each supported employment service staff member at all times.

1500 PROVIDER QUALIFICATIONS: SUPPLEMENTAL SUPPORT SERVICES

1501. Qualifications

The Provider must require all staff that coordinate the expenditure of supplemental support funds to have at least one of the following qualifications/experience:

1. A Bachelor's degree in a human services field.

2. Two (2) years college credit and two (2) years' experience working with persons with developmental disabilities.

3. Two (2) years of verified experience working with persons with a developmental disability and have been mentored by a case manager for two (2) additional years.

4. Four (4) years of experience as a case manager in a related field.

1502. Supplemental Supports

A. Permissible Supplemental Supports

1. Ancillary supports such as non-recurring set-up expenses for beneficiaries in the event of a disaster, crisis, emergency or life threatening situation. Allowable expenses are those necessary to enable a beneficiary to establish a basic household and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses. This service is furnished only to the extent that it is reasonable and necessary as determined through the beneficiary's PCSP development process, clearly identified in the beneficiary's PCSP, and the beneficiary is unable to meet such expenses, or when the services cannot be obtained from other sources.

2. Drug and alcohol screening in accordance with the beneficiary's treatment plan.

3. Activity fees such as dues at a YMCA, Weight Watchers, etc., used for behavior reinforcement or sensory stimulation. Fees are approved for the beneficiary only and for such time as to abate the life threatening condition. The services must be prescribed and monitored by medical professionals.

B. Exclusions

Supplemental Support may not include payment for room and board, monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. Supplemental Support may not be used to pay for furnishing living arrangements that are owned or leased by a Waiver provider where the provision of these items and services are inherent to the service they are already providing. Diversional or recreational items such as televisions, cable TV access or VCR's are not allowable.

1503. Provider of Last Resort

Supplemental support services can be accessed only as a last resort. A lack of other available resources must be documented and proven prior to a beneficiary receiving supplemental support services.

1600 PROVIDER QUALIFICATIONS: COMMUNITY LIVING-RESIDENTIAL SETTINGS

1601. Accessibility Requirements

Provider owned/leased/rented residential settings must be fully accessible by the beneficiary, compatible with the services being provided to the beneficiary, and compatible with the needs of each beneficiary and their staff, as provided in the beneficiary's PCSP. Each Provider owned/leased/rented residential facility must be in compliance with U.S.C. § 12101 et. seq. "American with Disabilities Act of 1990," and 29 U.S.C. §§ 706 (8), 794 – 794(b) "Disability Rights of 1964."

1602. Regulatory Approvals

All water, food service, and sewage disposal systems must have the required approval of local, state, and federal regulatory agencies, as applicable.

1603. Safe and Comfortable Environment

The Provider must ensure that each Provider owned/leased/rented residential settings provide a safe and comfortable environment tailored towards the needs of the beneficiary/ies, as provided for in their PCSP/s. This shall include, but not be limited to:

1. All Provider owned/leased/rented residential settings must meet all local and state building codes, regulations and laws.

2. The temperature must be maintained within a normal comfort range for the climate.

3. The interior and exterior of the residential setting must be maintained in a sanitary and repaired condition.

4. The residential setting must be free of offensive odors.

5. The residential setting must be maintained free of infestations of insects and rodents.

6. All materials, equipment, and supplies must be stored and maintained in a safe condition. Cleaning fluids and detergents must be stored in original containers with labels describing contents.

1604. Emergency and Evacuation Procedures

The Provider must establish emergency procedures which include detailed actions to be taken in the event of emergency and promote safety. Details of emergency plans and procedures must be in written form, and shall be available and communicated to all members of the staff and other supervisory personnel.

A. There shall be written emergency procedures for:

1. Fires.
2. Natural disasters.
3. Utility failures
4. Medical emergencies
5. Safety during violent or other threatening situations

Additionally, the emergency procedures must satisfy the requirements of applicable authorities, and contain practices appropriate for the locale (example: nuclear evacuations for those living near a nuclear plant).

B. The Provider shall maintain an emergency alarm system for each type of drill (fire and tornado).

C. Beneficiaries, as appropriate, must be educated and trained about emergency and evacuation procedures.

D. Evacuation procedures must address:

1. When evacuation is appropriate.
2. Complete evacuation from the physical facility.
3. The safety of evacuees.
4. Accounting for all persons involved.
5. Temporary shelter, when applicable.
6. Identification of essential services.
7. Continuation of essential services.
8. Emergency phone numbers.
9. Notification of the appropriate emergency authorities.

E. In group living environments, evacuation routes must be posted in conspicuous places.

1605. Safety Equipment

Providers must maintain the following items in each setting in which beneficiaries reside:

1. Functioning smoke detectors, heat sensors, carbon monoxide detectors and/or sprinklers
2. Functioning fire extinguishers
3. Functioning flash light
4. Functioning hot water heater
5. Emergency contact numbers (i.e. law enforcement, poison control etc.)
6. First-Aid kit

1606. Required Independence and Integration

Beneficiaries must be safe and secure in their homes and communities, taking into account their informed and expressed choices. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.

A. Providers must take reasonable steps to ensure that beneficiaries are safe and secure in their homes and communities, taking into account the beneficiary's informed and expressed choices.

B. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.

C. Beneficiaries shall be allowed free use of all space within the group living setting/alternative living site with due regard for privacy, personal possessions of other residents/staff, and reasonable house rules.

D. Settings must be able to provide beneficiaries access to community resources and be located in a safe and accessible location. Beneficiaries must have access to the community in which they are being served. The site shall assure adequate/normal interaction with the community as a group AND as an individual.

    - This can be achieved through transportation or through local community resources.

E. The living and dining areas must be provided with normalized furnishings for the usual functions of daily living and social activities.

F. The kitchen shall have equipment, utensils, and supplies to properly store, prepare, and serve three (3) meals a day. Beneficiaries must have access to food at any time. Any modification to this requirement must be based on an assessed need and documented in the beneficiary's PCSP.

G. Bedroom areas are required to meet the following:

    1. Shall be arranged so that privacy is assured for beneficiaries. Sole access to these rooms cannot be through a bathroom or other bedrooms. Bedrooms must be equipped with a functioning lock with only appropriate staff having keys.

    2. Beneficiaries must have a choice of roommate when shared by one or more individuals. The Provider must actively address the need to designate space for privacy and individual beneficiary interests.

    3. Physical arrangements shall be compatible with the physical needs of the individuals.

4. Each beneficiary shall have an individual bed. Each bed must have a clean, adequate, comfortable mattress.

    a. Beds are of suitable dimensions to accommodate the beneficiary who is using it. Mattresses must be waterproof as necessary.

    b. Each beneficiary must have a suitable pillow, pillowcase, sheets, blanket, and spread.

    c. Bedding must be appropriate to the season and beneficiary's personal preferences. Bed linens must be replaced with clean linens at least weekly.

5. Bedroom furnishings for beneficiaries shall include shelf space, individual chest or dresser space, and a mirror. An enclosed closet space adequate for the belongings of each beneficiary must be provided.

6. Eighty (80) square feet per beneficiary in multi-sleeping rooms; one hundred (100) square feet in single bedrooms.

H. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

I. Bathroom areas are required to meet the following criteria:

    1. Sole access may not be through another beneficiary's bedroom. Commodes, tubs, and showers used by beneficiaries must provide for individual privacy.

    2. A minimum of one commode and sink is provided for every four (4) beneficiaries. Lavatories and commode fixtures are designed and installed in an accessible manner so that they are usable by the beneficiaries living in the residential setting.

    3. A minimum of one tub or shower is provided for every eight (8) beneficiaries.

    4. Must be well ventilated by natural or mechanical methods.

1607. Home and Community Based Services (HCBS) Settings Requirements

All providers must meet the Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the rule is 42 CFR 441.301(c) (4)-(5). All Provider owned/leased/rented residential settings must have the following characteristics:

1. Be chosen by the beneficiary from among setting options including non-disability specific settings (as well as an independent setting), and an option for a private unit in a residential setting.

    a. Choice must be identified/included in the beneficiary's PCSP.

    b. Choice must be based on the beneficiary's needs, preferences and, for residential settings, resources available for room and board.

2. Ensure a beneficiary's rights of privacy, dignity and respect and freedom from coercion and restraint.

3. Must optimize, but not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

4. Facilitate beneficiary choice regarding services and supports and who provides them.

5. The setting must be integrated in and support full access to the greater community by the beneficiary, including the opportunity to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving CES Waiver services.

6. The unit or dwelling must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.

7. Each beneficiary has privacy in their sleeping or living unit, which must include the following:

    i. Units have entrance doors lockable by the beneficiary, with only appropriate staff having keys to doors.
    ii. Beneficiaries sharing units have a choice of roommates in that setting.
    iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

8. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.

9. Beneficiaries are able to have visitors of their choosing at any time.

10. The setting is physically accessible to the beneficiary.

11. Any modification of the additional conditions specified in items 6 through 10 above must be supported by a specific assessed need and justified in the beneficiary's PCSP. The following requirements must be documented in the beneficiary's PCSP:

    i. Identify a specific and individualized assessed need.
    ii. Document the positive interventions and supports used prior to any modifications to the PCSP.
    iii. Document less intrusive methods of meeting the need that have been tried but did not work.
    iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
    v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
    vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    vii. Include the informed consent of the beneficiary.
    viii. Include an assurance that interventions and supports will cause no harm to the beneficiary.

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Arkansas** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Community and Employment Support Waiver

C. Waiver Number:AR.0188
Original Base Waiver Number: AR.0188.

D. Amendment Number:AR.0188.R05.02

E. Proposed Effective Date: *(mm/dd/yy)*

10/01/17

Approved Effective Date: 10/01/17
Approved Effective Date of Waiver being Amended: 09/01/16

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment is to incorporate the following changes:

1.To require all Waiver participants be attributed to a Provider-led Arkansas Shared Savings Entity (PASSE) to receive care coordination after receiving an Independent Assessment by a Third Party Vendor that will establish their service intensity need and be used to develop the Person Centered Service Plan (PCSP).

2.To change the service definition of case management and to rename it care coordination. Care coordination is a broader service than case management and will be offered to all beneficiaries attributed to a PASSE. So that there is a seamless transition into the PASSE, care coordination will be offered as a Waiver service until a beneficiary is attributed, at which time care coordination will be delivered by the PASSE.

3. To add Person-Centered Service Plan (PCSP) Development as a component of the Care Coordination Service. The PCSP Developer will be responsible for developing and implementing the PCSP.

4. To change the supported employment service definition.

5. To clarify the use of restrictive interventions and restraints in our waiver. Nothing was changed or added to these requirements.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ **Waiver Application**	2, Attachment 1
☑ **Appendix A – Waiver Administration and Operation**	A-3, A-5, A-6, A-7
☑ **Appendix B – Participant Access and Eligibility**	B-6-a, B-6-f
☑ **Appendix C – Participant Services**	C1/C3, C-4-a
☑ **Appendix D – Participant Centered Service Planning and Delivery**	D-1-a, D-1-d
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☑ **Appendix G – Participant Safeguards**	G-2-a
☐ **Appendix H**	
☑ **Appendix I – Financial Accountability**	I-2-a
☑ **Appendix J – Cost-Neutrality Demonstration**	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☑ **Add/delete services**
- ☑ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
Require all Waiver participants to enroll in a PASSE for care coordination services after receiving an independent assessment by a third party vendor that will determine service intensity need and be used to develop the PCSP.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Arkansas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Community and Employment Support Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: AR.0188
Waiver Number:AR.0188.R05.02
Draft ID: AR.006.05.02

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 09/01/16
Approved Effective Date of Waiver being Amended: 09/01/16

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:
Not applicable.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

○ **Not applicable**

◉ **Applicable**
Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☑ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:
The Arkansas Provider Led Care Coordination Program (PCCM Entity). A Waiver Application will be submitted simultaneously with this Waiver Amendment.
Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☑ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☑ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The purpose of the Community and Employment Support Waiver is to support individuals of all ages who have a developmental disability, meet ICF level of care and require waiver support services to live in the community and prevent institutionalization.

The goals of HCBS Waiver are to support beneficiaries in all major life activities, promote community inclusion through integrated employment options and community experiences, and
provide comprehensive care coordination the 1915(b) Waiver Program.

Support of the person includes:
(1) Developing a relationship and maintaining direct contact,
(2) Determining the person's choices about their life,
(3) Assisting them in carrying out these choices,
(4) Development and implementation of a PCSP in coordination with an interdisciplinary team,
(5) Assisting the person in integrating into his or her community,
(6) Locating, coordinating and monitoring needed developmental, medical, behavioral, social educational and other services,
(7) Accessing informal community supports needed, and
(8) Accessing employment services and supporting them in seeking and maintaining competitive employment.

The objectives are as follows:
(1) To enhance and maintain community living for all beneficiaries in the HCBS Waiver program, and
(2) To transition eligible persons who choose the HCBS Waiver option from residential facilities to the community.

All waiver beneficiaries are attributed to a Provider-led Arkansas Shared Savings Entity (PASSE) that provides care coordination services administratively through the § 1915(b) Waiver.

All services must be delivered based on an individual person-centered service plan (PCSP), which is based on an Independent Assessment by a third party vendor and other psychological and functional assessments. The PCSP must have measurable goals and specific objectives, measure progress through data collection, be created by the participant's case plan developer through consultation with the team, which includes the person receiving services and the PASSE Care Coordinator, and be overseen by the PASSE Care Coordinator.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ◉ **Not Applicable**
- ○ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Due to space limitations in this section, actual comments and responses have been added to this document and can be located in the section titled "Optional."

Websites for the Arkansas Waiver Association, the Developmental Disabilities Provider Association and Arkansas Medicaid contain
information about the Waiver amendments. The information was posted to the Arkansas Medicaid Website from July 13, 2017, to August 11, 2017. Other websites would have posted the information soon thereafter. DDS staff participated at provider conferences and took comments by phone

and email from providers and people receiving or applying for services.
DDS conducted a formal public comment period, with a public hearing held on August 8, 2017, at 4:30 p.m. Written comments were received and considered by DDS, and oral comments were made at the public hearing. Public comments are located in the section title Optional, along with DDS's responses.

Prior to the formal public comment period, meetings were organized and held for participants and their families to ask any
questions and make any comments. The following meetings were held where the DDS director or her designated Assistant Director spoke regarding these amendments:

January
18th Presentation to Senate Public Health
30th Presentation to Black Caucus

February
14th Meeting with Lainey Morrow with Medicaid Saves Lives
24th Provider Meeting at Easter Seals

March
29th Public Hearing at Little Rock Public Library, Transformation Track A and Track B
29th Public Meeting for families and consumers at ICM

April
3rd St. Vincent Hospital, Transformation Presentation
6th Open Horizons Conference
6th Livestream Presentation with families and consumers at Arkansas Support Network
10th St. Vincent Hospital, Transformation Presentation
11th Public Meeting for families and consumers at Easter Seals
17th St. Vincent Hospital, Transformation Presentation
24th St. Vincent Hospital, Transformation Presentation

May
4th Waiver Meeting with Waiver providers
9th Town Hall Meeting in Russellville
24th Meeting with Lainey Morrow with Medicaid Saves Lives

June
5th Meeting with Lainey Morrow
21st Town Hall Meeting, Springdale

July
12th AWA Conference
14th AWA Conference
19th Staff and Provider Meeting to discuss Transformation
25th Town Hall Meeting, Fort Smith

Upon approval by CMS, DMS and DDS will implement the regulations, policies, rules and procedures that are promulgated in accordance with the Arkansas Administrative Procedure Act. This process allows for another opportunity for public comment and changes prior to the final rule submission. After review and approval from Arkansas Legislative Committees, the implementing regulations, policies, rules and procedures are incorporated into the DMS Medical Services Manual. This manual is available to all providers and the general public on the DMS website.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121)

and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Nye

First Name: Bradford

Title: Director, Office of Policy Development

Agency: Office of Legislative and Intergovernmental Affairs, Arkansas Department of Human Servic

Address: P O Box 1437, Slot S295

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 320-6303 **Ext:** ☐ **TTY**

Fax: (501) 404-4619

E-mail: Brad.Nye@dhs.arkansas.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Davenport

First Name: Regina

Title: Assistant Director for ACS Waiver Services

Agency: Division of Developmental Disabilities Services, Arkansas Department of Human Services

Address: P O Box 1437, Slot N502

Address 2:

City:	Little Rock
State:	**Arkansas**
Zip:	72203-1437
Phone:	(501) 683-0575 **Ext:** ☐ **TTY**
Fax:	(501) 682-8380
E-mail:	regina.davenport@dhs.arkansas.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:	Elizabeth Pitman
	State Medicaid Director or Designee
Submission Date:	Sep 14, 2017

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	Stehle
First Name:	Dawn
Title:	Director
Agency:	Divsion of Medical Services, Arkansas Department of Human Services
Address:	P.O. Box 1437, Slot S- 401
Address 2:	
City:	Little Rock
State:	**Arkansas**
Zip:	72203-1437

Phone:

(501) 683-0173 **Ext:** ☐ **TTY**

Fax:

(501) 682-6836

E-mail:

Dawn.Stehle@dhs.arkansas.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☑ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☑ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

This Waiver Amendment will operate concurrently with the § 1915(b) Arkansas Provider Led Care Coordination Program. Under these concurrent waivers, every participant will be enrolled in a Provider-Led Arkansas Shared Savings Entity (PASSE) and receive care coordination services administratively through the PASSE in which they are attributed.

Beginning on February 1, 2018 participants will be attributed to a PASSE. We anticipate attributing all Waiver participants in accordance with the following schedule:

Feb.	1400
Mar.	300
Apr.	300
May	400
Jun.	400
Jul.	400
Aug.	400
Sep.	400
Nov.	403

Any clients who were not assessed in this time period will be assessed in December, 2018. The CES Waiver care coordination service will no longer be available to Waiver participants once they are attributed to a PASSE and begin receiving care coordination through the PASSE. The state will cease offering the CES Waiver care coordination service as of January 1, 2019.

The State is scheduled to begin an independent functional assessment beginning October 1, 2017. Clients who have been deemed to meet Institutional Level of Care criteria will undergo an independent assessment to establish a service Tier that will be utilized when developing and approving the Person Centered Service Plan (PCSP). Results of the Independent Assessment will begin dictating the participant's level of service tier beginning on January 1, 2019.

Current participants will be transferred from their current level into a tier as follows:
1) Participants now classified as pervasive will be classified as Tier 3, until they undergo an Independent Assessment.

2) Participants now classified as limited or extensive will be classified as Tier 2, until they undergo an Independent Assessment.

For those participants receiving Supported Employment Services, the following two components will no longer be paid for as Supported Employment Waiver Services:

(1) Supported Employment Services furnished by a co-worker or job site personnel; and

(2) Personal Assistance.

Participants may still receive comparable services, however. Specifically, the supported employment vendor may enter into support agreements that allow for onsite employees to provide supported employment services; and participants may access personal care (a comparable service to personal assistance) as a state plan service.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State of Arkansas submitted and received final approval, a statewide transition plan for review to CMS in accordance with requirements found at 42 CFR 441.301(c) & 441.710. AR.01888-DDS Community and Employment Support Waiver was identified as being affected by the new requirements, and was therefore included in the Arkansas Statewide Transition Plan. This plan can be found at http://humanservices.arkansas.gov/daas/Pages/HCBS-Settings-Home.aspx.

Arkansas assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Arkansas will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment.

The Division of Developmental Disabilities Services (DDS) is the operating agency for one 1915(c) waiver impacted by the HCBS Settings Rule: AR.0188 DDS - Community and Employment Support (CES) Waiver. The purpose of this waiver is to support individuals of all ages who have a developmental disability and choose to receive services within their community. The person-centered service plan offers an array of services that allow flexibility and choice for the participant. Services are provided in the person’s home and community.

Individuals served by the CES Waiver can choose to reside in a private home in the community and receive HCBS services in their home. The home may be the person’s home, or the home of a family member or friend. The remainder live in either a group home, a provider owned or controlled apartment, or in the home of a staff person who is employed by the HCBS provider. It is expected that people who live in their own home or the home of a family member or friend who is not paid staff receive services in a setting that complies with requirements found at 42 CFR 441.301(c)(4).

DDS staff offers each person a choice of both care coordination and direct service providers. The chosen PCSP developer assesses the person’s needs and wants and facilitates the development of the person-centered plan, which is approved by DDS staff. DDS CES Waiver staff will monitor services through random CES visits (minimum 10% per staff caseload). The care coordinator implements the PCSP. In addition, as part of the DDS certification process, DDS Licensure and Certification staff monitors services in the person’s home. DDS CES Waiver staff and DDS Licensure and Certification staff have been trained on the CMS Final Rule. Information on the HCBS Settings rule will be included in annual training opportunities for DDS CES Waiver staff and DDS Licensure and Certification staff.

DDS is proposing to achieve and maintain full compliance with HCBS requirements, as indicated by this statewide transition plan. A transition plan chart is attached which outlines the processes and timeline which DDS and stakeholders will follow to identify and assess at-risk providers, remediate any areas of non-compliance, and conduct outreach to engage providers and

other stakeholders [see AR HCBS STP–Timeline Chart(12-15-2015)].

Description of State Assessment of Current Level of Compliance

Review of State Policies and Procedures

DDS staff have reviewed and identified policies, provider manual, and certification requirement changes needed to comply with the federal HCBS settings regulations. The following documents were reviewed and a detailed policy crosswalk is included in this STP : DDS Certification Standards for CES Waiver Services, Medicaid Manual for DDS CES Waiver, and the ACS Waiver renewal application. Each of these documents will be amended to comport with the federal requirements. DDS anticipates the necessary revisions to be completed by October of 2017.

Assessment of Provider Compliance with Residential and Non-Residential Settings Requirements

An inter-divisional HCBS Settings working group has met regularly since 2014 and will continue to meet during the implementation of the STP. The working group consists of representatives from DAAS, DDS, and Division of Medical Services (DMS) within the Arkansas Department of Human Services. The working group initially met to review the new regulations and develop the initial STP and corresponding timeline. The group has met with external stakeholders to discuss the new regulations.

DDS recognizes that group homes and provider owned or controlled apartments may be at risk for not meeting the full extent of regulations because the participant receiving services resides in and receives services in a home, group home, or apartment owned by the provider. The State considers DDS Staff Homes to have elements of provider-owned or controlled settings, and as such will plan to assess, validate, and remediate these as needed to assure full compliance with the HCBS Settings rule.

Provider self-assessment

To assess compliance with the new HCBS settings requirements, the inter-divisional HCBS Settings working group developed a residential provider self-assessment survey. The survey was developed using the exploratory questions provided in the CMS HCBS Toolkit. Each residential provider has completed and returned a self-study to DDS. The self-assessment survey served as a baseline “snapshot” of the residential provider’s existing self-assessed compliance with the HCBS Settings rule. All DDS providers participated in the self-assessment process. DDS used the self–study as a means to notify providers of the new federal regulations and prepare them for possible changes in how they provide services. Survey responses were validated through on-site visits. The residential provider self-assessment is an integral part of the HCBS compliance process. The information gathered from this survey allows the State to provide tailored technical assistance to DDS providers as they move into compliance with the HCBS settings rule.

Validation of self-assessment (site visits).

Staff employed by DAAS, DDS, and DMS were assigned to regional site visit teams. Employees with a background in survey/data collection, auditing, and fieldwork were chosen to serve as reviewers and assigned to a regional site visit team. The aforementioned site visit teams conducted on-site visits on 100% of residential provider owned or controlled apartments and group homes. Random samples of beneficiaries within each site were selected for a beneficiary survey during the site visit. The residential provider owned or controlled group home and apartment site visits were completed in July 2016. The site visits followed a standard process including a brief introduction with setting administrators/staff, initial rounds with administrators/staff using the Residential Site Review Survey, request for supporting documentation, interviews with beneficiaries using the Beneficiary Survey, and an exit summary with administrators/staff.

Upon completion of the initial site visits and review of supporting documents provided by the provider, notes from the site review team member were summarized in a standardized report.A cover letter and the corresponding report were mailed to each provider following the on-site visit. The letter summarized the visit, noted areas needing clarification that were observed and documented, requested clarification of provider policies and procedures and/or a corrective action plan, and provided a deadline with which to comply with the requested action(s). DHS has provided technical assistance to providers throughout this time period.

Ongoing Assessment of Settings

Regularly scheduled on-site visits completed by the DDS Licensure and Certification unit, that oversees HCBS regulatory

requirements, will occur to ensure HCBS Settings compliance. DDS expects every residential setting to receive a visit at least once every three years, in addition to the current random home visit procedure (minimum 10% per staff caseload) of DDS Licensure and Certification unit. These visits will include a site survey and beneficiary experience surveys with a select number of Medicaid beneficiaries. DDS CES Waiver staff and DDS Licensure and Certification staff have been trained on the HCBS Settings rule. Information on the HCBS Settings rule will be included in annual training opportunities for DDS CES Waiver staff and DDS Licensure and Certification staff. Ongoing training for providers on the HCBS Settings rule will be provided through annual meetings of provider membership organizations and via updates to the Arkansas HCBS website.

Settings found to be out of compliance with the new regulations during these routine reviews will be required to submit and have approved a corrective action plan which includes a timeframe for its completion. Failure to complete that plan may jeopardize the agency's certification and participation in the waiver program. Providers who wish to appeal our findings can follow the appeal rights process described in DDS Policy 1076 Appeals.

Remediation

The inter-divisional HCBS Settings working group developed and conducted provider trainings as well as provided tailored technical assistance to partially compliant and non-compliant providers. In order to achieve initial compliance, DDS conducted multiple regional training opportunities for providers, beneficiaries, and advocates to discuss reoccurring themes from provider-initiated technical assistance phone calls, appropriate remediation strategies, heightened scrutiny, and ongoing compliance.

During the first half of 2017, the HCBS site review subcommittee along with the HCBS Settings working group will monitor provider compliance efforts through corrective action plans and follow-up site visits. Some corrective action plans may only require a desk audit, meaning the site visit and beneficiary surveys did not highlight any non-compliance issues. However, the provider policies may not reflect the true intent of the HCBS Settings rule and as such will need to undergo revisions to become compliant with the HCBS Settings rule. However, follow-up site visits will be conducted with all providers submitting substantive corrective action plans that require a change in procedure or reflect a culture change within that setting to ensure that providers are implementing the corrective actions outlined in the plan.

Heightened Scrutiny

DDS recognizes that certain settings are presumed non-compliant with the HCBS Settings requirements. Specifically, some home and community based settings have institutional qualities – those settings that are publicly or privately owned facilities that provide inpatient treatment, those settings that are located on the grounds of, or immediately adjacent to, a public institution, or those settings that have the effect of isolating individuals from the broader community. These settings include those that are located on or near the grounds of an institution and settings which may isolate individuals from the community. These settings include group homes located on the grounds of or adjacent to a public institution, numerous group homes co-located on a single site, a disability-specific farm-like service setting and apartments located in apartment complexes also occupied by persons who do not receive HCBS services. DDS will request heightened scrutiny for those settings presumed not to be home and community based.

Based on the accumulation of findings, the inter-divisional HCBS Settings working group will make a determination on which settings represent a home and community-based setting and should be submitted to CMS for review. The inter-divisional HCBS Settings working group will pay particular attention to beneficiary rights and community integration (as documented in the site survey, beneficiary surveys, provider site visit report and provider-initiated corrective actions) to ensure that the settings submitted to CMS for review reflect the qualities of an HCBS Setting and overcome the presumption of an institutional setting. The HCBS Settings working group will finalize the list of settings to be published for public comment prior to submission to CMS for heightened scrutiny review.

In cases where the State asks for heightened scrutiny by CMS for certain settings, the inter-divisional HCBS Settings working group will provide CMS with documentation (including site visit reports, site-specific assessment tools/results, corrective action plans or remediation strategies implemented by the provider/setting, information received during public comment period, information from external stakeholders, information received from the provider/setting, person-centered service plans, etc.) in an effort to demonstrate that the setting does not have the qualities of an institution and that it does have the qualities of a home and community-based setting.

Following the provider self-assessment and on-site assessment(s), settings that meet any of the above criteria will be published in a public notice in the statewide newspaper, Arkansas Democrat-Gazette, to allow for public comment. The public notice will list the affected settings by name and location, and will identify the number of individuals served at each setting. The public notice will include all justifications as to how and why the setting meets HCBS requirements and will specifically note that the

public has an opportunity to comment on the state's evidence. The state will provide responses to these public comments in a subsequent version of the STP.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The following comments were received during the public comment period:

We received several comments regarding the requirement that PASSE care coordinators not be affiliated with the Waiver participant's direct service providers.

We responded as follows: Based on public comment, DHS has clarified that it is the responsibility of the PASSE to comply with Conflict Free Case Management rules.

Comment: This [PASSE Manual] does not match the CES Waiver for DD which says that "contact" must be made monthly, but "face-to-face" must be made at least quarterly. Please clarify if "face-to-face" can be telemedicine.

Response: Within the context of care coordination, we have clarified that the use of video conferencing for the purpose of required contacts is allowable after the initial face-to-face visit. Telemedicine is still allowable under the Medicaid State plan in order to deliver a medical service.

Comment: Regarding conflict free case management, who is the care coordinator? What is the role of the direct care supervisor? Are they care coordinators? What separates the current case manager from the future care coordinator?

Response: Under the PASSE care coordination model, all case management/care coordination activities will be done by the PASSE care coordinator. To ensure continuity of service and consistency, we have changed the definition of case management in the CES waiver and changed the name of it to care coordination. The current case managers will provide care coordination as it is defined in the CES waiver to their clients until such time as those clients are attributed to a PASSE. Then the PASSE will take over providing care coordination.

Comment: How is the eligibility determination discussed in [PASSE Manual] different from the independent assessment, and/or is this a prior authorization?

Response: [This] describes what functions a care coordinator will be required to perform for a DD Waiver client. One of those functions in assisting with the ICF/IID Level of care
redetermination every year. A DD Waiver client will only have to undergo the Independent Assessment (IA) once every three (3) years unless there is a change in condition and another IA is requested. The IA will not be used to determine whether a client is eligible to receive waiver services that will be determined by DDS's intake and eligibility unit. The IA is a functional assessment that helps determine the individual client's service need.

Comment: Please clarify 'current state,' 'future state,' and changes for 1) care coordination staffing including case managers, direct care supervisor (DCS), 2) related fees for the services, and 3)responsibility for plan of care between current providers such as DD waiver case management, DCSs and PASSEs.

Response: Under the PASSE care coordination model, all case management/care coordination activities will be done by the PASSE care coordinator. To ensure continuity of service and consistency, we have changed the definition of case management in the CES waiver and changed the name of it to care coordination. The current case managers will provide care coordination as it is defined in the CES waiver to their clients until such time as those clients are attributed to a PASSE. Then the PASSE will take over providing care coordination.

Comment: Who will manage things like my child's pullups and meds? I manage them at present time and do not want someone else to take over. Will I be able to continue to manage these things?

Response: Yes, you will be able to continue to manage those things. The independent assessment will look at what is currently taking place to determine service needs. If you are currently meeting your child's needs the independent assessment will note that and that will be considered when forming the person centered service plan (PCSP).

Comment: Can the assessment find someone who is pervasive not eligible for Waiver?

Response: No, the Independent Assessment is a functional needs assessment and is separate from the eligibility determination.

So, the assessment will be used to determine the intensity of services a Waiver client needs, not to make them eligible or non-eligible for Waiver.

Comment: Will the plan of care, with goals (outcomes) be the responsibility of the providers or the care coordinators? If it is done by the care coordinators, how does provider have input on the needs of the client if don't agree with goals set (or not) by care coordinator, we think the client needs?

Response: In Phase I, the development of the Person Centered Service Plan (PCSP) will stay the same as it has been in the past.

Comment: If a consumer is pervasive level of care with inclusive opportunities for independence, how will that affect the change within the PASSE?

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

Comment: Arkansas Medicaid is pushing supported employment. How is DDS proposing to actually provide licensing, training, and money to providers in order to serve our clients in this way? We're in a small town, have taken client with 20+ years dishwasher experience to apply several times for this job, last time, employer said had 200 people applying for 1 dishwasher job.

Response: DDS continues to promote supported employment options for individuals with disabilities. As part of our initiatives, DDS has worked with providers on a voluntary basis to provide assistance as providers transformed service delivery system in the employment arena. This assistance has included technical assistance through Consultants knowledgeable in the field who work directly with providers in their communities to develop provider/community specific planning; Inter/intra agency agreements to stabilize funding for Supported Employment and other activities. Through the implementation of the revised SE definition, greater flexibility in utilization of funding to better need employment support needs are being offered.

Comment: Do you get another Plan of Care development fee of $90.00 for revisions?

Response: Yes, with an approved Prior Authorization.

Comment: Who approves the plan of care?

Response: In Phase I, DDS will continue to approve.

Comment: The maximum of $90.00 per plan development is not enough money.

Response: Thank you for your comment.

Comment: Define specialty providers. The entire paragraph is confusing regarding care coordination. The whole 14 month transition time is confusing. Will care coordinators be only employed by the PASSE?

Response: As clients are attributed to a PASSE (if they are DD clients receiving services through the 1915(c) Waiver) the client will only receive care coordination under the PASSE. It will take approximately 14 months to completely transition all DD and BH clients into the PASSE model.

Comment: Will providers be allowed to subcontract with the PASSE with care coordinators?

Response: It will be the decision of each PASSE entity to determine the financial relationship with the care coordinators.

Comment: Why is lease supposed to be in the person centered file?

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

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

Response: DDS does not set rates for rent.

Comment; Who issues the Interim Service Plan?

Response: DDS will continue to approve interim plans of care.

Comment: Seems like the PSCP Developer does a lot. Who employs the PSCP, how are they reimbursed with all the time and work for which they are completing? Looks like this person gets all the leg work completed and the care coordinator just comes by to collect the completed work or monitor the work. Providers will be doing as much as they are now and more with reimbursement reductions. How?

Response: We disagree and believe the role of the care coordinator under the PASSE model will work in coordination with the supportive living provider and PCSP developer.

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

Comment: This section contains the language: "If the beneficiary or their legal guardian objects to the presence of any individual at the PCSP development meeting, then the individual is not permitted to attend...." DRA recommends that language be included to address situations where the beneficiary and guardian's wishes are in conflict. For example, the following language could be included: "If the wishes of the beneficiary or guardian are in conflict as to persons attending the meeting, the preferences of the beneficiary will be given primary consideration and take precedence where there is no compelling health and safety reason."

Response: DDS asserts that items regarding guardians will depend on the specifics listed in the actual guardianship order. Because of this, no blanket responses to these comments can be made.

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

Response: Currently, Waiver Providers cannot refuse to continue to serve unless they cannot maintain health and safety.

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

Response: This was the intent and the policy has been clarified to reflect your statement above.

Comment: The draft CES Manual prohibits care coordination by case direct care providers, and it also says that providers may do so as long as they implement certain firewalls, which is the process used today. It is not clear if this language was intended or not, but the firewalls are similar to what we propose under “Solutions.” The draft CES Manual fails to provide a clear distinction between the direct care and care provider and the care coordinator, creating overlapping and confusing responsibilities. The draft CES Manual reflects the difficulty in trying to separate functions that should not be separated. One glaring example is that it states that the direct care provider is to provide a “PCSP Developer” to
develop and implement the person-centered service plan (PCSP), but the Care Coordination section says the person-centered

service plan is the responsibility of the care coordinator.
Other examples: Under 213.000 Supported Living (which is delivered by the direct service provider), the draft Manual charges the direct care provider with the following responsibilities: C.2 “Serving as liaison between the beneficiary, parents, legal representatives, care coordinator entity and DDS officials.” --Isn’t this care coordination?

Response: We respectfully disagree.

Comment: "Coordinating schedules for both waiver and generic service categories.” – Yet Care Coordination Services Section 220.000 says the care coordinator is responsible for “coordinating and arranging all CES waiver services and other state plan services.” It also says the care coordinator is responsible for “generic needs.” [...] “…determine whether the person is receiving appropriate support in the management of medication.” – Yet, the Care Coordination section lists “Medication management plan” as a care coordinator responsibility. (It also says the care coordinator is responsible for “Coordination of …medication management.” Does this have some meaning different than the direct care providers’
“support in the management of medication”?)

Response: The role of the care coordinator will be to work closely with all service providers, including the supportive living provider if applicable to ensure appropriate services and supports are being provided to the beneficiary.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:
   Division of Developmental Disabilities Services

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that

division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Division of Medical Services (DMS), within the Department of Human Services (DHS), is the State Medicaid agency and has administrative authority for the Waiver including the following:
1) Develop and Monitor the Interagency Agreement to ensure that provisions specified are executed;
2) Oversee the Waiver program through a DMS case record review process that allows for response to all individual and aggregate findings;
3) Review and approve, via Medicaid Manual promulgation process, public policies and procedures developed by DDS regarding the Waiver and monitoring their implementation;
4) Reimburse providers enrolled in the Medicaid Program who provide services to eligible Waiver participants;
5) Promulgate the DDS Waiver Provider Manual, which provides the rules and regulations for participation in the Arkansas Medicaid Program, in accordance with the Arkansas Administrative Procedures Act;
6) Final authority on all functions related to provider participation in the Arkansas Medicaid Program;
7) Train providers on proper procedures to follow in submitting claims (through fiscal agent, Electronic Data Systems);
8) Notify providers of participative changes in the Arkansas Medicaid Program;
9) Respond to provider questions concerning submission of claims (through EDS);
10) Ensure that providers remain in compliance with rules and regulations required for participation in the Medicaid program;
11) Review of provider information and determination as to whether to enroll the provider into the Arkansas Medicaid Program;
12) Assign to each new enrolled provider a unique Medicaid provider number;
13) Notify DDS of any providers removed from the active Medicaid provider file;
14) Insure that a specified number of service plans are reviewed by DMS or their designated representative;
15) Provide to DDS relevant information pertaining to the Medicaid program and any federal requirements governing applicable waiver programs;
16) Monitor compliance with the interagency agreement;
17) Complete and Submit the CMS 372 Annual Report.

The Division of Developmental Disabilities Services (DDS), also within DHS, is responsible for operation of the Waiver including the following:
1) Develop and Implement internal, administrative policies and procedures to operate the Waiver DMS does not approve these internal procedures, but does review them to ensure there are no compliance issues with either State or Federal Regulations.
2) Develop and implement public policy and procedures;
3) Provide training to providers regarding certification requirements set forth by DDS;
4) Certify qualified providers who request to render Waiver services and provide information on certified providers to DMS;
5) Conduct certification surveys of providers in accordance with current DDS policies and procedures to their certification status;
6) Notify DMS of any provider who DDS disqualifies and removes from the Waiver Program;
7) Establish and monitor the person center service plan (PCSP) requirements that govern the provision of services;
8) Monitor professionals who conduct the PCSP development, implementation and monitoring process;
9) Coordinate the collection of data and issuance of reports through MMIS with DMS as needed to complete the CMS 372 Annual Report;
10) Provide to DMS the results of monitoring activities;
11 Develop and implement a Quality Assurance protocol that meets criteria as specified in the Interagency

Agreement.

DDS is also responsible for:
1) Determining waiver participant eligibility according to DMS rules and procedures;
2) Implementing service delivery through a prior authorization process;
3) Providing technical assistance to providers and consumers on Waiver requirements, policies, procedures and processes;
4) Conducting program and individual service concern reviews and investigations with subsequent follow-up, and imposing sanctions, when indicated.

DMS and DDS staff will meet at least on a semi-annual basis to discuss problems, evaluate the program, and initiate appropriate changes in policy or reimbursement rates so as to maintain an efficient administration of the Waiver.

DMS Waiver Quality Assurance staff uses Quality Management Strategy, case record reviews, monitoring report reviews, and meetings with DDS Waiver administrative staff to monitor the operation of the Waiver and assure compliance with waiver requirements. DHS Program Integrity through the Office of Medicaid Inspector General (OMIG) also conducts random onsite reviews of provider records throughout the year. DMS Waiver Quality Assurance staff reviews DDS reports, records findings and prioritizes any issues that are found as a result of the review process.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
   - (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
     Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
     DMS and DDS contract with a Third Party Vendor to conduct Independent Assessments that will be used to determine the beneficiaries' service tier for the purpose of attribution to a PASSE and will generate a risk and needs report that can be used to create his or her PCSP.
   - ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   - (●) **Not applicable**
   - ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
     Check each that applies:
     - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

       Specify the nature of these agencies and complete items A-5 and A-6:
     - [ ] **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
DDS is the division in charge of operational management of the Waiver and is responsible for oversight of tier determinations and PCSPs. DMS, as the State Medicaid Agency, retains authority over the waiver in accordance with 42 CFR §431.10(e). DHS's Contracting Official will oversee the contract between DHS and the Third Party Independent Assessor. The Contract will have performance measures that the Vendor will be required to meet.

   DMS's PASSE Certification Unit will have responsibility for monitoring the performance of the PASSE entities and the provision of Care Coordination.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Third Party Independent Assessor must submit monthly contractor reports to DMS and DDS that include:
1. Demographics about the Beneficiaries who were assessed;
2. An activities summary, including the volume, timeliness and outcomes of all Assessments and Reassessments; and
3. A running total of the activities completed.

   The Third Party Independent Assessor must submit an annual program performance report that includes:
1. An activities summary for the year, including the total number of assessments and reassessments;
2. A summary of the Third Party Contractor's timeliness in scheduling and performing assessments and reassessments;
3. A summary of findings from Beneficiary feedback research conducted by the Third Party Contractor;
4. A summary of any challenges and risks perceived by the Third Party Contractor in the year ahead and how the Third Party Contractor proposes to manage or mitigate those; and
5. Recommendations for improving the efficiency and quality of the services performed.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☑	☑	☐
Waiver enrollment managed against approved limits	☑	☑	☐
Waiver expenditures managed against approved levels	☑	☑	☑
Level of care evaluation	☑	☑	☐
Review of Participant service plans	☑	☑	☐
Prior authorization of waiver services	☑	☑	☐

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Utilization management	☑	☑	☐
Qualified provider enrollment	☑	☑	☐
Execution of Medicaid provider agreements	☑	☐	☐
Establishment of a statewide rate methodology	☑	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐
Quality assurance and quality improvement activities	☑	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
AA1: Number and percent of unduplicated participants served within approved limits specified in the approved HCBS Waiver. Numerator: Number of unduplicated participants served within approved limits specified in the HCBS Waiver. Denominator: Number of approved unduplicated participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA2: Number and percentage of applicants who had an initial LOC determination completed before receipt of services. Numerator: Number of applicants who had an initial LOC determination completed before receipt of services. Denominator: Number of LOC determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC Determination Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA3: Number and percentage of participants for whom the appropriate process and instruments were used to determine initial eligibility. Numerator: Number of participants' packets with appropriate process and instruments used to determine initial eligibility; Denominator: Number of participants' packets reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA4: Number and percentage of PCSPs completed in the time frame specified in the agreement with the Medicaid Agency. Numerator: Number of PCSPs completed in the time frame specified; Denominator: Number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Quarterly QA Report (Validation Chart Reviews)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: DMS reviews 20% of the charts reviewed by DDS during Individual File Reviews, as a validation review.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA5: Number and percentage of participants with delivery of at least one HCBS Waiver service per month as specified in the PCSP. Numerator: Number of participants with delivery of at least one HCBS Waiver service per month; Denominator: Number of participants served.

Data Source (Select one):
Other
If 'Other' is selected, specify:
No Waiver Service Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
	☐ **Weekly**	☑ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA6: Number and percentage of providers certified by DDS. Numerator: Number of provider agencies that obtained annual recertification in accordance with promulgated standards. Denominator: Number of provider agencies reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report (Validation Reviews of Provider Certification Files)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Certification File Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/-5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA7: Number and percentage of policies developed by DDS that are reviewed and approved by the Medicaid Agency prior to implementation . Numerator: Number of policies and procedures by DDS reviewed by Medicaid before implementation; Denominator: Number of policies and procedures developed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PD/QA Request Forms

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA8: Number and percent of waiver claims on the Overlapping Services Report (OSR) having the same date of service as a claim for institutional services, which correctly paid only for the date of discharge or date of admission according to policy. Numerator: Number of waiver claims on the OSR which correctly paid according to policy; Denominator: Number of waiver claims reviewed from the OSR.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Overlapping Services Report (OSR)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA9: Number and percent of waiver claims that were paid using the correct rate as specified in the waiver application. Numerator: Number of claims paid at correct rate; Denominator: Number of claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient Claims History Profile (Validation Reviews)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA10: Number and percent of reviewed claims with services specified in the PCSP. Numerator: Number of claims with services specified in the PCSP; Denominator: Number of claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient Claims History Profiles (Validation Review)

		Sampling Approach*(check each that applies):*

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Developmental Disabilities Services (the operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DDS and DMS have an Interagency Agreement for measures related to administrative authority of the HCBS Waiver.

In cases where the numbers of unduplicated beneficiaries served in the HCBS Waiver are not within approved limits, remediation includes HCBS Waiver amendments and implementing a waiting list. DMS reviews and approves all policy and procedures, including HCBS Waiver amendments, developed by DDS prior to implementation, as part of the Interagency Agreement. In cases where policy or procedures were not reviewed and approved by DMS, remediation includes DMS reviewing the policy upon discovery, and approving or removing the policy.

In cases where there are problems with level of care determinations completed by a qualified evaluator, where instruments and processes were not followed as described in the waiver, or were not completed within specified time frames, additional staff training, staff counseling or disciplinary action may be part of remediation. Similarly, remediation for PCSPs not completed in specified time frames includes completing the PCSP upon discovery, additional training for staff, and staff counseling or disciplinary action. DDS conducts all remediation efforts in these areas.

Remediation to address beneficiaries not receiving at least one waiver service a month in accordance with the PCSP and the agreement with DMS includes closing a case, conducting monitoring visits, revising a PCSP to add a service, checking on provider billing, and providing training. DDS conducts remediation efforts in these areas, and the tool used for case record review documents and tracks remediation.

Remediation associated with provider certifications that are not current according to the DDS/DMS agreement may include recertifying providers upon discovery if appropriate, requesting termination of the provider's Arkansas Medicaid enrollment, referral to the Office of Medicaid Inspector General for possible recoupment for services provided after certification expired, and allowing the participant to choose another provider. DDS conducts remediation in these areas.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**
○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☑	Autism	0		☑
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

Both persons with intellectual disability and persons with developmental disability are recognized as target groups. Developmental disability diagnoses include Cerebral Palsy, Epilepsy, Autism, Down Syndrome, and Spina Bifida as categorically qualified diagnoses. Onset must occur before the person is 22 years old and must be expected to continue indefinitely. Other diagnoses will be considered if the condition causes the person to function as though they have an intellectual disability.

DDS eligibility is established by Arkansas Code Annotated, Section 20-48-101. The statute applies to Intermediate Care Facilities for Intellectual or Developmental Disability (ICF/IDD) and the HCBS Waiver. DDS interprets a developmental disability to be (1) a categorically qualifying diagnosis and three (3) significant adaptive behavior deficits related to this diagnosis. Following are the categorically qualifying diagnoses:

Cerebral Palsy as established by the results of a medical examination provided by a licensed physician. Epilepsy as established by the results of a neurological examination provided by a licensed physician.

Autism as established as a result of a team evaluation by at a minimum a licensed physician, a psychologist or psychological examiner, and speech pathologist.

Down syndrome as established by the results of a medical examination provided by a licensed physician. Spina Bifida as established by the results of a medical examination provided by a licensed physician.
Intellectual Disability as established by significant intellectual limitations that exist concurrently with deficits in adaptive behavior that are manifested before the age of 22. "Significant intellectual limitations" are defined as a full scale intelligence score of approximately 70 or below as measured by a standard test designed for individual administration. Group methods of testing are unacceptable.

The qualifying disability must constitute a substantial handicap to the person's ability to function without appropriate support services including, but not limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment. When the age of onset of the qualifying disability is indeterminate, the Assistant Director or the Director for Developmental Disabilities Services will review evidence and determine if the disability was present before age 22.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c*.
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*.

  The limit specified by the State is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:
  - ( ) **Other**

    Specify:
- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that

individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

- ○ **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

  - ○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - ○ **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

- ○ **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- ○ **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4303
Year 2	4803
Year 3	4863
Year 4	4883
Year 5	4903

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	4183
Year 2	4723
Year 3	4743
Year 4	4763
Year 5	4783

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Community Transition of children in foster care	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Community Transition of children in foster care

Purpose *(describe):*

Two hundred waiver openings (slots) are reserved for persons in foster care in the care or custody of the Department of Human Services, Division of Children and Family Services, including children adopted since July 1, 2010.

Describe how the amount of reserved capacity was determined:

The reserved capacity was determined based on the need for children to live in a caring community setting; capacities determined by existing children waiting for waiver services, factored by transition to regular capacity at time of reaching adulthood and upon existence of regular capacity vacancy.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	200
Year 2	200
Year 3	200
Year 4	200
Year 5	200

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

1) General Requirements: DDS policy requirements for information release, choice of community versus institution (102 choice form),and social history documents are executed.

2) Selection for participation is as follows:

a) In order of waiver application eligibility determination date for persons determined to have successfully applied for the waiver, but who through administrative error were or are inadvertently omitted from the Waiver wait list.

b) In order of waiver application eligibility determination date of persons for whom waiver services are necessary to permit discharge from an institution, e.g. persons who reside in ICFs/IID, Nursing Facilities, and Arkansas State Hospital patients; or admission to or residing in a Supported Living Arrangement (group homes and apartments).

c) In order of date of Department of Human Services (DHS) custodian choice of waiver services for eligible persons in the custody of the DHS Division of Children and Family Services or DHS Adult Protective Services.

d) In order of waiver application determination date for all other persons.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- (●) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Adults newly eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

Children who are receiving Title IV-E subsidy services or funding.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (●) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- (●) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- [x] **A special income level equal to:**

Select one:

- (●) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**
○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ **The following standard included under the State plan**

  Select one:

  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ○ **A percentage of the Federal poverty level**

    Specify percentage:
  - ○ **Other standard included under the State Plan**

    Specify:
- ○ **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:**

  Specify:
- ◉ **Other**

  Specify:

  The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process including income that is placed in a Miller Trust.

ii. Allowance for the spouse only (*select one*):

- ◉ **Not Applicable (see instructions)**
- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**
○ **AFDC need standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○ **The State does not establish reasonable limits.**
○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ **The following standard included under the State plan**

  Select one:

  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage: [ ]
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ○ **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ○ **Other standard included under the State Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

◉ **Other**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process including income that is placed in a Miller Trust.

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○ **The State does not establish reasonable limits.**
○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):
○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**

- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ◉ **Other**

  Specify:

  The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process including income that is placed in a Miller Trust.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ◉ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The State does not establish reasonable limits.**
- ○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires

regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

The Care Coordinator will monitor the beneficiary monthly until the beneficiary is attributed to a PASSE. Once attributed, the PASSE will take over the care coordination and monthly monitoring.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ◉ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ○ **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The initial evaluation of level of care is determined by a licensed psychologist or psychiatrist or individual working under the supervision of a licensed psychologist or psychiatrist.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The initial determination of eligibility for both the HCBS Waiver and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) requires the same type of evaluations. These include an evaluation of functional abilities that does not limit eligibility to persons with certain conditions, an evaluation of the areas of need for the person, a social history, and psychological evaluation applicable to the category of developmental disability, which are intellectual disability, cerebral palsy, epilepsy, autism, spina bifida, Down syndrome or other condition that causes a person to function as though they have an intellectual disability or developmental disability.

The DDS Psychology Team is responsible for determining initial eligibility for the Waiver. This eligibility process mirrors eligibility for ICF/IID institutional care. The same criteria as specified in "B1b" is applied for both HCBS Waiver and ICF/IID initial evaluations and reevaluations.

A person meets the level of care criteria when he or she:

(1) Requires the level of care provided in an ICF/IID, as defined by 42 CFR § 440.150; and
(2) Would be institutionalized in an ICF/IID in the near future, but for the provision of Waiver services.

According to 42 CFR 435.1009, Ark. Code Ann. § 20-48-101 et seq. and DDS Policy 1035, Eligibility, the DDS Psychology Team uses the same criteria to determine eligibility for HCBS Waiver as for ICF/IID. The criteria are:
(1) Verification of a categorically qualifying diagnosis;
(2) Age of onset is established to be prior to age 22;
(3) Substantial functional limitations in activities of daily living (adaptive functioning deficits) are present and are as a result of the categorically qualifying diagnosis. Adaptive functioning deficits are defined as an individual's inability to function in three of the following six categories as consistently measured by standardized instruments administered by qualified professionals: Self-Care, Understanding and Use of Language, Learning, Mobility, Self-Direction, and Capacity for Independent Living; and
(4) The disability and deficits are expected to continue indefinitely.

The DDS Psychology team is composed of psychological examiners and psychologists (employed or contracted). It must consider any standardized evaluation of intellect and adaptive behavior when conducted by the appropriate credentialed professional as specified by the instrument. Current standard of practice dictates the acceptability of testing instruments. Examples of instruments that may be considered acceptable in the determination of eligibility for the HCBS Waiver are Wechsler Scales of Intelligence, the Stanford-Binet Scales of Intelligence, the Vineland Adaptive Behavior Scales and the Adaptive Behavior Assessment Scales.

The DDS Psychology Team reviews the evaluations that are submitted and determines whether: the instruments used are appropriate based on age, mental capacity, medical condition and physical limitations; the evaluation was performed by a qualified evaluator; scores were interpreted by the evaluator; and the report was signed and dated. DDS maintains records of instruments used and assures the appropriateness of each instrument. The DDS Psychology Team also considers social history narratives, an evaluation of the person's areas of needs, and other written reports.

A Qualified Developmental Disability Professional (QDDP) assures that an annual evaluation of the person's institutional level of care is submitted to DDS. DDS requires that a Qualified Medical Professional, as defined by the State Medicaid Agency (i.e., a physician) prescribes home and community based services to meet the assessed needs of the individual. The DDS 703 form is used to submit this information. The DDS 703 form is comparable to the DHS 703 form used by the Office of Long Term Care to determine eligibility for ICF/IID but includes modifications specific to the HCBS Waiver.

Annually, and before the end of the current PCSP year, DDS notifies the beneficiary's Care Coordinator of the need for PCSP renewal and the date for the next full evaluation by the DDS Psychology Team. For a full evaluation by the DDS Psychology Team, the provider must submit an IQ testing report, if required, and adaptive functioning test results, based on age and the DDS -703 Physician's form.

1) For persons over the age of five, the diagnosis is established as consistently measured by scores of intelligence which fall two or more standard deviations below the mean of a standardized test of intelligence, administered by a licensed professional.
2) For children birth to five, the diagnosis is established as consistently measured by developmental scales, administered by qualified personnel authorized in the manual accompanying the instrument used, which indicate impairment of general functioning similar to that of a person with an intellectual or developmental disability.

For children who have not finished school, initial eligibility will be based upon adaptive functioning testing and IQ testing performed every three years. For persons who have completed school, initial eligibility will be based upon adaptive functioning testing and IQ testing performed once after age twenty-two. Thereafter, a current adaptive behavior evaluation is required every five years. Evaluation may be required by DDS on a more frequent basis if information suggest that adaptive behavior or IQ scores have changed to the degree that eligibility is questioned.

Eligibility for waiver services is presumed when the person is eligible and receiving services in an ICF/IID.

Eligibility for persons with co-occurring diagnoses of intellectual disability or developmental disability and mental illness is established when the DDS Psychology Team has determined that the primary disability for the person is the intellectual or developmental disability, not the mental illness.

DDS reserves the right to require an evaluation of eligibility at any time.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

DDS evaluates all applicants using the process described in B6d for the initial application for ICF/IID and waiver services. The completed application packet is sent to the DDS Psychology Team who reviews the information, makes a determination of eligibility and documents the determination on Form DHS 704.

DDS requires that, annually, providers send documentation of a standard functional assessment conducted by a Qualified Developmental Disability Professional (QDDP) for each person served by the Waiver. DDS staff review the results of the functional assessment and determine continued functional eligibility. This process is consistent with the requirements and processes for ICF/IID.

For periodic reevaluations to confirm diagnosis and functional eligibility, the person receiving waiver services or their provider obtains and submits psychological and intelligence testing, and adaptive evaluations to DDS for a determination of eligibility by the DDS Psychological Team. The team reviews the documentation to determine whether the instruments used in the evaluation process were appropriate according to the age, mental, medical and physical condition of the beneficiary. If the team determines the instruments are acceptable, they verify the age of onset and the corresponding functional deficit and make a determination of continued eligibility. This team may require additional evaluations, but will not conduct any testing or evaluations themselves.

If a beneficiary disagrees with an eligibility determination, they may appeal to the Assistant Director for Quality Assurance for an administrative review of the findings. Beneficiaries may also appeal directly to the DHS Office of Appeals and Hearing, in accordance with DDS Appeals Policy 1076.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○ **Every three months**
○ **Every six months**
◉ **Every twelve months**
○ **Other schedule**
Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
◉ **The qualifications are different.**
Specify the qualifications:

A QDDP at the Provider organization prepares and signs documentation annually to request from DDS continuation of HCBS services (annual level of care reevaluation) for each participant. DDS staff who review this annual documentation will meet QDDP qualifications or have their reviews signed by a staff person who meets QDDP qualifications.
DDS staff who perform periodic redeterminations of eligibility (not level of care) will meet the qualifications of a Psychological Examiner.

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

DDS staff generate a monthly report identifying any person whose periodic functional assessment and annual institutional level of care packet are due. Periodic functional assessment are described in B.6. d. Packets include the reports and assessments noted in this section.

DDS sends the report to the beneficiary's Care Coordinator, who is responsible for ensuring timely reevaluation. For quality assurance purposes, DDS managers also produce a monthly report identifying the same information sorted by DDS staff. Waiver managers follow up with staff, who notify care coordinators.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All records are maintained in an electronic environment with protected security and access. This system includes level of care records. All electronic records are housed by the Department of Information Systems in the state designated storage medium. The responsibility for day to day operations remains with DDS.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LOC A1: Number and percentage of applicants for whom an application packet is completed and submitted timely to the DDS psychology team for an LOC initial determination. Numerator: Number of applicants for whom an application packet is completed and submitted timely to the DDS psychology team for an LOC initial determination; Denominator: Number of application packets submitted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Intake and Referral Report of Timely Application Submissions

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC A2: Number and percentage of applicants who had an initial LOC determination completed before receipt of services. Numerator: Number of applicants who had an initial LOC determination completed before receipt of services; Denominator: Number of initial LOC determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual File Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LOC C1: Number and percentage of participants for whom the appropriate process and instruments were used to determine initial eligibility. Numerator: Number of participants' packets with appropriate process and instruments used to determine initial eligibility; Denominator: Number of participant's packets reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
	☐ **Weekly**	☑ **100% Review**

☐ **State Medicaid Agency**		
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
(LOC A1) The Intake and Referral (I&R) Application Tracking system tracks all applications on an ongoing basis. At 45 days, the Intake Specialist sends a notice to families to notify them that the information is due. For applications over 90 days old, the Intake Manager reviews overdue applications for cause and then contacts Intake staff to develop a corrective action plan, which will be implemented within 10 days. The Intake Manager will submit an I&R Report of Timely Application submissions to the I&R administrator monthly for review to identify any systemic issues and to determine if there is a need for corrective action. The I&R administrator will submit a quarterly report to the QA Assistant Director and describes any corrective actions.

(LOC A2) The system in place for new applicants to enter the HCBS waiver program does not allow for services to be delivered prior to an initial determination of Level of Care.

(LOC C1) The DDS Psychology Team manager reviews 100% of all initial waiver application determinations submitted within the previous month for process and instrumentation review. A Requirement checklist form for each application in the sample is completed for procedural accuracy and appropriateness of testing instruments utilized in adjudications. Results are tracked. The Psychology Supervisor contacts Psychology staff to develop corrective action plan, which will be implemented within 10 days. The Psychology supervisor submits a quarterly report to the QA Assistant director and outlines corrective actions.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. *informed of any feasible alternatives under the waiver; and*
ii. *given the choice of either institutional or home and community-based services.*

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver intake and referral is the responsibility of DDS intake and referral staff. The DDS staff person explains the service options of the Waiver or ICF/IID to each beneficiary or their legal guardian by phone, personal visit, email, or mail. The beneficiary or legal guardian completes the HCBS Choice Form and selects either the Community and Employment Supports Waiver program or ICF/IID placement. For persons residing in an ICF/IID, choice between the programs is offered annually at the time of their annual PCSP review. Anyone residing in an ICF/IID can request Waiver services at any time by contacting DDS. Transition Coordinators work with the Waiver Applications Unit Administrator and assigned DDS Waiver Specialist. Annual choice is offered by DDS staff prior to the individual's annual review. The choice form provides a means to track whether choice was offered. It also provides supporting evidence that the options elicit an informed choice as attested to by the signature of the DDS representative.

Beneficiaries may change individual service providers at any time.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Individual Community and Employment Support Waiver application packets including the choice form are maintained in an electronic format during the application process. Each applicant’s electronic case file is maintained by the assigned DDS Specialist who is located in a designated DHS county offices. Documentation of the beneifciary’s annual choice following initial entrance into the Waiver program is maintained in the electronic case file.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
DDS provides information in an alternate format once the need for accommodation is identified. Identification of need is made through observation, document review for diagnosis and other case related information, and self or third-party notification. Awareness is provided through training, employee technical assistance, communications with provider organizations and consumer advocates, and Department of Human Services (DHS) electronic medias. A HCBS Waiver handbook is available in Spanish, hardcopy and online. In addition, the handbook will be made available in any other language, large print or any other medium to reasonably accommodate needs as identified by the individual. DHS contracts for interpreter services when needed.

DDS also operates a TDD line to assist those individuals with hearing or speech difficulties.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Care Coordination**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Statutory Service	**Supportive Living**		
Extended State Plan Service	**Specialized Medical Supplies**		
Other Service	**Adaptive Equipment**		
Other Service	**Community Transition Services**		

Service Type	Service		
Other Service	Consultation		
Other Service	Crisis Intervention		
Other Service	Environmental Modifications		
Other Service	Supplemental Support		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Care Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01 010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Care coordination is ensuring that specialty services are coordinated and appropriately delivered by specialty providers. It includes the following activities:
1) Health education and coaching;
2) Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;
3) Assistance with social determinants of health, 3 such as access to healthy food and exercise;
4) Promotion of activities focused on the health of a patient and the community, including without limitation outreach, quality improvement, and patient panel management;
5) Coordination of Community-based management of medication therapy.

The care coordinator is responsible for the total plan of care for each beneficiary assigned to him or her. This includes, but is not limited to, the following:

1) Behavioral Health Treatment Plan;
2) Person Centered Service Plan;
3) Primary Care Physician Care Plan;
4) Individualized Education Program;
5) Individual Treatment Plans for developmental clients in day habilitation programs;
6) Nutrition Plan;

7) Housing Plan;
8) Any existing Work Plan;
9) Justice system-related plan;
10) child welfare plan; or
11) Medication management plan.

The care coordinator is responsible for obtaining copies of all treatment and service plans related to an individual beneficiary and coordinating services between those plans. The goal is to prevent duplication of services, ensure timely access to all needed services, and identify any service gaps for the beneficiary. The ultimate goal of the care coordinator is to assist the beneficiary in remaining in the most appropriate and least restrictive setting for that beneficiary.

Other services provided by the care coordinator include:

1) Coordinating and arranging all CES waiver services and other state plan services;
2) Identifying and accessing needed medical, social, educational and other publicly funded services (regardless of funding source);
3) Identifying and accessing informal community supports needed by eligible beneficiaries and their families.
4) Monitoring and reviewing services provided to the beneficiary to ensure all plan services are being provided and to ensure the health and safety of the beneficiary;
5) Facilitating crisis intervention;
6) Providing guidance and support to meet generic needs;
7) Conducting appropriate needs assessments and referral for resources;
8) Monitoring services provided to ensure quality of care and case reviews which focus on the beneficiary's progress in meeting goals and objectives established on existing case plans;
9) Providing assistance relative to obtaining waiver Medicaid eligibility and ICF/IID level of care eligibility determinations;
10) Ensuring submission of timely (advanced) and comprehensive behavior and assessment reports, continued PCSPs, revisions as needs change and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;
11) Arranging for access to advocacy services as requested by beneficiary.
12) Providing assistance upon receipt of DDS or DHS notices or denials, including assistance with the reconsideration and appeal process.
The care coordinator will also be responsible for assisting the beneficiary with transitioning between service settings, for example with transition from the residential treatment setting to community based care.

Care coordination services must be available to attributed beneficiaries 24 hours a day through a hotline or web-based application.

If a beneficiary has already been assigned to or selected a PCP or PCMH, that PCP or PCMH will be responsible for coordinating the beneficiary's medical care. If the beneficiary does not have a PCP selected, care coordinator must assist the beneficiary with selecting a PCP or provide a referral to a PCP.

A care coordinator cannot have more than 50 beneficiaries on its caseload at any one time. The care coordinator must make a monthly face-to-face contact with each beneficiary assigned. The care coordinator must also obtain all treatment plans for the beneficiary and obtain all medical records for the beneficiary in order to adequately coordinate services, identify health needs, and provide health coaching and health education.

If the beneficiary is seen in an emergency room or urgent care clinic or is admitted to an acute inpatient psychiatric facility, the care coordinator must follow up with the beneficiary within seven (7) days of discharge from the facility. The follow up visit is to ensure that all discharge instructions are being followed and any follow-up appointments have been scheduled. Care coordination services must be available to attributed beneficiaries 24 hours a day.

Each individual who is determined to meet the ICF/IID level of care and enrolled in the Waiver must receive an Independent Assessment (IA) performed by a Third Party Vendor. The IA, along with the individual’s application packet and functional assessments, will determine whether the Participant is in Tier 2 or Tier 3.

Person-Centered Service Plan Development: PCSP Development consists of development of the PCSP. The PCSP is a treatment plan developed and driven by the beneficiary and/or parent or guardian to deliver specific services to enhance and maintain community living, support the person in all major life activities, determine the person's

choice about their life, assist the person in carrying out those choices, access employment services,& assist the person with integrating into the life & activities of their community. The PCSP must be based on individualized services needs identified in the person's diagnosis and IA results. The plan must include goals for the medically necessary treatment of identified problems, identify the individuals responsible for treatment, specific treatment modalities prescribed, and limitation for services. The PCSP must be congruent with the age and abilities of beneficiary, person-centered and strength-based; with emphasis on the needs as identified by the beneficiary and demonstrate cultural competence.

DHS and DDS will implement a Provider Led Organized Care model of case management/care coordination where each Waiver Beneficiary is assessed for a Tier Determination, as well as needs and risks. The beneficiary will then be enrolled in a Provider-led Arkansas Shared Savings Entity (PASSE). Once enrolled in a PASSE, care coordination services will no longer be available under the 1915 (c) Waiver. They will be provided under the 1915 (b) Waiver.

Until such time as every beneficiary can be moved over into the Provider Led Managed Care model of case management/care coordination, DDS will continue to implement the following firewalls and mitigation strategies:
1) DDS will make eligibility determinations for the Waiver, including both level of care and financial need determinations;
2) DDS will review the Provider conducted annual clinical needs-based assessment prior to approving each beneficiary's PCSP;
3) The individual who performs the annual needs based assessment may not be a provider of services on the PCSP and may not provide direct care. DDS will monitor to make sure that assessors are not providing treatment or direct care to waiver beneficiaries;
4) DDS will perform utilization reviews;
5) DDS will review and approve/deny beneficiaries' PCSPs at the annual time of renewal or with any submitted amendment/modification;
6) Beneficiaries will be encouraged to advocate or have an advocate present during planning meetings;
7) Providers will administratively separate case management functions and staff and direct care functions and staff;
8) DDS established a consumer council to monitor issues of choice;
9) DDS established an accessible means for consumers to file grievances or complaints and to appeal to DDS regarding concerns about choice, quality, and outcomes;
10) DDS Waiver Specialists and the DDS Assistant Director of Waiver Services will oversee all plans to ensure consumer choice and control; and
11) DDS has tools in place that measure consumer experiences and capture the quality of care.

Care Coordination services may be available during the last 180 consecutive days of a Medicaid eligible person's institutional stay to allow care coordination activities to be performed related to transitioning the person to the community. The person must be approved and in the Waiver program for care coordination to be billed.

Care Coordination will be provided for up to a maximum of a 90 day transition period for all persons who seek to voluntarily withdraw from Waiver services. The transition period will allow for follow up to ensure that the beneficiary is referred to other available services and to assure that the beneficiary's needs can be met through optional services. It also serves to assure that the beneficiary understands the effects and outcomes of withdrawal and to ascertain if the beneficiary was coerced or otherwise was unduly influenced to withdraw. During this 90 day timeframe, the beneficiary remains enrolled in the Waiver and the case remains open. During the transition period, Waiver services will continue to be available up and until such time as the individual finalizes their intent to withdraw.

Care Coordination waiver services will be furnished when payment to the hospital, NF or ICF/IID is being made through private pay or private insurance and Medicaid is not reimbursing for this care. While the waiver beneficiary is in a hospital, nursing facility or institution (ICF) receiving treatment, they are not residing in the treatment facility. Rather, just like any non-institutionalized person or person without a developmental disability, their community residence (home in which they reside) is maintained. When Medicaid is not the payer for the treatment, the waiver individual can remain enrolled in the Waiver without harm to the payments for the treatment. When this provision applies, approval is in 3 month increments with no approval beyond 1 year.

Given the nature of the population of the CES waiver, it is sometimes necessary to place cases in abeyance to allow the case to remain open while the beneficiary is temporarily placed in a licensed or certified treatment program for the purposes of behavior, physical or health treatment or stabilization. On a monthly basis, the care coordination provider must conduct a monitoring contact and report the status to the applicable DDS Specialist. If the care

coordination provider does not conduct the monitoring contact for the month, the DDS Specialist is responsible for the monitoring contact.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The reimbursement amount is $173.33 per month.

Minimum of one face-to-face contact per month. After the initial contact, the monthly contact can be made via video conference.

When a beneficiary is placed in abeyance - minimum of one visit or contact a month by the Care Coordinator or the DDS Specialist (When the DDS Specialist performs the monitoring functions, no waiver fee is charged or reimbursed - the cost is absorbed in the DDS Waiver Administrative budget). Abeyance is used when a person is temporarily (must be out of service at least one month with abeyance approved in 3 month increments, not to exceed one year) placed in a licensed or certified treatment program for purposes of behavior, physical or health treatment or stabilization.

Care coordination is not available to beneficiaries who have been attributed to a PASSE. These beneficiaries will receive care coordination through the PASSE entity. However, PCSP development will remain as a CES Waiver service.

Person-Centered Service Plan Development may be billed when the beneficiary enters the Waiver and must be reviewed at least annually, or more frequently if there is documentation of a significant change of condition that requires an update in the beneficiary's treatment plan.

Yearly maximum of 1 per year (prior authorization for additional PCSP development can be requested).There will be a maximum rate of $90.00 per Plan development.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Care Coordination Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Care Coordination

Provider Category:
Agency
Provider Type:
Certified Care Coordination Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
An individual must meet the following qualifications to provide care coordination to beneficiaries:

A. Be a Registered Nurse (R.N.), a physician, or have a bachelor’s degree in a social science or health-

related field; or
Have at least one (1) year of experience working with developmentally or intellectually disabled clients or behavioral health clients;
B. Successfully complete a background check, that includes a criminal background and child and adult maltreatment registry check;
C. Successfully pass an initial drug screen prior to providing care coordination and working directly with clients;
D. Successfully pass an annual drug screen to continue to be allowed to provide care coordination; and
E. Cannot be excluded or debarred under any state or federal law, regulation or rule or not eligible or prohibited to enroll as a Medicaid provider.

A PCSP Developer must meet the following qualifications to develop and implement the Person-Centered Service Plan:

A. Be a Registered Nurse (R.N.), a physician, or have a bachelor's degree in a social science or health-related field;
B. Have at least one (1) year of experience working with developmentally or intellectually disabled clients;
C. Successfully complete a background check, that includes a criminal background and child and adult maltreatment registry check;
D. Successfully pass an initial drug screen prior to and working directly with beneficiaries;
E. Successfully pass an annual drug screen; and
F. Cannot be excluded or debarred under any state or federal law, regulation or rule or not eligible or prohibited to enroll as a Medicaid provider.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Quality Assurance

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**

09 Caregiver Support	09012 respite, in-home

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Respite services are provided on a short term basis to participants unable to care for themselves due to the absence of or need for relief to the non-paid primary caregiver. Federal Financial Participation (FFP) may not be claimed for the cost of room & board, except when provided as part of the respite care furnished in a facility approved by the state; FFP may not be claimed for room and board when Respite is provided in the participant's home or private place of residence.
Receipt of respite does not necessarily preclude a participant from receiving other services on the same day. For example, a participant may receive day services, such as supported employment, on the same day as respite services.

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite may not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.

Respite services may be provided through a combination of basic child care & support services required to meet the needs of a child. Waiver will not pay for child care services.

Respite may be provided in the following locations:

1) Participant's home or private place of residence;

2) The private residence of a respite care provider;

3) Foster home;

4) Licensed respite facility; or

5) Other community residential facility approved by the state, not a private residence. Respite care may occur in a licensed or accredited residential mental health facility.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is a 30 day consecutive maximum on respite services in non-HCB settings.

All units must be billed in accordance with the participant's PCSP. Extensions will be provided when extended benefits are determined to be medically necessary.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Respite Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Certified Respite Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
The provider entity must be certified by AR DDS as an HCBS provider and have elected to provide respite services. The provider must provide evidence that they require the following qualifications and requirements of staff who provide respite services:
1.Staff must:
a.Have a high school diploma, or GED, and
b.At least one year of relevant supervised work experience with a public health, human services or other community service agency, or
c.Have two years of verifiable successful history working with persons with developmental disabilities.
2.Staff must demonstrate the ability to:
a.Understand written person-centered service plans, follow instructions, and document services delivered,
b.Communicate effectively,
c.Perform CPR and administer First Aid,
d.Access emergency service systems, and
e.Access transportation services as appropriate.
3.Staff must:
a.Not be disqualified from employment due to a criminal record according to Ark. Code Ann. §20-38-101 et seq., and
b.Not be listed on either the adult or child maltreatment registry, and
c.Have satisfactorily completed a drug screen in accordance with the Organization's policies.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Quality Assurance

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
03 Supported Employment	03022 ongoing supported employment, group
Category 4:	**Sub-Category 4:**
03 Supported Employment	03030 career planning

Service Definition *(Scope):*
Supported Employment is a tailored array of services that offers ongoing support to participants with the most significant disabilities to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for individuals for whom competitive employment has not traditionally occurred, or has been interrupted or intermittent as a result of a significant disability, and who need ongoing supports to maintain their employment.

Supported Employment array consist of the following supports:

1) Discovery Career Planning-information is gathered about a participant's interests, strengths, skills, the types of supports that are most effective, and the types of environments and activities where the participant is at his or her best. Discovery/Career Planning services should result in the development of the Individual Career Profile which includes specific recommendations regarding the participant's employment support needs, preferences, abilities and characteristic of optimal work environment. The following activities may be a component of Discovery/Career Planning: review of the participant's work history, interest and skills; job exploration; job shadowing; informational interviewing including mock interviews; job and task analysis activities; situational assessments to assess the participant's interest and aptitude in a particular type of job; employment preparation (i.e. resume development); benefits counseling; business plan development for self-employment; and volunteerism.

The service provider must produce and maintain the following documents to demonstrate compliance and delivery of services- Individual Career Profile-Discovery Staging Record.

2) Employment Path-Participant's receiving Employment Path services must have goals related to employment in integrated community settings in their Person Centered Support Plan (PCSP). Employment Path is a time-limited service that requires prior authorization for the first 12 months. One reauthorization of up to 12 months is possible, but only if the participant is also receiving Job Development services which indicates the participant is actively seeking employment. Service activities must be designed to support such employment goals. Employment Path services can replace non-work services. Activities under Employment Path should develop and teach soft skills utilized in integrated employment which include but are not limited to following directions, attending to tasks, problem solving skills and strategies, mobility training, effective and appropriate communication.-verbal and nonverbal, and time management.
The service provider must maintain the following documents to demonstrate compliance and delivery of services- PCSP, progress notes, Arkansas Rehabilitation Services Referral.

Employment supports consists of two primary components-Job development and Job Coaching.
Employment Supports Job Development services are individualized services that are specific in nature to obtaining certain employment opportunity. The initial outcome of Job Development Services is a Job Development Plan to be incorporated with the Individual Career Profile no later than 30 days after job development services

commence. Job development plan should specify at a minimum the short and long term employment goals, target wages, tasks hours and special conditions that apply to the worksite for that participant; jobs that will be developed and/or description of customized tasks that will be negotiated with potential employers; initial list of employer contacts and plan for how many employers will be contacted each week; conditions for use of on-site job coaching. The service provider must maintain the following documents to demonstrate compliance and delivery of services-Job Development Plan and participant's remuneration statement.

Employment Supports Job Coaching services are on-site activities that may be provided to a participant once employment is obtained. Activities provided under this services may include, but are not limited to, the following: Complete job duty and task analysis; assist the participant in learning to do the job by the least intrusive method; develop compensatory strategies if needed to cue participant to complete job; analyze work environment during initial training/learning of the job, and make determinations regarding modifications or assistive technology.

This service may also be utilized when the participant choses self-employment. Activities such as assisting the participant to identify potential business opportunities, assisting in the development of business plan, as well as other activities in developing and launching a business. Medicaid Waiver funds may not be used to defray expenses associated with starting or operating a self-employment business such as capital expenses, advertising, hiring and training of employees.

The service provider of Employment Supports Job Coaching must develop a fading plan for this service to be achieved within 12 months. Additional authorizations of Employment Supports Job Coaching with no additional fading gains will require additional documentation of level of need for service.

Employment supports extended services. The expected outcome of Employment Supports Extended Services is sustained paid employment at or above minimum wages with associated benefits and opportunities for advancement in a job that meets the participant's personal and career planning goals. This service allows for the continued monitoring of the employment outcome through maintenance of regular contact with the participant and employer. Activities allowed under this service must include, but are not limited to, a minimum of one contact per quarter with the employer.

Transportation between the participant's place of residence and the employment site is included as a component of supported employment services when there is no other resource for transportation available. Other transportation resources must be accessed first and exhausted. The cost for transportation is included as a part of the supported employment rate paid to providers.

The service provider must maintain the following documents to demonstrate compliance and delivery of this service-ARS letter of closure, remuneration statement (paycheck stub) and participant's work schedule if available.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supported employment cannot exceed $3.59 per 15 minute unit with a maximum of 32 units a day. Supported Employment provided as long term support requires monitoring at a minimum of two meetings with the individual and one employer contact each month. The person is required to work 15 hours minimum per week in accordance with ARS regulations. Exceptions must be justified by the individual's care coordinator and prior approved by ARS. ARS approves the exception with monthly monitoring. Exception justifications (such as medical involvement) citing why the person cannot work at least 15 hours per week must be prepared in writing by the individual's care coordinator and submitted to the ARS counselor assigned to the case.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Agency	Certified Supported Employment Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Certified Supported Employment Vendor
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DDS Certification as a supported employment provider.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The entity responsible for verification is the DDS Quality Assurance in conjunction with Arkansas Rehabilitation Services.
Frequency of Verification:
DDS Quality Assurance in conjunction with Arkansas Rehabilitation Services verify provider qualification annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Habilitation
Alternate Service Title (if any):
Supportive Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**

02 Round-the-Clock Services	02011 group living, residential habilitation

Category 3: **Sub-Category 3:**

04 Day Services	04010 prevocational services

Category 4: **Sub-Category 4:**

04 Day Services	04020 day habilitation

Service Definition *(Scope):*
Supportive Living is an array of individually tailored services & activities to enable participants to reside successfully in their own home, with family, or in an alternative living residence or setting. Alternative living residences include apartments, leased or owned homes, or provider group homes. Supportive living services must be provided in integrated community settings. Services are flexible to allow for unforeseen changes needed in schedules and times of service delivery. Services are approved as maximum days that can be adjusted within the annual plan year to meet changing needs.

The payments for these services exclude the costs of the person's room & board expenses including general maintenance, upkeep or improvement to the participant's or their families' homes.
Care & supervision for which payment will be made are those activities that directly relate to active treatment goals & objectives.

Residential habilitation supports are to assist the participant to acquire, retain or improve skills in a wide variety of areas that directly affect the person's ability to reside as independently as possible in the community. These services provide the supervision & support necessary for a person to live in the community. The supports that may be provided to an eligible person include the following:

-Decision making, including the identification of & response to dangerously threatening situations, making decisions & choices affecting the person's life & initiating changes in living arrangement or life activities;

-Money management, including training, assistance or both in handling personal finances, making purchases & meeting personal financial obligations;

-Daily living skills, including habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medications (to the extent permitted under state law) & other areas of daily living including proper use of adaptive & assistive devices, appliances, home safety, first aid and emergency procedures;

-Socialization, including training, assistance or both in participation in general community activities, & establishing relationships with peers. Activity training includes assisting the person to continue to participate on an ongoing basis;

-Community integration experiences, including activities intended to instruct the person in daily living & community living skills in integrated settings. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. Community experiences include activities & supports to accomplish individual goals or learning areas including recreation and specific training or leisure activities. Each activity is then adapted according to the participant's individual needs. Transportation to or from community integration experiences is an integral part of this service and is included in the daily rate computation. DDS will ensure duplicate billing between Waiver services & other Medicaid state plan services will not occur. The habilitation objectives to be served by such training must be documented in the person's service plan;

-Mobility, including training, assistance or both aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing & using public transportation, independent travel or movement within the community;

-Communication, including training in vocabulary building, use of augmentative communication devices & receptive and expressive language;

-Behavior shaping and management, including training, assistance or both in appropriate expressions of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate

behaviors;

-Reinforcement of therapeutic services, including conducting exercises or reinforcing physical, occupational, speech & other therapeutic programs.

Companion & activities therapies are services and activities to provide reinforcement of habilitative training. This reinforcement is accomplished by using animals as modalities to motivate participants to meet functional goals established for the participant's habilitative training. Through the utilization of an animal's presence, enhancement and incentives are provided to participants to practice and accomplish such functional goals as follows:
1) Language skills;
2) Increase range of motion;
3) Socialization by developing the interpersonal relationships skills of interaction, cooperation and trust & the development of self-respect, self-esteem, responsibility, confidence and assertiveness;
This service does not include the cost of veterinary or other care, food, or ancillary equipment that may be needed by the animal that is providing reinforcement.

The Direct Care Supervisor employed by the Supportive Living provider is responsible for ensuring the delivery of all supportive living direct care services including the following activities:
1) The coordination of all direct service workers who provide care through the direct service provider;
2) Serving as liaison between the person, parents, legal representatives, case manager, & DDS officials;
3) Coordinating schedules for both waiver & generic service categories;
4) Providing direct planning input and preparing all direct service provider segments of any initial person-centered service plan and annual continued stay review;
5) Assuring the integrity of all direct care service Medicaid waiver billing in that the service delivered must have DDS prior authorization & meet required waiver service definition and must be delivered before billing can occur;
6) Arranging for staffing of all alternative living settings;
7) Ensuring transportation as identified in participant's PCSP specific to supportive living services;
8) Timely collaboration with the care coordinator to obtain comprehensive behavior & assessment reports, continued PCSP, revisions as needs change and information and documents required for ICF/IID level of care & waiver Medicaid eligibility determination;

Health maintenance activities may be provided a supportive living worker All health maintenance activities except injections and IV's, can be done in the home by a designated care aide, such as a waiver worker, with appropriate documentation of training. With the exception of injectable medication administration, tasks that consumers would otherwise do for themselves, or have a family member do, can be performed by a paid designated care aide at their direction, as long as the criteria specified in the Arkansas Nurse Practices Consumer Directed Care Act has been met. Health maintenance activities are available in the Arkansas Medicaid State Plan as self-directed services. State Plan services must be exhausted before accessing waiver funding for health maintenance activities.

Persons may access both supportive living and respite on the same date as long as the two services are distinct, do not overlap and the daily rate maximum is correctly prorated as to the portion of the day that each respective service was actually provided. DDS monitors this provision through retrospective annual look behind with providers responsible to maintain adequate time records and activity case notes or activity logs that support the service deliveries. Maximum daily rate is established in accordance with budget neutrality wherein both supportive living and respite cannot exceed the daily maximum.

Controls to assure payments are only made for services rendered: requirement by assigned staff to complete daily activity logs for activities that occurred during the work timeframe with such activities linked to the PCSP objectives; supervision of staff by the direct care supervisor with sign off on timesheets weekly; audits & reviews conducted by DDS Quality Assurance (annually) & random; DDS Waiver Services annual reviews (retrospective), random attendance at planning meetings & visits to the home; DMS random audits; & oversight by the chosen and assigned case manager. Retainer payments are allowable to providers for the lesser of 14 consecutive days or number of days a participant is hospitalized or otherwise away from his or her home.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
All units must be billed in accordance with the participant's PCSP. Extensions will be provided when extended benefits are determined to be medically necessary.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☑ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Supported Living Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supportive Living

Provider Category:
Agency
Provider Type:
Certified Supported Living Provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*
The provider must be certified by DDS as an HCBS provider and have elected to provide Supportive Living services. The provider must maintain evidence that they require the following qualification and requirements of staff who provide supportive living and transportation.
1.Staff must:
a.Have a high school diploma, or GED, and
b.At least one year of relevant supervised work experience with a public health, human services or other community service agency, or
c.Have two years of verifiable successful history working with persons with developmental disabilities.
2.Staff must demonstrate the ability to:
a.Understand written person-centered service plans, follow instructions, and document services delivered,
b.Communicate effectively,
c.Perform CPR and administer First Aid,
d.Access emergency service systems, and
e.Access transportation services as appropriate.
3.Hold a current and valid driver's license or a Commercial Driver's License (CDL), as appropriate, if they provide transportation.
4.Not be disqualified from employment due to a criminal record according to Ark. Code Ann. §20-38-101 et seq., and
5.Not be listed on either the adult or child maltreatment registry, and
6.Have satisfactorily completed a drug screen in accordance with the Organization's policies.
7.Show proof of specific training in behavioral support plans and de-escalation techniques.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Quality Assurance
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	4032 supplies
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	1060 prescription drugs
Category 3:	**Sub-Category 3:**
17 Other Services	7990 other
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized medical equipment and supplies include:

1) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

2) Such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations and has been deemed medically necessary by the prescribing physician;

3) Necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. The most cost effective item will be considered first.

Additional supply items are covered as a Waiver service when they are considered essential and medically necessary for home and community care. A physician must document and order all items. And all items must be included in the PCSP. When such items are included as a Medicaid state plan service, this will be an extension of such services. A denial of extension of benefits by utilization review will be required prior to approval for waiver funding by DDS. Items covered include:

1) Nutritional supplements;

2) Non-prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage.

3) Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under state plan are exhausted.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specialized medical supplies are only provided to individuals age 21 and over. Most medically necessary supplies are provided to children age 21 and under in the state plan pursuant to the EPSDT benefit; however, specialized medical supplies may be billed under the Waiver to the extent they are not covered by EPSDT benefits in the State Plan to children age 21 and under.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Specialized Medical Supplies provider.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Specialized Medical Supplies

Provider Category:
Agency
Provider Type:
Certified Specialized Medical Supplies provider.
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified by DDS as an HCBS provider and have selected to provide the service Specialized Medical Supplies
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DDS Quality Assurance
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adaptive Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adaptive Equipment means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants.

This service includes adaptive, therapeutic and augmentative equipment that enables a person to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. Adaptive equipment needs for supported employment for a person is also included. This service may include specialized equipment such as devices, controls or appliances that will enable the person to perceive, control or communicate with the environment in which they live and to improve the person's functional capacity to perform daily life tasks that would not be possible otherwise.

Adaptive equipment includes enabling technology, such as safe home modifications, that empower participants to gain independence through customizable technologies that allow them to safely perform activities of daily living without assistance while still providing monitoring and response for those participants, as needed. Enabling technology allows participants to be proactive about their daily schedule and integrates participant choice. Before any enabling technology may be approved, it must be shown to meet a goal of the PCSP, ensures the participant's health and safety, and provides for adequate monitoring and response. Each participant who receives enabling technology must have an assessment conducted and a plan created for how that technology will be used to meet a PCSP goal, ensure the participant's health and safety, and provide adequate monitoring and response.

Personal Emergency Response Systems (PERS) can be approved when it can be illustrated to be necessary to protect the health and safety of the participant. PERS is a stationary or portable electronic device used in the participant's place of residence, which enables the participant to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device. PERS services are limited to participants who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. Included in this support are assessment, purchase, installation and monthly rental fee. PERS shall consist of installation and testing, as well as monthly monitoring performed by a response center.

Equipment may only be purchased if not available to the person from any other source. When items are included as a Medicaid state plan service, a denial by utilization review will be required prior to approval for waiver funding by DDS. Professional consultation must be accessed to ensure that the equipment will meet the needs of the person when the purchase will at a minimum exceed $500.00. Consultation must be conducted by a medical professional applicable as determined by the participant's condition for which the equipment is needed. Computer equipment can be approved when it will allow the participant control of their environment, to assist the participant to gain

independence, or it can be demonstrated as necessary to protect the health and safety of the participant. The waiver does not cover supplies. Printers may be approved for non-verbal participants. Computer desks or other furniture items will not be covered. Communication boards are an allowable device. Computers may be approved for communication when there is substantial documentation that a computer will meet the needs of the person more appropriately than a communication board. Software will be approved only when required to operate the accessories included for environmental control; or to provide text-to-speech capability.

Vehicle Modifications are adaptations to an automobile or van to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant. Payment for permanent modification of a vehicle is based on the cost of parts and labor, which must be quoted and paid separately from the purchase price of the vehicle to which the modifications are or will be made. Transfer of any part of the purchase price of a vehicle, including preparation and delivery, to the price of a modification is fraudulent activity. All suspected fraudulent activity will be reported to the Office of Medicaid Inspector General (OMIG) for investigation. Reimbursement for a permanent modification cannot be used or considered as down payment for a vehicle. Lifts that require vehicle modification and the modifications are, for purposes of approval and reimbursement, one project and cannot be separated by plan of care years in order to obtain up to the maximum.

Vehicle Modification Exclusions: The following are specifically excluded:

1) Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the participant;

2) Purchase, down payment, monthly car payment, or lease cost of the vehicle;

3) Regularly scheduled upkeep and maintenance of the vehicle.

Conditions - The care and maintenance of environmental equipment, adaptive equipment, vehicle modifications and personal emergency response systems are entrusted to the individual or legally responsible person for whom the aids are purchased. Negligence (defined as failure to properly care for or perform routine maintenance) shall mean that the service will be denied for a minimum of two plan years. Any abuse or unauthorized selling of aids by the individual or legally responsible person shall mean that the aids will not ever be replaced using Waiver funding. Deterrent for non-compliance is in the form of public comment through promulgation of this stipulation; notice of cause and effect at the time of individual equipment approval; monitoring is accomplished when the item is later requested again with denial if the original item is found to been sold; identification of other funding sources when the item is needed to help assure health and safety. Examples: Special needs (100% state general revenue) funding is available for persons not receiving waiver services. If waiver services are not available then special needs is an option. Another example or option is that waiver services would continue but not in the home of the person who was responsible for the loss.

All adaptive equipment must be solely for the waiver individual and used only by that individual. All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids with the lowest bid with comparable quality being awarded; however, DDS may require 3 bids for any requested purchase. Swimming pools (in-ground or above ground) and hot tubs are not allowable as either an environmental modification or adaptive equipment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Adaptive Equipment Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive Equipment

Provider Category:
Agency

Provider Type:
Certified Adaptive Equipment Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
DDS Certification as an HCBS provider and have selected Adaptive Equipment as a service.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Quality Assurance

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Community Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Community Transition Services are non-recurring set-up expenses for participants who are transitioning from an institutional or provider-operated living arrangement, such as an ICF or group home, to a living arrangement in a private residence where the participant or his or her guardian is directly responsible for his or her own living expenses. Waiver funds can be accessed once it has been determined that the Waiver is the payer of last resort.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the PCSP development process, clearly identified in the PCSP, and the person is unable to meet such expenses or when the services cannot be obtained from other sources.

Community Transitions Services cannot duplicate environmental modifications. This will be prevented through DDS control of prior authorizations.

Costs for Community Transition Services, furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the Waiver, are considered to be incurred and billable when the person is determined to be eligible for Waiver services. If for any unseen reason, the individual does not enroll in the Waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid.

Exclusions: Community Transition Services may not include payment for room and board; monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a Waiver provider where the provision of these items and services are inherent to the service they are already providing. Diversionary or recreational items such as televisions, cable TV access or VCR's are not allowable.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Community Transition Service Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Agency

Provider Type:
Certified Community Transition Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
The provider entity must be certified by DDS as an HCBS provider and have elected to provide community transition services. The provider must maintain evidence that they require the following qualifications and requirements of staff who coordinate expenditure of community transition funds:
1. Persons who provide community transition services must:
a. Hold a Bachelor's degree in a human services field, or
b. Have at least two years college credit and two years' experience working with persons with developmental disabilities, or
c. Have two years of verified experience working with persons with a developmental disability and have been mentored by a case manager for two additional years or
d. Have four years of experience as a case manager in a related field.
2. These individuals must:
a. Not be disqualified from employment due to a criminal record according to Ark. Code Ann. §20-38-101 et seq., and
b. Not be listed on either the adult or child maltreatment registry, and
c. Have satisfactorily completed a drug screen in accordance with the Organization's policies.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Quality Assurance

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Consultation

HCBS Taxonomy:

Category 1: 17 Other Services

Sub-Category 1: 7990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Consultation services are clinical and therapeutic services which assist the individual, parents, legally responsible persons, responsible individuals and service providers in carrying out the person's service plan. Consultation activities are provided by professionals licensed as one of the following:

1) Psychologist

2) Psychological Examiner

3) Mastered Social Worker

4) Professional counselor

5) Speech pathologist

6) Occupational therapist

7) Registered Nurse

8) Certified parent educator or provider trainer

9) Certified communication and environmental control specialist

10) Qualified Developmental Disabled Professional (QDDP)

11) Positive Behavior Support (PBS) Specialist

12) Physical therapist

13) Rehabilitation counselor

14) Dietitian

15) Recreational Therapist

16) Behavior Analyst

These services are direct in nature. The parent educator or provider trainer is authorized to provide the activities identified below in items 2, 3, 4, 5, 7 and 13. The provider agency will be responsible for maintaining the necessary information to document staff qualifications. Staff, who meets the certification criteria necessary for other consultation functions, may also provide these activities. Selected staff or contract individuals may not provide training in other categories unless they possess the specific qualifications required to perform the other consultation activities. Use of this service for provider training CANNOT be used to supplant provider trainer responsibilities that are included in provider indirect costs. These activities include:

1) Provision of updated psychological and adaptive behavior assessments;

2) Screening, assessing and developing therapeutic treatment plans;

3) Assisting in the design and integration of individual objectives as part of the overall individual service planning process as applicable to the consultation specialty;

4) Training of direct services staff or family members in carrying out special community living services strategies identified in the person's service plan as applicable to the consultation specialty;

5) Providing information and assistance to the persons responsible for developing the person's overall service plan as applicable to the consultation specialty;

6) Participating on the interdisciplinary team, when appropriate to the consultant's specialty;

7) Consulting with and providing information and technical assistance with other service providers or with direct service staff or family members in carrying out the person's service plan specific to the consultant's specialty;

8) Assisting direct services staff or family members to make necessary program adjustments in accordance with the person's service plan applicable to the consultant's specialty;

9) Determining the appropriateness and selection of adaptive equipment to include communication devices, computers and software consistent with the consultant's specialty;

10) Training or assisting persons, direct services staff or family members in the set up and use of communication devices, computers and software consistent with the consultant's specialty;

11) Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment and plan modification consistent with the consultant's specialty;

12) Training of direct services staff or family members by a professional consultant in:

a) Activities to maintain specific behavioral management programs applicable to the person,

b) Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the person,

c) The provision of medical procedures not previously prescribed but now necessary to sustain the person in the community.

13) Training or assisting by advocacy consultants to individuals and family members on how to self-advocate.

14) Rehabilitation Counseling for the purposes of supported employment supports that do not supplant the federal Rehabilitation Act of 1973 and PL 94-142 and the supports provided through the Arkansas Rehabilitation Services.

15) Training and assisting persons, direct services staff or family members in proper nutrition and special dietary needs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The maximum annual amount is $1,320.00 and is reimbursable at no more than $136.40 per hour.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Consultation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consultation

Provider Category:
Individual

Provider Type:
Certified Consultation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
DDS Certification as an HCBS provider and have selected to provide Consultation services. The certified HCBS provider must ensure that the individual providing Consultation has current credentials which correspond to the specific area of consultation they provide. Consultation service providers must demonstrate evidence that they require that professionals who provide the direct service hold a current license or certification by the Arkansas state board or organization of licensing or certification as follows:

1. Psychologists: Current license from the Arkansas Psychology Board as a Psychologist
2. Psychological Examiners: Current license from the Arkansas Psychology Board as a Psychological Examiner.
3. Mastered Social Workers: Current license as an LMSW or ACSW by the Arkansas Social Work Licensing Board.
4. Professional counselors: Current license as a counselor by the Arkansas Board of Examiners in Counseling.
5. Speech pathologists: Current license in Speech Therapy by the Arkansas Board of Examiners in Speech Language Pathology and Audiology.
6. Occupational therapists: Current license in Occupational Therapy by the Arkansas State Medical Board.
7. Registered Nurses: Current license as a Registered Nurse by the Arkansas State Board of Nursing.
8. Certified parent educators: Qualified Developmental Disabilities Professional as defined in 42 C.F. R. Subsection 483.430(a).
9. Certified communication and environmental control adaptive equipment or aids providers: Documentation as a current provider of Durable Medical Equipment with the Arkansas Medicaid Program.
10. QDDP must present documentation of credentials in accordance with 42 CFR Subsection 483.430 (a).
11. Positive Behavior Support Specialist must be certified through our Center of Excellence University of Arkansas Partners for Inclusive Communities.
12. Physical Therapists as licensed by Arkansas State Board of Physical Therapy.
13. Rehabilitation counselors with Masters Rehabilitation Counseling must be certified through Arkansas Rehabilitation Service.
14. Dieticians with degree in Nutrition must be certified by Arkansas Dietetics Licensing Board.
15. Recreational Therapists with degree in Recreational Therapy-State certification not required but to provide services must provide credentials (appropriate degree).
16. Behavior Analyst certified by the Behavior Analyst Certification Board as defined in Arkansas Code Ann. §23-99-418.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Quality Assurance

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Crisis Intervention

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	T1030 crisis intervention
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	T1040 behavior support
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Crisis Intervention is delivered in the eligible person's place of residence or other local community site by a mobile intervention team or professional. Intervention shall be available 24 hours a day, 365 days a year. Intervention services shall be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geographic area conducive to rapid intervention as defined by the provider responsible to deploy the team or professional. Services may be provided in a setting as determined by the nature of the crisis; i.e., residence where behavior is happening, neutral ground, local clinic or school setting, etc., for persons participating in the Waiver program and who are in need of non-physical intervention to maintain or re-establish a behavior management or positive programming plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The maximum rate is $127.10 per hour; the annual maximum is $2640.00.

This waiver service is only provided to individuals age 21 and over. All medically necessary Crisis Intervention services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Crisis Intervention Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:

Agency

Provider Type:

Certified Crisis Intervention Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DDS Certification as a Crisis Intervention provider.

Crisis Intervention service providers must demonstrate evidence that they require that professionals who provide the direct service hold a current license or certification by the Arkansas Board of licensing or certification as follows:

1. Psychologists: Current license as a Psychologist by the Arkansas Board of Psychology.

2. Psychological Examiners: Current license as a Psychological Examiner by the Arkansas Board of Psychology.

3. Mastered social workers: Current license as an LMSW, LCSW, or ACSW by the Arkansas Social Work Licensing Board.

4. Professional counselors: Current license as a counselor by The Arkansas Board of Examiners in Counseling.

5. Qualified Developmental Disabilities Professional as defined in 42 C.F.R. Subsection 483.430(a).

6. Certified Positive Behavior Supports Specialist

Crisis Intervention Providers must maintain documentation that they require that professionals who provide the direct service have satisfactorily passed a criminal background check and adult and child maltreatment registry checks. Criminal background checks and adult maltreatment checks must be repeated every five years and child maltreatment registry check every two years.

Crisis Intervention Providers must require that direct staff have satisfactorily passed a pre-employment drug screen.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Quality Assurance

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Environmental Modifications are modifications made to or at the home, required by the participant's PCSP, which are necessary to ensure the health, welfare and safety of the participant, or that enable the participant to function with greater independence, and without which, the participant would require institutionalization. Such environmental modifications may include the installation of ramps, widening of doorways, modification of bathroom facilities, installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment, installation of sidewalks or pads to accommodate ambulatory impairments, and home property fencing when medically necessary to assure non-elopement, wandering or straying of persons who have dementia, Alzheimer's disease, other causes of memory loss or confusion as to location or decreased mental capacity or aberrant behaviors.

Expenses for the installation of the modification and any repairs made necessary by the installation process are allowable. Portable or detachable modifications that can be re-located with the individual and that have a written consent from the property owner or legal designee will be considered. All services shall be provided in accordance with applicable state and local building codes. Requests for modifications must include an original photo of the site where modifications will be done; to scale sketch plans of the proposed modification project; identification of other

specifications relative to materials, time for project completion and expected outcomes; labor and materials breakdown and assurance of compliance with any local building codes. Final inspection for the quality of the modification and compliance with specifications and local codes is the responsibility of the Waiver case manager. Payment to the contractor is to be withheld until the work meets specifications, including a signed customer satisfaction statement.

Exclusions: Outside fencing is limited to one fence per lifetime. Total perimeter fencing is excluded. Excluded are those modifications or improvements to the home which are of general utility, and are not of direct medical and remedial benefit to the individual, such as carpeting, roof repair, central air conditioners, etc. Also excluded are modifications or improvements that are of aesthetic value (such as wallpaper, marble countertops, or ceramic tile) Modifications that add to the total square footage of the home are excluded from this benefit. Expenses for remodeling or landscaping which are cosmetic, designed to hide the existence of the modification, or result from erosion are not allowable. Environmental modifications that are permanent fixtures will not be approved for rental property without the prior written authorization and a release of current or future liability by the residential property owner. Environmental modifications may not be used to adapt living arrangements that are owned or leased by providers of waiver services. Swimming pools (both in and out of ground) and hot tubs are not allowable. The moving of modifications, such as fencing or ceiling tracks and adaptive equipment that may be permanently affixed to the structure or outside of a premises is not allowed.

Conditions - All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids with the lowest bid with comparable quality being awarded; however, DDS may require 3 bids for any requested modification. All modifications must be completed within the plan of care year in which the modifications are approved.

Environmental modifications may only be funded by Waiver if not available to the participant from any other source. When environmental modifications are included as a Medicaid state plan service, a denial by utilization review will be required prior to approval for Waiver funding by DDS.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Environmental Modifications Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency
Provider Type:
Certified Environmental Modifications Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certification by DDS as an HCBS Provider and have elected to provide Environmental Modifications services.

Certified providers must demonstrate evidence that they require that professionals who provide the direct services be appropriately licensed and bonded in the State of Arkansas, as required, and possess any other appropriate credentials, skills, and experience to perform jobs requiring specialized skills, including but not limited to electrical and plumbing services and heating and ventilation.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DDS Quality Assurance
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Supplemental Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Supplemental Support services meet the needs of the person to improve or enable the continuance of community living. Supplemental Support Services will be based upon demonstrated needs as identified in a person's PCSP as unforeseen problems arise that, unless remedied, could cause a disruption in the participant's services, placement,

or place the participant at risk of institutionalization. Waiver funds will be used as the payer of last resort.

This service can be accessed ONLY as a last resort. Lack of other available resources must be proven.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Supplemental Support Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supplemental Support

Provider Category:
Agency

Provider Type:
Certified Supplemental Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
The provider entity must be certified by DDS as an HCBS provider and have elected to provide supplemental support services. The provider must maintain evidence that they require the following qualifications and requirements of staff who coordinate expenditure of supplemental support funds:
1. Persons who provide community transition services must:
a. Hold a Bachelor's degree in a human services field, or
b. Have at least two years college credit and two years' experience working with persons with developmental disabilities, or
c. Have two years of verified experience working with persons with a developmental disability and have been mentored by a case manager for two additional years or
d. Have four years of experience as a case manager in a related field.
2. These individuals must:
a. Not be disqualified from employment due to a criminal record according to Ark. Code Ann. §20-38-101 et seq., and
b. Not be listed on either the adult or child maltreatment registry, and
c. Have satisfactorily completed a drug screen in accordance with the Organization's policies.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Quality Assurance

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Arkansas Code Ann. §20-38-101 et seq., Standards for Conducting Criminal Record Checks for Employees of Developmental Disabilities Service Providers, and HCBS Waiver Standards require HCBS Waiver providers to conduct criminal background checks for all employees, as defined in statute and standards. In certain circumstances a provider may waive DDS disqualification of an applicant or employee in accordance with section 504 of the DDS Criminal Records Standards (Act 990 of 2013).

Employee is defined as a person who:
1) is employed by a service provider to provide care to individuals with disabilities served by the service provider; or
2) provides care to individuals with disabilities served by a service provider on behalf of, under supervision of, or by arrangement with the service provider; or
3) submits an application to a service provider for the purposes of employment; or
4) is a temporary employee placed by an employment agency with a service provider to provide care to individuals with disabilities served by the service provider; or
5) submits an application to the Licensing or Certification Agency for the purpose of being licensed or certified as a service provider; or

6) resides in an alternative living home in which services are provided to individuals with developmental disabilities; and
7) has or may have unsupervised access to individuals with disabilities served by a service provider.

Criminal record checks are required for all employees and shall include both a state and national record check. A "state only" criminal record check is allowed if the provider can verify the applicant has lived continuously in the State of Arkansas for the past five years.

The provider may extend an offer of conditional employment pending the outcome of the DDS determination of employment eligibility, unless the applicant has self-reported a disqualifying offense. If the provider receives a criminal record report on an employee from the Arkansas State Police that shows no criminal record, the provider may continue to employ the person. If the provider receives a criminal record report on an employee from the Arkansas State Police that shows a criminal record, the provider must remove the person from unsupervised access to persons served.

DDS checks the Arkansas State Police website for criminal records. If DDS finds a criminal record on a provider employee, DDS makes a determination for employment eligibility based on the record and sends notice to the provider. If a FBI record check is required, the FBI report is sent to DDS Quality Assurance. DDS makes a determination of employment eligibility based on the record and sends notice to the provider.

The DDS determination of employment eligibility is based on comparison of the conviction noted in the Arkansas State Police or FBI criminal record report with those offenses identified in Arkansas Code Ann. §20- 38-101 et seq. as disqualifying offenses. A person who is defined as an employee in this statute is not eligible to work for a DDS provider if they have a disqualifying offense. The provider is required to terminate employment of a person who has been disqualified. DDS Quality Assurance staff reviews evidence of criminal record checks by providers and employment determinations by DDS during the annual review of all certified providers.

DDS staff also have access to persons served and are also required to undergo criminal background checks. If a disqualifying criminal conviction is found, the individual's employment with DDS is terminated.
In certain narrowly prescribed circumstances, a provider may waive DDS disqualification of an applicant or employee in accordance with Section 504 of the DDS Criminal Record Check Standards.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Arkansas maintains two statewide Central Registry of substantiated cases of abuse and neglect. The DHS Division of Children and Family Services (DCFS)maintains the registry for children and Adult Protective Services (APS) maintains the adult abuse registry. All DDS CES certified providers must initiate a check of both registries. Providers must also check any adult over the age of 18 residing in an alternative living home or group home, including employees spouses. This check will provide documentation that the prospective employee's name and any adult family member's names do not appear on the statewide central registry. Each provider is required to adopt policies that comply with Licensure Standards addressing what actions will be taken if an adult family member's name appears on the central registry when the individual being served is in an alternative living home or group home. If a record is found in either registry, the individual who received this information shall notify the Director of the program in writing so that corrective measures may be determined. When a provider is notified that an individual's name is on either Registry, the provider must take corrective measures that comply with DDS Licensure Standards.DDS Quality Assurance staff review evidence of central registry checks for each provider during the annual review.

In addition, all DDS staff are required to undergo abuse registry checks. If any disqualifying record is found the individual's employment with DDS is terminated.

Process for ensuring that mandatory screenings have been conducted: on-site Quality Assurance monitoring by Licensure/Certification staff includes review of personnel files for compliance.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type
Supported living arrangement apartments owned and operated by waiver providers
Group Homes

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The State has undertaken activities as described in the transition plan to ensure that all residential settings comply with the characteristics described in the Final Rule.The group homes are community based and located in residential areas. The homes provide access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, and provide for privacy and easy access to resources and activities in the community. Each group home contains bedrooms and bathrooms that allow privacy . Individuals are allowed free use of all space within the group home with due regard for privacy, personal possessions of other residents and staff and reasonable house rules. The living and dining areas are provided with furnishings that promote the functions of daily living and social activities. Persons are provided access to community resources and supports and are encouraged to build community relationships. Persons are granted access to visitors at times convenient to the individual. Individuals are allowed a choice of roommates, if they are in a shared bedroom.
Group homes, owned and operated by Waiver certified providers, must meet all the applicable state and federal laws and regulations. Existing group homes licensed by DDS prior to July 1, 1995 may serve groups of no more than fourteen unrelated adults, age 18 years and above, with developmental disabilities. Arkansas imposed a moratorium and no additional group homes have been approved since July 1, 1995. Group homes built after July 1, 1995 are limited to a capacity of no more than 4 unrelated adults with developmental disabilities.
The capacity for supported living apartments owned and operated by waiver providers, regardless of date of DDS licensing, may serve a number of persons consistent with the number of bedrooms each apartment contains, but in no event more than four unrelated adults, age 18 and above, with developmental disabilities in each self-contained apartment unit.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Supported living arrangement apartments owned and operated by waiver providers

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility

Waiver Service	Provided in Facility
Respite	☐
Community Transition Services	☐
Adaptive Equipment	☑
Crisis Intervention	☑
Supplemental Support	☐
Supportive Living	☑
Care Coordination	☑
Supported Employment	☑
Consultation	☑
Specialized Medical Supplies	☑
Environmental Modifications	☐

Facility Capacity Limit:

No more than 4 unrelated adults in each self contained apartment

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Staff resident ratios are determined for each individual and included in their person-centered service plan. If they may share staff in a living arrangement, that is also documented in their person-centered service plan.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Respite	☐
Community Transition Services	☐
Adaptive Equipment	☑
Crisis Intervention	☑
Supplemental Support	☐
Supportive Living	☑
Care Coordination	☑
Supported Employment	☑
Consultation	☑
Specialized Medical Supplies	☑
Environmental Modifications	☐

Facility Capacity Limit:

14 beds

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Staff resident ratios are determined for each individual and included in their person-centered service plan. If they may share staff in a living arrangement, that is also documented in their person-centered service plan.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

  Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

  Payment for waiver services will not be made to the adoptive or natural parent, step-parent or legal representative or legal guardian of a person less than 18 years old. Payments will not be made to a spouse or a legal representative for a person 18 year of age or older.

  For purposes of exclusion, "parent" means natural or adoptive parents and step parents. For any service provider, all DDS qualifications and standards must be met before the person can be a paid service provider. Qualified relatives, other than as specified in the foregoing, can provide any service. Controls are maintained through documentation as is required for all services provided; specific to date and time of service delivery with descriptor or activities linked to the approved plan of care goals and objectives. In addition, incident reports received through the DHS automated incident reporting system are analyzed annually.

  Controls for services rendered: All care staff are required to document all services provided daily according to their work schedules, direct care support service supervisors are responsible for the day to day supervision and monitoring of the direct care staff; care coordinators are responsible to periodically review with the participant any problems in care delivery and report any deficiencies to the Waiver DDS Specialist and DDS Quality Assurance provider certification staff. DDS specialists conduct a 100% review of service utilization for each plan of care at the time of each plan of care 12 month expiration date to identify any gaps in approved services with corrective action by the provider to be taken; DDS Quality Assurance conducts annual provider reviews; and DMS conducts both random Quality Assurance audits and audits specific to the financial integrity of services delivered.
- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any willing and qualified organization may apply for certification as an HCBS Waiver provider. DDS provides continuous open enrollment for certification as an HCBS Waiver provider. Interested parties who call or email DDS are directed to the DDS web page created for this purpose.
http://humanservices.arkansas.gov/ddds/Pages/WaiverServiceProviders.aspx

At this site, applicants have access to information regarding the requirements and procedures to become certified as a HCBS Waiver provider. In the application, providers may specify the maximum number of persons they can serve, the areas of the state they serve, and the services they wish to offer. Providers may stipulate in the application that they reserve the right to refuse to offer services to persons who choose them if they can document and justify that they cannot ensure the health and safety of an individual. When an organization completes an application and prepares all other requested information, DDS Certification and Licensure Administrator assigns staff to review the application and provide technical assistance regarding the application process to the organization. After an organization has satisfied initial requirements, DDS issues a temporary certificate to the organization. At this point, the provider may contact the Medicaid fiscal agent's Provider Enrollment Unit to enroll with Medicaid and obtain provider numbers for each service. The provider's transition from temporary to regular certification is dependent upon the provider's demonstration of compliance with DDS standards in the delivery of services to one or more individuals during an on-site visit by Certification and Licensure staff.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP A1: Number and percentage of providers who obtained initial certification in accordance with promulgated standards. Numerator: Number of applicants who

obtained initial certification in accordance with promulgated standards; Denominator: Total number of completed new provider applications.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Initial Certifications

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
QP A2: Number and percentage of providers that obtained annual re- certification in accordance with promulgated standards. Numerator: Number of providers that obtained annual re-certification in accordance with promulgated standards; Denominator: Total number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Certification Activity

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP C1: Number and percentage of provider agencies that meet DDS requirement for abuse and neglect reporting training for staff. Numerator: Number of provider agencies investigated who complied with Standard 303.A.1.l & 304.A.8; Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Abuse and Neglect Staff Training Deficiencies

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP C2: Number and percentage of provider agencies that meet DDS requirements for training staff on the specific needs of the persons they serve. Numerator: Number of provider agencies who complied with Standard 305.A.2.a-d ,305.A.3.a, & 305.A.4.a-c; Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Individualized Staff Training Deficiencies

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The state verifies annually, during an on-site providers meet and adhere to promulgated state standards regarding HCBS Waiver providers, and identifies and rectifies situations where providers do not meet DDS requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
(PM QP A1)If deficiencies are cited as a result of the on-site review of a temporary provider, DDS gives the provider an opportunity to develop a plan of correction. Within 30 days after receipt of an acceptable plan of correction, DDS staff returns for a follow-up onsite review. If the provider has not achieved substantial compliance, DDS does not issue a Certificate to the temporary provider.

(PM QP A2, C1,C2)If deficiencies are cited as a result of an annual onsite certification review of a certified provider, DDS gives the provider an opportunity to develop a plan of correction. The plan of correction must address how individual problems have been resolved as well as what processes the provider will put in place to assure the deficiencies do not occur again in the future. After receipt of an acceptable plan of correction, depending on the severity of the cited deficiencies, DDS staff either issues a Certificate, or returns for a follow-up onsite review. If the follow-up review reveals that the provider has not successfully corrected the deficiencies, DDS may impose an array of enforcement remedies, and may ultimately revoke the certification of the provider.

(PM QP A2, C1,C2)DDS maintains investigative staff so that, on an ongoing basis, they may investigate any complaints regarding the provider. Utilizing a process similar to certification, DDS requires a plan of correction, referred to in this case as an Assurance of Adherence to Standards, and may impose enforcement remedies and revoke certification if the provider does not comply with requirements.

(PM QP A2, C1,C2)When DDS determines, during a certification review or an investigation, that the provider has not provided required abuse and neglect reporting training, or has not provided required training on the specific needs of the person the staff serves, the provider is cited and must submit an acceptable plan of correction. The plan must include an attestation that the identified staff has been trained, as well as a description of the processes the provider will put in place to assure the deficiencies do not occur again in the future.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☑ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Current Limits:

1) The annual expenditure cap for environmental modifications and adaptive equipment is $7,687.50. Basis for the limit: Environmental Modifications and Adaptive Equipment - the rate is prospective based on provider costs up to a maximum of $7,687.50. However, if exceeding the cap for adaptive equipment is medically necessary, the difference in the total amount needed for adaptive equipment and $7,687.50, will be offset against the supportive living maximum. The maximum was based on average consumer needs at the time of limitation setting in 1990.

2) The maximum annual allowance for Supplemental Support Services, Community Transition Services and Specialized Medical Supplies, collectively or individually, is $3,690.00. When services are accessed in the same year, the combined maximum allowance is $3690.00. Basis for cost limit: Specialized Medical Supplies, Supplemental Supports and Community Transition Services - the rate is prospective based on provider costs up to a maximum of $3,690.00. The maximum was based on average consumer needs at the time of limitation setting in 1990.

3) There is a maximum daily rate for supportive living services, and respite. Supportive living includes provider indirect costs for each component in the array. Individual daily rates in all levels require prior approval by DDS staff.

(1) Tier 3 - maximum daily rate is $391.95 with a maximum of $143,061.75 annually.

2) Tier 2 - maximum daily rate is $184.80 with a maximum of $67,452.00 annually.

All services must be billed in accordance with the participant's PCSP. Extensions of Benefits can be given. No exceptions are made if the documentation does not support that the person is eligible for a higher limit. Once the maximum limit for Tier 3 is reached, funding sources other than Medicaid are sought to provide for the additional care needed. Once all other sources are exhausted health and safety cannot be

assured; case closure proceedings are initiated and implemented.

Each prior authorization approval that identifies the limit approved is provided to the case manager who in turn provides a copy to the participant. If a higher level is requested and denied, then written notice to include appeal rights is provided to the case manager and the participant. All waiver limits, along with other waiver information, is published on the DDS and DHS websites and incorporated in training modules and guides.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☑ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

All waiver beneficiaries will now receive an independent assessment upon entry into the waiver or expiration of their existing case plan. This independent assessment will be one of many tools used to place beneficiaries into a level (or tier) of support. Tier 2 is for beneficiaries who need less than 24 hours a day, seven days a week of paid care or services. Tier 3 is for beneficiaries who need 24 hours a day, seven days a week of paid care or services.

The Independent Assessment, along with the individual's application packet and functional assessments, will determine whether the Beneficiary is in Tier 2 or Tier 3. The Independent Assessment will assess the beneficiary in the following areas:

i. Individual Areas
a. Medical history, current medical conditions, or conditions observed by the assessor or self-reported by the individual;
b. Behavioral;
c. Home living activities;
d. Community activities;
e. Employment;
f. Health and safety assessment; and
g. Social functioning

ii. Caregiver (natural supports) areas
a. Physical/behavioral (health);
b. Involvement;
c. Social resources;
d. Family Stress; and
e. Safety

iii. Current Risk Assessment Review
a. Safety Plan, if available;
b. Behavior Plan;
c. Physical Plan; and
d. Medical Plan

DDS has transferred the old three level methodology over to the new two tier system. Tier 2 has a maximum daily rate of 184.80, based on the extensive level of care. Tier 3 now has a maximum daily rate of 391.95, the previous Pervasive level maximum.

Current beneficiaries will be transferred as follows:

1) Beneficiaries now classified as pervasive will be classified as Tier 3, until their yearly PCSP is due and they undergo an Independent Assessment.
2) Beneficiaries now classified as limited or extensive will be classified as Tier 2, until their yearly PCSP is due and they undergo an Independent Assessment.

If a Tier 2 client reaches the maximum but still has unmet needs, he or she can request a new independent assessment due to a change in circumstances, which will determine if a higher Tier is now appropriate. Once the maximum limit for Tier 3 is reached, funding sources other than Medicaid are sought to provide for the additional care needed. Once all other sources are exhausted health and safety cannot be assured; case closure proceedings are initiated and implemented in accordance with Appendix F and consistent with 42 CFR 431 Subpart E.

DDS is currently undergoing a comprehensive rate study and will re-evaluate all service rates and limits. DDS plans to implement a new rate methodology based on this study beginning in October 2017.

☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please Refer to Main, Attachment # 2

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Person Centered Services Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

A. Be a Registered Nurse (R.N.), a physician, or have a bachelor's degree in a social science or health-related field;
B. Have at least one (1) year of experience working with developmentally or intellectually disabled clients;
C. Successfully complete a background check, that includes a criminal background and child and adult maltreatment registry check;
D. Successfully pass an initial drug screen prior to and working directly with beneficiaries;
E. Successfully pass an annual drug screen; and
F. Cannot be excluded or debarred under any state or federal law, regulation or rule or not eligible or prohibited to enroll as a Medicaid provider.

- ☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

DDS starts the flow of information about the beneficiary's direction of and engagement in PCSP development during the intake and referral process for waiver services. Intake and Referral staff provide this information in written format and through conversations with the beneficiary and any legal representative. DDS staff provide the same information after the beneficiary has been determined eligible and is approved for HCBS Waiver services when the person chooses a provider. The entity chosen by the beneficiary for PCSP development reinforces these rights and assures active participation by the person and any legal representative. DDS Waiver Handbooks, found on the DDS website and the website of the Arkansas Waiver Association, share this information in a user-friendly format and include contact information regarding the PCSP, provider choice, and rights and responsibilities.

The beneficiary may invite any person they choose to participate at any step of the PCSP development process. DDS staff and the chosen provider inform all persons of any confidentiality and conflict of interest issues.

The care coordinator must participate as the person who will oversee implementation of the PCSP. The PCSP developer will develop the plan and ensure the PCSP is updated at least annually. The PCSP developer will inform the beneficiary about the benefits of inviting other individuals, such as direct service providers, professionals associated with other services (e.g., representatives of public school, other DHS Divisions, generic community supports), and DDS staff. It remains the decision of the beneficiary to invite others to participate in the process.

When necessitated by the support needs of the person, advocates or other support person identified by the beneficiary, may accompany the beneficiary to help assure that the person understands the discussion and can make their desires understood. All persons responsible for implementation of the PCSP, as well as the beneficiary, must sign the PCSP. The PCSP developer ensures that the plan is distributed to the beneficiary and other people involved in the implementation of HCBS services included in the plan.

If the PCSP developer fails to include the beneficiary and any legal representative in the PCSP development process, the PCSP is not valid. DDS staff provide information to the beneficiry regarding their direction of and engagement in the

PCSP development process. People with complaints about a person's direction of, engagement in, or satisfaction with the outcome of the PCSP development process may call DDS Quality Assurance, which will investigate the complaint in compliance with DDS Policy 1010, Service Concern Investigation. DDS Quality Assurance conducts an on-site review of each provider annually and cites deficient practices related to each person's direction of and engagement in the PCSP development process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

2. Interim Service Plan (ISP):

When a person accesses HCBS Waiver services for the first time, the person is issued a prior approved interim service plan for up to 60 days. The Interim Service plan may include care coordination and supportive living for direct care supervision. DDS staff track the expiration dates of ISPs and ensure that a PCSP is complete before the interim plan expires. The Independent Assessment may be completed while the ISP is in place.

B.PCSP:
1. Development, Participation and Timing

The PSCP developer is responsible for scheduling and coordinating the PCSP development meeting, including inviting other participants and making sure that the location and the participants are acceptable to the HCBS Waiver beneficiary. If the beneficiary objects to the presence of any individual, that person may not attend the meeting. Aside from any objections from the beneficiary or their legal guardian, the team may consist of professionals who might assist with generic resources, professionals who conducted assessments or evaluations, and friends and persons who support the participant may attend the meetings. DDS staff will attend if the participant invites them. The PSCP developer is responsible for managing and resolving any disagreements which occur during the PCSP development meeting.

2. Assessment Types, Needs, Preferences, Goals and Health Status

Prior to development of the PCSP, in addition to the Independent Assessment, the PCSP developer should secure for review additional information which would be beneficial to the PCSP development process including but not limited to:

a. The results of any evaluations that are specific to the needs of the beneficiary;
b. the results of any psychological testing to include a measure of IQ and the adaptive behavior assessments conducted to establish eligibility;
c. the results of any adaptive behavior assessments conducted to establish eligibility;
d. any social, medical, physical and mental histories;and
e. a risk assessment

Licensed professionals conduct applicable assessments. Other assessments which do not require a licensed person, are

conducted by persons who are most familiar with the beneficiary.

The PCSP development team must utilize the results of the Independent Assessment in creating the PCSP. When developing the PCSP the development team must consider cost-efficient options that foster independence, such as shared staffing and other adaptations. When such options are not utilized in the PCSP for a Tier 3 participant, it must be documented that the beneficiary's health and safety require one on one staffing, twenty-four hours a day.

3. Information regarding availability of services

DDS staff informs the beneficiary of available waiver services at the time of initial application. After the Independent Assessment is complete, DDS meets with the beneficiary to discuss which services are needed based on the assessment. DDS meets with the beneficiary again to offer choice of provider for each service need identified that will be addressed through the provision of HCBS services in the PCSP. The PCSP developer has the responsibility to present information regarding service availability during the PCSP development process.

4. Addressing goals, needs and preferences and assignment of responsibilities

DDS prescribes the elements of the PCSP that requires that PCSP developers address how the team discussed, planned for and incorporated the beneficiary's goals, needs (including health care needs), and preferences, as well as any cultural considerations. The Care Coordinator is responsible for implementation of and monitoring the PCSP. DDS requires that the PCSP be reviewed and prior authorized prior to implementation of services. During the onsite review of each provider, Certification and Licensure staff review PCSPs to make sure all elements are included.

5. Coordination of services

The care coordinator has the responsibility for coordinating and monitoring the implementation of all services identified in the PCSP, including waiver, state plan and generic services. The care coordinator must coordinate with the direct service providers to ensure quality service delivery.

6. Updating PCSP

The PCSP developer is responsible for making sure that the PCSP is updated at least annually. The team uses the data gathered by the Care Coordinator as they work with the beneficiary to determine if goals should change. The team also relies on input from the beneficiary regarding whether they want to work on new or revised goals. The beneficiary may request an update of their PCSP at any time. If their is a change in circumstances such that the beneficiary's tier level may have changed, he or she (or their provider) may request a new independent assessment be done.

7. Participant Engagement

From the time an individual first makes contact with DDS to apply for HCBS Waiver services, they are informed of their rights to make choices about each aspect of the services that are available. It is the responsibility of every person at the state and the provider level to make sure that the beneficiary is aware of and exercises their rights and to ensure that the process is driven to the maximum extent possible by the individual. During the person-centered planning meeting, every person present is responsible for supporting and encouraging the beneficiary to express their wants and desires and to then incorporate those into the PCSP.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

DDS requires that the Interdisciplinary Team address risks to the beneficiary during the PCSP development process. In conjunction with the beneficiary and their legal guardian, the team must address health and behavioral risks and risks to personal safety, either real or perceived, and known or potential. The team must document each identified risk and write the PCSP with individualized mitigation strategies. The strategies must be designed to respect the needs and preferences of the beneficiary. The team must identify how and who will be responsible for the ongoing monitoring of risk levels

and risk management strategies as well as addressing how key staff will be trained regarding those risks.

DDS requires that providers document practices and decisions regarding risk assessment and the ongoing management of risks. Providers must specify the tool they use. HCBS Waiver beneficiaries, as they exercise their rights about their services, make choices about the amount of risk they wish to take. In negotiating trade-offs between choice and safety, providers are required to document the concerns of the team members, the negotiation process and the analysis and rationale for the decisions made and the actions taken.

DDS Certification Standards require that care coordination providers in conjunction with direct service providers develop and implement behavior management plans to address behavioral risks. The specific details of behavior management plans are addressed in Appendix G2.Ai. The Standards also require that care coordination providers and direct service providers minimize certain personal safety risks by imposing certain "physical environment" requirements without compromising the natural, home-like atmosphere in any setting in which the beneficiary resides.

DDS requires that providers develop backup plans to address contingencies such as emergencies, including the failure of a support worker to appear when scheduled. Complete descriptions of backup arrangements must be included in the PCSP. Each provider must specify the type of back-up arrangements that are employed, and make sure that each PCSP addresses the unique needs and circumstances of the beneficiary.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

DDS staff explain the HCBS Waiver program, service options, and provider choice and give written information in a face-to-face meeting with the beneficiary and any legal representative. When desired by the beneficiary and any legal representative, DDS provides information by phone, mail, or email. DDS staff gives the person and any legal representative a copy of the HCBS Waiver Certified Provider List prepared and maintained by DDS Quality Assurance initially as services begin, annually, and upon request. DDS staff encourages the beneficiary and any legal representative to visit, call, or look at the website of a provider if the person lacks experience with that provider. DDS ensures that person may choose providers of each service in the service plan.

Annually, DDS staff offer each beneficiary and any legal representative an opportunity to change their choice of setting of service from community (HCBS Waiver) services to services in an ICF/IID. DDS staff also offer a choice of a different provider initially as services begin, annually, and upon request. DDS staff supports the beneficiary to make a choice of provider without any specific recommendations that could sway the beneficiary's choice. DDS prohibits providers from soliciting beneficiaries to choose their organization. Providers are permitted to engage in marketing of their services consistent with DDS Policy 1091 and DDS Certification Standards. The Arkansas Waiver Association has a checklist that may assist people in choosing a provider; it is available at http://arkansaswaiver.com/resources/Prov_Select.pdf

DDS provides information to promote awareness of a beneficiary's right to change providers annually and upon request in the Waiver Handbooks posted on the DDS and Arkansas Waiver Association websites, in the promulgated Medicaid provider manual, and on the Rights and Choice Form that is given annually to beneficiaries. The Rights and Choice Form states, "I have the right to change providers at any time I may choose without fear of retaliation". People with complaints about obtaining information about and selecting from among qualified providers may call DDS Quality Assurance, which will investigate the complaint in compliance with DDS Policy 1010, Service Concern Investigation. The DDS Ombudsman works with people to obtain information about and select from among qualified providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DMS arranges with DDS for a specified number of service plans to be reviewed annually as specified in the interagency agreement with DMS in their role as overseer. DMS conducts a retrospective review of identified program, financial and administrative elements critical to CMS quality assurance. DMS randomly reviews plans and

ensures that they have been developed in accordance with applicable policies and procedures, that plans ensure the health and welfare of the waiver recipient and that financial components or prior authorizations, billing and utilization are correct and in accordance with applicable policies and procedures. DMS oversight results are reconciled quarterly with DDS. Where applicable individual actions to correct any known non-compliance or questionable practice are taken with the service provider or DDS staff, sometimes a change in policy or procedure may be necessary when systemic issues are discovered.

DMS uses the sampling guide "A Practical Guide for Quality Management in Home & Community-Based Waiver Programs" developed by Human Services Research Institute and the Medstat Group for CMS in 2006. A systematic random sampling of the active case population was drawn whereby every "nth" name in the population was selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 8%, is drawn. An online calculator was used to determine the appropriate sample size for this waiver population. To determine the "nth" integer, the sample is divided by the population. Those names are drawn until the sample size is reached.

To provide PCSP for this review, DMS requires providers to submit an electronic copy of the PCSP, including all components described in Appendix D.1.d and D.1.e, to DDS. DMS communicates findings from the review to DDS for remediation. Systemic findings may necessitate a change in policy, standards, or manuals.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The care coordination provider, DDS HCSB Waiver staff, DDS Certification and Licensure staff and DMS Quality Assurance staff are responsible for monitoring the implementation of the PCSP and beneficiary health and welfare.

The care coordination provider is charged with the first-line responsibility for monitoring the implementation of the PCSP and the beneficiary health and welfare. They must maintain regular contact with the beneficiary, making at least

one contact with the beneficiary or their legal representative each month. During the contact, the care coordinator must discuss issues related to HCBS Waiver and non-waiver services and whether or not the beneficiary feels that their needs are being met, if they remain satisfied with their provider and express an understanding that they may change providers, and any issues related to the health and safety of the beneficiary. If they identify problems, they must take action to remediate the issue. The care coordinator is required to maintain documentation of their conversation with the individual as evidence that they are fulfilling their obligation to monitor the PCSP.

DDS Standards also require that the care coordinator, along with the team, must review the PCSP at least annually. The team must review the beneficiary's objectives and determine if they are accomplished, to be continued, or should be modified or discontinued. The team must use beneficiary's input, data collection and case notes to make decisions as they review the PCSP.

DDS HCBS staff conducts a file review and a random on-site review of PCSPs. DDS staff compares planned services to those actually provided as documented on utilization reports from the Medicaid Management Information System (MMIS). These activities are conducted once every twelve months for each PCSP as it is renewed but may be conducted more frequently or when problems requiring remediation are identified.

DDS Quality Assurance staff conduct annual onsite reviews of 100% of certified providers. They select a sample of at least 10% of beneficiaries by the provider and conduct interviews, observations and file reviews to monitor implementation of the PCSP and the health and welfare of the individual. If any of the processes reveal a problem with implementation of the PCSP, QA staff cite a deficiency in the report of their review to the provider. The provider must submit an acceptable plan of correction and implement corrective actions.

Division of Medical Services staff (the Medicaid agency) also conducts a follow-behind review of 20% of PCSP previously reviewed by DDS staff as part of their oversight responsibilities.

DDS participates in the National Core Indicator (NCI) project. During the interview, staff ask beneficiaries if they exercised their right to choose providers, if their services are meeting their needs and wants and if they have an effective backup plan when emergencies occur. DDS reviews the annual NCI report to identify any areas of need and takes appropriate action as necessary.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP A1: Number and percentage of providers who developed service plans that were adequate and appropriate to the needs of individuals as indicated by their assessment(s). Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1408.A.3 Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Service Plan Assessment Deficiencies

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP A2: Number and percentage of providers who developed service plans that addressed the individual's personal goals . Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1404.A.6, 1404.G, & 1408.A.4; Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Service Plan Personal Goal Deficiencies

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP A3: Number and percentage of providers who developed service plans that addressed the individual's risk factors. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1404.C; Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Service Plan Risk Factor Deficiencies

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP C1: Number and percentage of providers who updated service plans at least annually. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1401.A.6 & 1412.A; Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Service Plan Annual Update Deficiencies

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP C2: Number and percentage of providers who reviewed and revised service plans as warranted by changes in individual needs. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1401.A.6 & 1411.A.3&4; Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Service Plan Individual Needs Deficiencies

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP D1: Number and percentage of providers who delivered services in the type, scope, amount, frequency & duration specified in the service plan. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 2201.F and 2202.E and 2203.E and 2205.F and 2206.F and 2207.E and 2208.E Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Service Plan Frequency and Duration Deficiencies

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP E2: Number and percentage of participants who were offered choice as indicated by an appropriately completed and signed freedom of choice form that specified choice of providers. Numerator: Number of participants who were offered choice as

indicated by an appropriately completed and signed freedom of choice form that specified choice of providers; Denominator: Number of files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual File Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The state operates a system of review that assures completeness, appropriateness, and accuracy of the PCSP development and service delivery, and assures freedom of choice by the beneficiary. The system focuses on person-centered service planning and delivery, beneficiary rights and responsibilities, and beneficiary outcomes.

During onsite provider certification reviews, DDS Certification and Licensure staff review PCSP for 10% of the beneficiaries served for verification of service delivery in the type, scope, amount, frequency and duration specified. They also review to determine if the PCSP address assessed needs, personal goals, risk factors, and were developed according to established procedures. They also review to determine if PCSP are updated annually or when needs change.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If deficiencies are cited based on any of the deficiencies relative to the performance measures stated above as a result of an annual onsite certification review of a certified provider, DDS gives the provider an opportunity to develop a plan of correction. The plan of correction must address how individual problems have been resolved as well as what processes the provider will put in place to assure the deficiencies do not occur again in the future. After receipt of an acceptable plan of correction, depending on the severity of the cited deficiencies, DDS staff either issues a Certificate, or returns for a follow-up onsite review. If the follow-up review reveals that the provider has not successfully corrected the deficiencies, DDS may impose an array of enforcement remedies, and may ultimately revoke the certification of the provider.

DDS maintains investigative staff so that, on an ongoing basis, they may investigate any complaints regarding the provider. Utilizing a process similar to certification, DDS requires a plan of correction, referred to in this case as an Assurance of Adherence to Standards, and may impose enforcement remedies and revoke certification if the provider does not comply with requirements.

When DDS determines, during a certification review or an investigation, that the provider has not met the requirements in any of the standards mentioned above, the provider is cited and must submit an acceptable plan of correction. The plan must include an attestation that the deficiency has been corrected for the specific individuals on which the deficiency was written, as well as a description of the processes the provider will put in place to assure the deficiencies do not occur again in the future.

Annually, DDS mails Choice Forms to the beneficiary which offer the beneficiary choice 1)between institutional care and HCBS Waiver services and 2) among qualified providers who serve the county in which the beneficiary resides and offers the services that the beneficiary needs. If the beneficiary has not returned the appropriately completed and signed Choice forms within 30 days, DDS will call the beneficiary to discuss the forms and will conduct a visit if the beneficiary needs assistance to complete the forms. If the beneficiary requests provider staff, either direct care or care coordinator to assist with choice forms, the provider staff will call DDS to relay this information. DDS will contact the beneficiary to inform them that DDS will assist them with the choice process, rather than the provider.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

It is initially the responsibility of the DDS Intake and Referral Specialist to inform the person or the legally responsible representative of appeal rights specific to application intake policies and procedures:
1) As HCBS Waiver services are requested; and
2) When initial choice of home and community based services as an alternative to institutional care is offered.

It is the responsibility of DDS to inform the person or the legally responsible representative of appeal rights specific to the applicant or of program denial of ICF/IDD Level of Care or Medicaid Income Eligibility. It is the responsibility of DDS staff to

inform the person or legally responsible representative of appeal rights specific to closure of an application case for failure of the person or legal representative to comply with requests for required application assessment information. DDS staff sends copies of official letters to the DDS Psychology Team. When the determination is favorable to the applicant the team issues a notice of approval.

When the applicant is determined to meet eligibility criteria DDS staff inform the person or the legally responsible person of appeal rights specific to:
1) Continued choice for institutional or community based services;
2) Provider choice, including the right to change providers;
3) Service denials;
4) When their chosen providers refuse to serve them, and
5) Case closure.

The right to change providers more frequently than annually is specified in the Waiver handbook that is published on the DDS website, the promulgated Medicaid provider manual, and on the Rights and Choice form that is given to the participants annually. The form states: "I have the right to change providers at any time I may choose without fear of retaliation." This topic is covered on NCI surveys conducted by the DDS Quality Assurance Section.

Thereafter, the case manager provides continued education at each annual review and provides support at any time a service request is denied. The individual or the legal representative may file an appeal or may authorize the case manager to file an appeal on behalf of the individual.

When any adverse action occurs, including reduction, suspension or termination of HCBS Waiver services, written notice is provided to the individual, the legally responsible person, and both the case management provider and the providers of other HCBS waiver services in accordance with the Medicaid Provider Manual, Section 191.000 and the Arkansas Administrative Procedures Act, A.C.A. 25-15-201 et seq. A copy of Section 191.000 is enclosed with the notice to the individual, the legal representative, and the providers. This notice is sent both through regular and certified mail. The participant may ask for the determining entity to reconsider the denial, this request must be made in writing within 15 business days of receipt of the notice.

If the reconsideration upholds the denial, reduction, suspension, or termination, participants, or their representative, may request a hearing, in writing within 30 days of receipt of the notice.

Notices of adverse action and the opportunity to request a fair hearing are maintained in the case file. When the adverse action is case closure, services shall continue during the appeal process if a fair hearing is timely requested and the service provider assumes the risk of nonpayment for services delivered during this time.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

○ **No. This Appendix does not apply**

◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Division of Developmental Disabilities Services (DDS)- the Operating Agency

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS maintains an investigative unit which investigates complaints and concerns. The unit will accept any type of grievance or complaints except those that are related only to an employee grievance against their employer or any other personnel issues, unless it affects the provision of services to beneficiaries. DDS Policy 1010 Service Concern Resolution prescribes the methods and timeframes for conducting an investigation of a concern or complaint. In brief, the investigator has three working days from the time the complaint is received to make initial contact with the person making the complaint. The investigator must begin the fact finding process within one day of initiation of the investigation and must complete the investigation within 30 days, unless granted an extension for cause. The investigator may conduct an onsite visit to conduct face-to-face interviews with involved parties as well as reviewing pertinent documents and records. The investigator provides a written report to the certified provider and to the individual making the complaint. If the investigator substantiates the complaint, they issue a deficiency to the certified provider and request an Assurance of Adherence to Standards which must explain how they will remedy the situation with the individual involved as well as how they will prevent similar situations from occurring in the future.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Arkansas Child Maltreatment Act, Ark. Code Ann. §12-18-101 et seq., and the Arkansas Adult Maltreatment Act, Ark. Code Ann. §12-12-1701 et seq. defines the acts that are considered abuse or neglect. The acts define who is a mandated reporter and includes employees of DDS and Certified Waiver Providers. Failure on the part of a mandated reporter to report suspected abuse or neglect is a criminal offense. The AR Department of Human Services (DHS), Division of Children and Family Services (DCFS) and the Arkansas State Police, Crimes Against Children Division (CACD) are responsible for investigating allegations of child abuse or neglect. The DHS Division of Aging and Adult Services is responsible investigating allegations of adult abuse or neglect.

DHS Incident Reporting Policy 1090 and DDS Certification Standards for HCBS Waiver Services, Section 300 describe the incidents that the certified providers must report. The certified providers must report incidents, using automated form DHS 1910 via secure e-mail, to the DDS Quality Assurance Certification and Licensure section within two working

days following the incident. In instances that might be of interest to the media, the providers must immediately report the incident to DDS QA staff who in turn notifies the DHS Communication Director. Providers must report suicide, death from adult abuse or child maltreatment, or a serious injury within one hour of occurrence, regardless of the hour.

The following is a list of the incidents which must be reported and are tracked by DDS. However, the State does not require follow-up or investigation of each listed incident. A description of how DDS makes the determination that follow-up action is required and by whom is described in Item G-1-d. Specifically, DDS has designated the following incidents as critical and sufficiently serious as to require follow-up:
1) attempted suicide,
2) suspected abuse or neglect by a staff person,
3) elopement,
4) use of restrictive interventions,
5) death, and
6) arrest.

When investigative staff receive reports of any of the critical incidents, they evaluate the information contained in the report to determine if the incident requires an investigation or possible follow up at the next annual review of the provider.

Incidents which must be reported (but are not necessarily considered critical, unless also on the above list):
1. Death
2. The use of any restrictive intervention, including seclusion, or physical, chemical or mechanical restraint,
3. Suspected maltreatment or abuse as defined in Ark. Code Ann. §§ 12-18-103 & 12-12-1703;
4. Any injury that:
   a. Requires the attention of an Emergency Medical Technician, a paramedic, or physician,
   b. May cause death,
   c. May result in a substantial permanent impairment, or
   d. Requires hospitalization.
5. Suicide, threatened or attempted,
6. Arrest or conviction of any crime,
7. Any situation in which the location of a person has been unknown for two hours,
8. Any event in which a staff threatens a person served by the program,
9. Sentinel events, such as unexpected occurrences involving actual or risk of death or serious physical or psychological injury,
10. Medication errors made by staff that cause or have the potential to cause serious injury or illness,
11. Any rights violation that jeopardizes the health and safety or quality of life of a person served by the program,
12. Communicable disease,
13. Violence or aggression,
14. Vehicular accidents,
15. Biohazardous accidents,
16. Use or possession of illicit substances or licit substances in an unlawful or inappropriate manner,
17. Property destruction, and
18. Any condition or event that prevents the delivery of services for more than 2 hours.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DDS provides training and information to participants and legally responsible persons in the form of the Arkansas Guide to Services for Children and the Arkansas Guide to Services for Adults, The DDS Waiver Handbook, and the DDS website. DDS Quality Assurance investigations staff will provide training to providers regarding the reporting requirements contained in the Certification Standards for HCBS Waiver Services. Additionally, the Certification Standards require that certified providers provide training to all staff regarding the prevention of adult and child maltreatment, reporting adult and child maltreatment and DHS and DDS requirements for reporting incidents. The requirement stipulates that the provider conduct this training each year. The HCBS Waiver Certification Standards also require that certified providers inform all participants of their rights and provide support and training to them so that participants may recognize attempts to exploit them.

The DHS Division of Children and Family Services (DCFS) provides statewide training on child abuse and neglect

prevention, as well as how to report suspected abuse or neglect. The DHS Division of Aging and Adult Services provides statewide training regarding adult maltreatment.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The DHS Division of Aging and Adult (DAAS), Adult Protective Services, (APS) receives reports of critical events designated as adult abuse or neglect and investigates those allegations. The methods to evaluate the reports and the time-frames for responding are defined at Ark. Code Ann. § 12-12-1711(b)(1). The law requires that, if the APS staff who receives the report believes that the act described by the reporter constitutes criminal behavior, they must contact the appropriate law enforcement agency. If the APS staff believes the individual to have an immediate need, the staff must treat it as an emergency and report it to 911 services. The APS investigator must see the individual within 24 hours of the report. In non-emergency situations, investigation staff must see the individual who is the subject of concern within three working days and must complete the investigation within 60 days. Based on information provided in the Case Summary Report and the recommendation of the APS staff, the APS Field Manager determines if the allegations are unfounded, founded or incomplete. If founded, the case summary report must contain details of how the APS staff met their responsibility to protect the person and to remedy the circumstances found to exist.

The DHS Division of Children and Family Services (DCFS) receives reports of critical events designated as child abuse or neglect and investigates those allegations. The method to evaluate the report and the time-frames for responding are defined at Ark. Code Ann. § 12-18-102. The Arkansas Child Maltreatment Hotline accepts reports of alleged maltreatment and determines if the report constitutes an event defined as abuse or neglect and if the report constitutes a Priority I or Priority II offense. A Priority I offense is sexual abuse, death, broken bones, head injuries, exposure to poison and noxious chemicals and substances and other critical injuries or events. A Priority II offense is one that involves serious issues, but those that are not life threatening.

Generally, DHS DCFS investigates allegations designated as Priority II and the Arkansas State Policy, Crimes Against Children Division (CACD) investigates Priority I allegations. If the nature of a child maltreatment report suggests that a child is in immediate risk, DCFS or CACD initiates an investigation immediately or as soon as possible. DCFS maintains primary responsibility for ensuring the health and safety of children regardless of whether the investigation is conducted by CACD or DCFS. DCFS and CACD complete investigations and make an investigative determination within thirty days. If the circumstances of the child present an immediate danger, the DCFS may take the child into protective custody for up to 72 hours.

When a DDS certified provider reports an incident to the Adult or Child Hotline, they must also submit an incident report (DHS 1910) to the DDS QA investigation unit. The DDS Quality Assurance investigator reviews and evaluates the incident reports to determine if correct procedures and time frames are followed. If the certified provider staff did not report the incident according to proscribed timeframes, the investigative staff will issue a deficiency to the certified provider and request an Assurance of Adherence of Standards which describes how the provider will ensure future compliance with the required reporting time frames.

If the investigator reviewing the incident report determines that the incident should have been reported to a hotline and was not, the investigator will immediately report the incident to the appropriate hotline. Additionally, the investigative staff will issue a deficiency to the certified provider and request an Assurance of Adherence of Standards which describes how the provider will ensure future compliance with the required hotline reporting requirements.

If an incident warrants investigation, the DDS Quality Assurance investigator will initiate an investigation according to the Community and Employment Supports (CES) Waiver Minimum Certification Standards. The policy requires that investigative staff complete an investigation within 30 days.

DDS has designated the death of an individual as a critical incident. DDS Policy 1018, Mortality Review of Deaths guides the process to conduct a review of each death in order to identify issues and trends related to deaths in order to improve division and provider practices by identifying issues, recommending changes, influencing development of excellent policies and to gather data in order to identify and analyze trends. The purpose is to facilitate Continuous Quality Improvement by gathering information to identify systemic issues that may benefit from scrutiny and analysis in order to make system improvements and to provide opportunities for organizational learning DDS maintains an investigation unit which investigates complaints and concerns, which may or may not constitute a critical Community and Employment Supports (CES) Waiver Minimum Certification Standards concern, prescribes the methods and timeframes for conducting an investigation of a concern or complaint. In brief, the investigator has three working days

from the time the complaint is received to make initial contact with the person making the complaint. The investigator must begin the fact finding process within one day of initiation of the investigation and must complete the investigation within 30 days. The investigator provides a written report to the certified provider and to the individual making the complaint. If the investigator substantiates the complaint, they issue a deficiency to the certified provider and requests an Assurance of Adherence to Standards which must explain how they will remedy the situation with the individual involved as well as how they will prevent similar situations from occurring in the future.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHS DDS Quality Assurance Certification and Licensure section is responsible for overseeing the reporting of and response to critical incidents regarding HCBS Waiver participants. There are three primary facets to the oversight process. One part of the process occurs during the annual onsite review of the certified provider to ensure that the provider is following applicable policies and procedures and that necessary follow up is conducted on a timely basis. The second occurs as the investigative staff reviews and responds as appropriate to reports of incidents that certified providers submit to DDS Investigative Unit. Thirdly, DDS Certification and Licensure unit maintains a database of incidents in order to facilitate the identification of trends and patterns in the occurrence of critical incidents in order to identify opportunities for improvements and support the development of strategies to reduce the occurrence of incidents in the future.

DDS Certification Standards require that certified providers develop and implement policy that requires reporting adult abuse, maltreatment or exploitation, or child maltreatment to the Child Abuse or Adult Maltreatment Hotline. Standards also require that certified providers develop and implement policy that requires that program staff report certain incidents that occur within the program. The policy must:
1. Include all incidents described as by DDS,
2. Include any other incidents determined reportable by the program, and
3. Require notification to the parent or guardian of all children age birth to 18 or adults who have a guardian, each time the provider submits an incident report to DDS or according to the Internal Incident Reporting policy.
4. Develop and implement policy regarding follow-up of all incidents.

During the annual onsite review, Certification and Licensure staff review the documentation maintained by the provider which supports compliance with these requirements. Staff review documentation of incidents to determine if the incident constitutes a reportable incident and confirm that a report was submitted. Certification and Licensure staff interview provider staff to determine if they are familiar with the requirements of incident reporting.

DDS investigative staff receive and review incident reports that certified providers submit according to guidelines described in d. above. They review the report to determine if the provider responded appropriately to the incident, if they reported timely, if they reported to the appropriate hotline if necessary and it the incident requires investigation by the DDS investigative unit.

DDS Certification and Licensure unit maintains a database of incidents that includes the type of incident, the name of the provider, the name of the HCBS Waiver participant, and the date of occurrence. Certification and Licensure staff review the information on a quarterly basis to determine if there are trends that are relative to specific providers at a system-wide level or within the waiver population. If trends are identified, the information is provided to the DDS Quality Assurance Committee which meets quarterly to determine if any actions are needed.

DDS Certification and Licensure Administration maintains oversight of investigative activities. Investigative staff maintains
a database that includes timeframes regarding initiation and resolution, including notification to the parties involved. Staff generate monthly reports and administrative staff analyzes data on a quarterly basis. Systemic issues, when identified, are presented to the DDS Quality Assurance Committee which meets on a quarterly basis.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS permits the use of physical restraints when the challenging behavior exhibited by the Waiver beneficiary threatens the health or safety of the individual or others. Physical restraint or means the application of physical force without the use of any device, for the purposes of restraining the free movement of an individual's body. Manually holding all or part of a person's body in a way that restricts the person's free movement; including any approved controlling maneuvers. This does not include briefly holding, without undue force, a person in order to calm the person, or holding a person's hand to escort the person safely from one area to another.

DDS does not permit medications to be used to modify behavior or for the purpose of chemical restraint. Chemical Restraint means the use of medication for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition.

DDS does not permit the use of mechanical restraints. Mechanical Restraint means any physical apparatus or equipment used to limit or control challenging behavior. This apparatus or equipment cannot be easily removed by the person and may restrict the free movement, or normal functioning, or normal access to a portion or portions of a person's body, or may totally immobilize a person.

Definitions:

"Challenging behaviors" are behaviors defined as problematic or maladaptive by others who observe the behaviors or by the person displaying the behaviors. They are actions that:
1. Come into conflict with what is generally accepted in the individual's community,
2. Often isolate the person from their community, or
3. Can be barriers to the person living or remaining in the community, and
4. Vary in seriousness and intensity.

DDS requires that, before a provider may use physical restraints, they must have developed alternative strategies to avoid the use of restraints by developing a behavior management plan which incorporates the use of positive behavior support strategies as an integral part of the plan. The plan must:
1. Be designed so that the rights of the beneficiary are protected,
2. Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or puts the individual at medical risk,
3. Identify the behavior to be decreased,
4. Identify the behavior to be increased,
5. Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior,
6. Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person,
7. Identify the event that likely occurs right before a behavior of concern,
8. Identify what staff should do if the event occurs,
9. Identify what staff should do if the behavior to be increased or decreased occurs,
10. Involve the fewest interventions or strategies possible, and
11. Specify the length of time restraints must be used, who will authorize the use of restraints, and methods for monitoring restraints.

A behavior management plan must be written and supervised by a qualified professional who is, at a minimum, a Qualified Developmental Disabilities Professional. The provider must provide training to all persons who implement the behavior management plan. Training requirements include Introduction to Behavior Management, Abuse and Neglect and any other training as necessary.

The provider must collect data and review the plan. Since the success of a behavior management plan is measured by reductions in challenging behaviors, performance of alternative behaviors and improvements in quality of life, the provider is required to:
1. Develop a simple, efficient and manageable method of collecting data,
2. Collect data regarding the frequency, length of time of each use, the duration of use over time and the impact of the use of restraint, restrictive intervention or seclusion,
3. Review the data regularly, and
4. Revise the plan as needed if the interventions do not achieve the desired results.

DDS Standards require that the provider report to DDS the use restraints. The DDS investigative staff review each report to determine if the use of the technique was authorized or misapplied. Additionally, in an effort to detect the unauthorized use of or misapplication of restraints, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider.

DDS Standards stipulate that providers prohibit maltreatment or corporal punishment of individuals. DDS Standards also require that providers guarantee an array of rights which includes the right to be free from the use of a physical or chemical restraint, medications, or isolation as punishment for the convenience of the provider except when such measure is necessary for the health and safety of the beneficiary or others.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DDS Quality Assurance Certification and Licensure section is responsible for overseeing the use of restraints. DDS Standards require that the provider report to DDS the use of restraint. The DDS investigative staff review each report to determine if the use of the technique was authorized or misapplied. Additionally, in an effort to detect the unauthorized use of or misapplication of restraints, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider. DDS also maintains an investigative unit, whose staff investigates any complaints or concerns regarding the possible misuse of restraints or interventions.

DDS investigative staff collect data from provider incident reports. The data includes the frequency, length of time of each use, the duration of use over time and the impact of the use of restraint. The staff produces a report on a monthly basis and reviews the data to detect any trends specific to individuals or providers that may emerge. On a quarterly basis, the Certification and Licensure Administrator presents a quarterly report of the data to the DDS Quality Assurance Committee. If a trend is identified, DDS may initiate an investigation to identify root causes and require corrective action to reduce or eliminate the inappropriate use of restraints and restrictive interventions.

DDS investigative staff also collect data from deficiencies cited by the Certification and Licensure staff based on their annual onsite provider reviews as well as deficiencies cited by investigative staff based on complaints or concerns. This data is analyzed as described in the above paragraph.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive interventions are defined as procedures that restrict an individual's freedom of movement, restricts access to their property, prevents them from doing something they want to do, requires an individual to do something they do not want to do, or removes something they own or have earned. Restrictive interventions include the use of time-out or separation (exclusionary and non- exclusionary).

Restrictive interventions that include aversive techniques, restrict an individual's right, involve a mechanical or chemical restraint are prohibited.

Time-out or separation is permitted. Time-out or separation is a restrictive intervention in which a person is temporarily, for a specified period of time, removed from positive reinforcement or denied the opportunity to obtain positive reinforcement for the purpose of providing the person an opportunity to regain self-control. During which time, the person is under constant visual and auditory contact and supervision. Time-out interventions include placing a person in a specific time-out room, commonly referred to as exclusionary time-out and removing the positively reinforcing environment from the individual, commonly referred to as non-exclusionary time-out. The person is not physically prevented from leaving. Time-out may only be used when it has been incorporated into a positive behavior plan which has specified the use of positive behavior support strategies to be used before utilizing time-out.

DDS requires that, before a provider may use any restrictive intervention, they must have developed alternative strategies to avoid the use of those interventions by developing a behavior management plan which incorporates the use of positive behavior support strategies as an integral part of the plan. The plan must:
1.Be designed so that the rights of the individual are protected,
2.Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or puts the individual at medical risk,
3.Identify the behavior to be decreased,
4.Identify the behavior to be increased,
5.Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior,
6.Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person,
7.Identify the event that likely occurs right before a behavior of concern,
8.Identify what staff should do if the event occurs,
9.Identify what staff should do if the behavior to be increased or decreased occurs, and
10.Involve the fewest interventions or strategies possible.

A behavior management plan must be written, implemented and supervised by a Care Coordinator. The provider must provide training to all persons who implement the behavior management plan. Training requirements include Introduction to Behavior Management, Abuse and Neglect and any other training as necessary.

The provider must collect data and review the plan. Since the success of a behavior management plan is measured by reductions in challenging behaviors, performance of alternative behaviors and improvements in quality of life, the provider is required to:
1.Develop a simple, efficient and manageable method of collecting data,
2.Collect data regarding the frequency, length of time of each use, the duration of use over time and the impact of restraint and seclusion,

3.Review the data regularly, and
4.Revise the plan as needed if the interventions do not achieve the desired results.
DDS Standards require that the provider report to DDS the use of any restrictive intervention. The DDS investigative staff review each report to determine if the use of the technique was authorized or misapplied. Additionally, in an effort to detect the unauthorized use of or misapplication of restraints, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider.

DDS Standards stipulate that providers prohibit maltreatment or corporal punishment of individuals. DDS Standards also require that providers guarantee an array of rights which includes the right to be free from the use of a physical or chemical restraint, medications, or isolation as punishment for the convenience of the provider except when a physical restraint is necessary for the health and safety of the individual.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DDS QA is responsible for overseeing and detecting the unauthorized use of restrictive interventions. DDS Standards require that the provider report to DDS the use of any restrictive intervention. The DDS investigative staff review each report to determine why the use of the technique occurred and what corrective action the provider took to prevent the reoccurrence of the use of the restrictive intervention. Additionally, in an effort to detect the unauthorized use of restrictive intervention, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider. DDS also maintains an investigative unit, whose staff investigates any complaints or concerns regarding the possible use of restrictive interventions.

DDS investigative staff collect data from provider incident reports. The data includes the frequency, length of time of each use, the duration of use over time and the impact of the restrictive intervention. The staff produces a report on a monthly basis and reviews the data to detect any trends specific to individuals or providers that may emerge. On a quarterly basis, the Certification and Licensure Administrator presents a report of the data to the DDS Quality Assurance Committee. If a trend is identified, DDS may initiate an investigation to identify root causes and require corrective action to reduce or eliminate the use of restrictive interventions.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Seclusion is defined as the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with other or leaving. DDS QA is responsible for overseeing and detecting the unauthorized use of seclusion. DDS Standards require that the provider report to DDS the use of seclusion. The DDS investigative staff review each report to determine why the use of the technique occurred and what corrective action the provider took to prevent the reoccurrence of the use of seclusion. Depending on the circumstances described in the incident report, DDS investigative staff conduct an onsite investigation and cite providers with deficient practices as necessary.

Additionally, in an effort to detect the unauthorized use of seclusion, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider. DDS also maintains an investigative unit, whose staff investigates any complaints or concerns regarding the possible use of seclusion.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The direct care service provider has on-going responsibility for first-line monitoring beneficiary medication regimens. The provider is responsible at all times to assure that the service plan identified and addressed all needs with other supports as necessary to assure the health and welfare of the beneficiary, even if they do not provide round-the-clock services to that person.

The Care Coordinator must develop and implement a Medication Management Plan for all beneficiaries receiving prescription medications. The plan must describe;
1. How that direct service staff will, at all times, remain aware of the medications being used by the beneficiary,
2. How the direct service staff will be made aware of the potential side effect effects of the medications being used by the beneficiary,
3. How the program staff will ensure that the beneficiary or their guardian will be made aware of the nature and the effect of the medication,
4. How the program staff will ensure that the beneficiary or their guardian gives their consent prior to the use of the medication, and
5. How the program staff will ensure that administration of the medication will be performed in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

The provider staff providing direct services must maintain medications logs that document at least the following:
1. Name and dosage of the medication given,
2. Route medication was given,
3. Date and time the medication was given,
4. Initials of the person administering or assisting with administration of the medication,
5. Any side effects or adverse reactions, and
6. Any errors in administering the medication.

The direct service provider must ensure that a supervisory level staff monitors the administration of medications at least monthly by reviewing medication logs to ensure that;
1. The beneficiary consumed the medications accurately as prescribed,
2. The medication is effectively addressing the reason for which they were prescribed,
3. Any side effects are being managed appropriately,

When medication is used to treat specifically diagnosed mental illness, the medication has been prescribed and is being managed by a psychiatrist who is periodically provided information regarding the effectiveness of and any side effects experienced from the medication. The prescription and management may be by a physician, if a psychiatrist is not available, or when requested and agreed to by the person or the person's guardian and when based upon the documented need of the person. Medications may not be used to modify behavior in the absence of a specifically diagnosed mental illness, or for the purpose of chemical restraint.

DDS standards recognize that prescription PRN and over-the-counter medications are appropriate in the use of treating specific symptoms of illnesses. The Provider must keep data regarding:
1. How often the medication is used,
2. The circumstances in which the medication is used,
3. The symptom for which the medication was used, and
4. The effectiveness of the medication.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DDS Quality Assurance unit is responsible for overseeing the second-line medication management process to ensure that beneficiaries medications are managed appropriately. The DDS Quality Assurance Certification and Licensure staff conduct an onsite review of every provider every year. During the onsite review, Certification and Licensure review records, conduct interviews and observe interactions between staff and HCBS Waiver beneficiaries. Staff review medication management plans and medication logs. They also review internal incident reports as well as those incident reports that the provider submitted to DDS to detect any potentially harmful practices. If they find errors, Certification and Licensure staff cite the provider with a deficient practice and require a plan of correction. When warranted, Certification and Licensure staff perform a follow-up review of providers to determine if they have implemented the practices described in their plan of correction.

DDS maintains an investigative unit that will investigate complaints or concerns regarding how providers manage medications. The investigative staff cite the provider with a deficient practice and require a plan of correction if they identify a harmful or potentially harmful practice.

Prescription drugs are a state plan Medicaid service. The DMS Drug Utilization Review (DUR) Committee and the DUR Board monitors how prescription drugs are prescribed. Their monitoring includes checking the number of medications prescribed and the possible concurrent use of contraindicated medications.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. **Provider Administration of Medications.** *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and

policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Providers must adhere to the Arkansas Nurse Practice Act, which addresses how medications may be administered and by whom. DDS Certification Standards build upon that by describing requirements for medication management plans, medication logs, monitoring effects, reporting errors, and use of PRN and OTC medications. The Care Coordination provider must develop and implement a Medication Management plan for all beneficiaries receiving prescription medications. The plan must describe:
1. How the program will ensure that direct service supervisors and direct service staff will, at all times, remain aware of the medications being used by the beneficiary,
2. How the program will ensure that direct service supervisors and direct service staff will be made aware of the potential side effect effects of the medications being used by the beneficiary,
3. How the program will ensure that the beneficiary will be made aware of the nature and the effect of the medication,
4. How the program will ensure that the beneficiary gives their consent prior to the administration of the medication, and
5. How the administration of the medication will be performed in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

The Organization providing direct services must ensure that staff maintain Medication Logs that document at least the following:
1. Name and dosage of the medication given,
2. Route of medication,
3. Date and time the medication was given,
4. Initials of the person administering or assisting with administration of the medication,
5. Any side effects or adverse reactions, and any actions taken as a result, and
6. Any errors in administering the medication.
A. The Organization providing direct services must ensure that a supervisory level staff documents oversight of the administration of medications at least monthly by reviewing medication logs to determine if;
1. The person consumed the medications accurately as prescribed,
2. The medication is effectively addressing the reason for which it was prescribed, and
3. Any side effects are noted, reported and are being managed appropriately.

The direct service provider must ensure that designated staff report to a supervisor and record the following medication errors missed dose,wrong dose,wrong time of dose,wrong route, and wrong medication.

The direct service provider must ensure that designated staff record any charting omission, loss of medication, unavailability of medications, falsification of records, and any theft of medications.

Additionally, the direct service provider must keep data regarding how often the medication is used, the circumstances in which the medication is used, the symptom for which the medication was used, and the effectiveness of the medication.

Providers are also required to develop and implement policies which describe how staff will administer or assist with the administration of medications. The policy must, at least, describe the qualifications of who may administer medications,describe the qualification of who may assist with the administration of medications, specify which class of drugs may be administered by which staff,
and require that PRN medications are used only with the consent of the person and according to approval from the prescribing health care professional.

Providers are required to provide training to staff who provide direct services which details the specifics of the person's service plan including training that provides information related to any medications taken by the person they serve, including possible side effects.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Providers are required to report medication errors to the DDS Quality Assurance unit.

(b) Specify the types of medication errors that providers are required to *record:*

The direct services provider must ensure that designated staff report to a supervisor and record medication errors as follows: missed dose, wrong dose,wrong time of dose, wrong route, and wrong medication.

The direct services provider must ensure that designated staff record the following: any charting omission, loss of medication, unavailability of medications, falsification of records, and theft of medications.

(c) Specify the types of medication errors that providers must *report* to the State:

Providers are required to report medication errors to the DDS Quality Assurance unit medication errors that cause or have the potential to cause serious injury or illness.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DDS Quality Assurance unit is responsible for monitoring the performance of providers in the administration of medications to persons. The DDS Quality Assurance Certification and Licensure staff conduct an onsite review of every provider every year. During the onsite review, Certification and Licensure review records, conduct interviews and observe interactions between staff and HCBS Waiver participants. Staff review medication management plans, logs and error reports. They also review internal incident reports as well as those incident reports that the provider submitted to DDS to detect any potentially harmful practices. If they find errors, Certification and Licensure staff cite the provider with a deficient practice and require a plan of correction. When warranted, Certification and Licensure staff perform a follow-up review of providers to determine if they have implemented the practices described in their plan of correction.

DDS maintains an investigative unit that will investigate complaints or concerns regarding how providers manage medications. The investigative staff cite the provider with a deficient practice and require a plan of correction if they identify a harmful or potentially harmful practice.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW1 : Number and percentage of participants or legal guardians who received information about how to report abuse, neglect, and exploitation as documented on the applicable form. Numerator: Number of participants who received information about how to report abuse, neglect, and exploitation as documented on the applicable form; Denominator: Number of files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual File Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW2: Number and percentage of providers who reported critical incidents to DDS within required time frames. Numerator: Number of providers who reported critical incidents within required time frames; Denominator: Total number of critical incidents reported to DDS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Critical Incidents Reported to DDS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW3: Number and percentage of critical incidents reported to APS or CPS.
Numerator: Number of critical incidents reported to APS, CPS ; Denominator: Total number of critical incidents required to be reported to APS or CPS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Critical Incidents Reported to APS or CPS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW4: Number and percentage of providers who took corrective actions regarding critical incidents to protect the health and welfare of the individual. Numerator: Number of providers who took corrective actions regarding critical incidents to protect the health and welfare of the individual; Denominator: Number of providers required to take protective actions regarding critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Corrective Actions

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW5: Number and percentage of criminal background checks determinations completed by DDS on a timely basis. Numerator: Number of criminal background checks determinations completed by DDS on a timely basis; Denominator: Total number of criminal background checks determinations due.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Criminal Background Check Determinations

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW6: Number and percentage of complaint investigations that were completed on a timely basis. Numerator: Number of complaint investigations that were completed on a timely basis; Denominator: Number of complaint investigations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Timely Completed Complaint Investigations

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW7: Number and percentage of reported deaths which were reviewed by the Mortality Review Committee Numerator: Number of reported deaths which were reviewed timely by the Mortality Pre-Review Committee; Denominator: Number of deaths reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data Source Report of Timely Mortality Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW8: Number and percentage of individuals for whom providers adhered to DDS requirements for the use of restrictive interventions. Numerator: Number of individuals for whom providers adhered to DDS requirements for the use of

restrictive interventions as documented on an incident report; Denominator: Number of individuals for whom the provider utilized restrictive intervention.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Restrictive Interventions

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
HW9-Number and percentage of providers who demonstrate responsibility for maintaining overall health care standards. Numerator: Number of provider agencies who complied Standard 1404.C and 1408.A.8.f and 2202.A.1 and 2202.B.13. Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of provider deficiencies.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW4- Number and percentage of providers who took corrective actions regarding critical incidents to protect the health and welfare of the individual. Numerator: Number of providers who took corrective actions to protect the health and welfare of the individual; Denominator: Number of providers required to take protective actions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of incident reports.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW8-Number and percentage of individuals for whom providers adhered to DDS requirements for the use of restrictive interventions. Numerator: Number of individuals for whom providers adhered to DDS requirements for the use of restrictive interventions as documented on an incident report; Denominator: Number of individuals for whom the provider utilized restrictive intervention.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of incident reports.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW9-Number and percentage of providers who demonstrate responsibility for maintaining overall health care standards. Numerator: Number of provider agencies who complied Standard 704 .B. Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On site provider reviews and investigations.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
(HW 1) DDS mails the DDS ACS 106 "Waiver Rights and Choice Form" to each individual annually. The form contains a statement which informs them that they have the right to report abuse and contains the contact information for Child and Adult Hotlines. Individuals are required to return the signed form to DDS Waiver section.

(HW4) Prior to initiation of an annual onsite provider certification review, Certification and Licensure (C&L) staff gathers incident reports which the provider has submitted throughout the year. C&L staff identifies reports that describe incidents which require protective actions, such as behavior management plans, changes in staffing levels, or changes in goals. During the onsite review, the reviewers will determine, through the use of interviews, observations and file reviews, if the provider has taken necessary action to protect the individual in question.

(HW 5) DDS investigative staff reviews criminal background checks which are provided to DDS by the Arkansas State Police, The Online Criminal Background System. Staff accesses the system each Friday and provides a written response to the provider who requested the background check. If a disqualifying conviction appears on the background check, DDS staff includes a determination that the prospective employee is disqualified from employment. The staff must provide the response to the provider within 14 calendar days.

(HW 6) Community and Employment Supports (CES) Waiver Minimum Certification Standards, requires that DDS investigative staff completes investigations within 30 calendar days of receipt of the concern.

(HW 8) DDS requires that providers submit incident reports each time they utilize a restrictive intervention. DDS investigative staff reviews each report and determines if the methods described in the incident report adhere to the requirements for the use of the type intervention used. DDS staff may contact the provider to obtain additional information, if necessary.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
(HW 1) If the signed form is not in the DDS file, the Specialist will contact the individual to ensure that they received the form and will secure a signed form for the file.

(HW 2) When DDS determines, during an investigation, or based on Incident Reports submitted by the provider, that the provider has consistently not complied with reporting time frames, or has not complied with reporting requirements with regard to critical incidents, the investigation manager cites a deficiency and requires that the provider submit an Assurance of Adherence to Standards. The Assurance must include a description of the processes the provider will put in place to assure the deficiencies do not occur again.

(HW3) Additionally, when the DDS staff reviews an Incident Report and determines that the described incident is reportable to APS or CPS and has not been reported by the provider, the DDS staff immediately calls the appropriate hotline to report the incident.

(HW4) Prior to initiation of an annual onsite provider certification review, Certification and Licensure (C&L) staff gathers incident reports which the provider has submitted throughout the year. C&L staff identifies reports that describe incidents which require protective actions, such as behavior management plans, changes in staffing levels, or changes in goals. During the onsite review, the reviewers will determine, through the use of interviews, observations and file reviews, if the provider has taken necessary action to protect the individual in question.

(HW6) If DDS staff consistently does not complete investigations within required time frames, or if DDS staff does not provide timely responses to providers requesting criminal background checks, the Certification and Licensure Manager counsels the staff and utilizes the DHS Minimum Conduct Standards for Employees and DHS Employee Discipline policy to ensure compliance.

(HW8) If DDS staff determines that a provider did not adhere to regulations regarding the use of restrictive interventions, the DDS staff issues a deficiency and requires an Assurance of Adherence to Standards from the provider. DDS investigative staff may conduct an onsite investigation if determined necessary.

(HW 7) The Death Review Coordinator prepares an annual report that addresses any trend identified by the Committee as well as the identification of any prevention activities proposed because of any review. The report contains recommendations regarding specific actions such as:

1. Revision of provider or Division policy or forms,
2. Development of new provider or Division policy to address systemic issues discovered in the review process,
3. Training, either on a statewide or individual provider basis,
4. Facilitation of best practice, including new risk-prevention practices, through dissemination of recommendations for development of or modification to provider policies, or
5. Issuance of a statewide safety alert.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DDS and DMS, in consultation with a CMS technical assistance contractor, developed the framework for a Performance Measure report in May 2013 as the basis for the Quality Improvement System (QIS). The purpose of the Performance Measure report is to produce acceptable evidence for Arkansas' compliance with HCBS Subassurances. The Performance Measure report accomplishes this purpose by prioritizing areas of discovery, gathering data in those areas, analyzing trends among the data, and determining how best to implement system improvements.

DDS Quality Assurance staff and DDS Waiver staff refined the measurements within the framework. DDS Quality Assurance staff developed a format for the report and began gathering data on specific measures from sections for each subassurance in July 2013. The first Performance Measure report was published in October 2013 and was reviewed by the DDS Quality Assurance Committee on 10/22/13. A quarterly Performance Measure report has been reviewed in each DDS Quality Assurance Committee since that time. The first Annual report was reviewed by the DDS Quality Assurance Committee on 07/21/14.

In addition to the Performance Measure report, DDS performs an on-site review of each provider annually, reviews incident reports, performs investigations of service concerns, and performs Mortality Review. Information from these activities provide the data for the Performance Measure report.

1) Roles and Responsibilities - DMS remains responsible for the administration and oversight of all Medicaid waivers, including those operated by other divisions. DMS Waiver Quality Assurance Administrator represents DMS in the development and implementation of the QIS and monitors each 1915(c) HCBS waiver. The DMS Waiver QA Administrator works closely with the operating agencies and serves as primary liaison with CMS regarding the waivers. This position serves to centralize responsibility and accountability for the waiver with DMS, and also provides leadership in promoting and improving quality in 1915(c) HCBS waivers. The DMS Waiver QA Administrator reports to the DMS Assistant Director, who keeps the DMS Director informed of concerns about and activities related to the waiver. DMS Waiver Quality Assurance Administrator serves on the DDS Quality Assurance Committee.

The DDS Assistant Director for Waiver Services is responsible for the operation of the waiver program. This includes helping design, develop and implement portions of the QIS for the waiver. The DDS Assistant Director, managers and staff are responsible for technical assistance to providers, monitoring person centered service plan (PCSP) implementation by providers, financial and statistical reports, prior authorization of individual PCSP budgets, internal operations, application processing, PCSP database system,participation on the DDS Quality Assurance Committee and regular contact with people served.

DDS Quality Assurance Unit develops and reviews DDS' compliance with Performance Measures. The Performance Measure report is posted quarterly and reviewed at DDS Quality Assurance meetings . DDS Quality Assurance section performs an on-site review of each provider annually, reviews incident reports, performs investigations of service concerns, and performs Mortality Review.

The DMS Waiver Quality Assurance Unit reviews a representative sample of individual case files annually. This unit reviews for compliance with assurances including level of care, PCSP, qualified providers, health and welfare, administrative authority, and financial accountability. The DMS Waiver Quality Assurance Unit reports findings to DMS Division Director, the DDS Assistant Director for Waiver Services and the DDS Assistant Director, advises on any needed remediation and tracks system improvement.

2) Processes to Establish Priorities and Develop Strategies for Remediation & Improvement -
The DDS Waiver Program and Assistant Directors and managers share Performance Measure report and other reports with DMS Waiver QA Unit, discuss findings of the reports, and address any issues or concerns. DDS and DMS establish priorities and develop strategies for any necessary remediation and system improvement. DDS personnel are responsible to track data, perform remediation activities, and report improvement to their Assistant Directors.

When major issues are identified that impact one or more of the Subassurances, the DDS Waiver Program and Assistant Directors and managers will inform the DDS and DMS Directors and Assistant Directors and seek their input on the issues and any needed remediation.

3) Compiling and Communicating Quality Management Information - At the end of each waiver year, the DMS QA Administrator will compile a report based on findings from DDS, DMS Quality Assurance, and the CMS 372 report. This annual report will include key information relevant to each subassurance, information about participation in and cost of the waiver based on the CMS 372 report and information on any key findings, including status of remediation and improvement activities. The DMS QA Administrator will make the report available to DDS and DMS administration.

4) Periodic Evaluation and Revision of the QMS - The QIS, including Performance Measure report, will be revised during implementation as DDS measures performance related to the subassurances and the evidence that is produced. The DMS Waiver QA Administrator and the DDS Waiver Program and Quality Assurance Assistant Directors and managers will meet annually to review and discuss the QIS, including the performance Measure report and to make any necessary changes. If the QIS is revised as a result of this annual review, the DMS Waiver QA Administrator will send the revised QIS to CMS.

DDS personnel responsible for Quality Assurance are:

1) Assistant Director for Waiver Services
2) Assistant Director for Transformations and Special Projects

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Arkansas DDS has developed and implemented an HCBS quality improvement strategy that includes a continuous improvement process, measures of program performance, and measures of experience of care.
Components:
Continuous improvement process: DDS convened in November of 2011 a Quality Assurance Committee, made up of state agency staff, providers, and other stakeholders. This Committee meets at least quarterly. Measures of program performance: DDS has developed robust measures of program performance though Performance Measures related to the subassurances.
Experience of care: DDS has conducted the National Core Indicator Adult Consumer Survey since July of 2006. During these seven survey cycles, DDS has improved its process and the transparency of its results. NCI survey data is on the DDS webpage.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DDS and DMS will review the Quality Improvement Strategy annually. Review consists of analyzing reports and progress toward stated initiatives, resolution of individual and systemic issues found through discovery and notating of desired outcomes. When change in the strategy is indicated, a collaborative effort between DMS and DDS is set in motion to complete a revision to the Quality Management Strategy that may include changes for submission as an amendment of the HCBS Waiver to CMS. The collaborative process includes participation by the section or unit who has specific strategy responsibility with open discussion opportunity prior to a strategy change of direction.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

MMIS claims data are audited periodically for program policy alignment; and claims processing worksheets are audited, processed and returned on a daily basis. Discovery and monitoring also includes an ongoing review of CMS-372 reports and CMS-64 reports.

The entity responsible for the periodic independent audit of the waiver program is Arkansas Legislative Audit. Audits are conducted in compliance with state law. All providers who receive a total of $100,000 up to $500,000 in state funding are required to submit a GAS audit annually. Providers who receive $500,000 or more are required to submit an A133 audit annually. The audit must be an independent audit of the provider's financial statements. All audits are reviewed by the Department of Human Services, Office of Chief Counsel (OCC) audit staff for compliance with audit requirements. If there are any concerns or problems noted, the OCC Audit staff will notify the funding division. The funding division (in this case DDS) defers the notifications to the DDS Quality Assurance Services Unit for dispensation.

Waiver programs and providers must use the Medicaid Management Information System (MMIS) for billing and payment. The Division of Medical Services (DMS) and its fiscal agent are responsible for maintaining the MMIS and the Decision Support System (data warehouse for reporting). The Division of Developmental Disabilities Services (DDS) is responsible for identifying necessary edits and audits to be used in the MMIS for proper billing and payment, and for notifying DMS of the changes needed in MMIS. DMS is responsible to determine priority for programming changes requested of Electronic Data Systems to include denial or non-priority of the change request. DMS may review claims activity through utilization review and conduct random financial audits for billing practices and utilization.

DDS is responsible for reviewing billing claims activity for each provider with DDS Specialists conducting a 100% post payment financial audit annually. This audit consists of a paper review of paid services based on MMIS records as compared to DDS prior approved Waiver services for the PCSP being reviewed. This audit occurs prior to approval of all renewed PCSPs with providers required to justify any underutilization and correct any billing errors found. When payment is questioned, a referral is made to the DMS Program Integrity for onsite resolution.

The Office of Medicaid Inspector General (OMIG) conducts annual random reviews of HCBS Waiver programs. If a review finds errors in billing, and fraud is not suspected, Medicaid recoups the money from the Waiver provider. If fraud is suspected, a referral of the Waiver provider is made to the Arkansas Attorney General's Office for appropriate action.

DDS Individual File Reviews include a review of claims paid to provider agencies for services specified in the service plan. DMS arranges with DDS for a specified number of service plans to be reviewed annually as specified in the interagency agreement with DMS in their role as overseer. DMS conducts a retrospective review of identified program, financial and administrative elements critical to CMS quality assurance. DMS randomly reviews plans and ensures that they have been developed in accordance with applicable policies and procedures, that plans ensure the health and welfare of the participant and that financial components or prior authorizations, billing and utilization are correct and in accordance with applicable policies and procedures. DMS uses the sampling guide “A Practical Guide for Quality Management in Home & Community-Based Waiver Programs” developed by the Human Services Research Institute and the Medstat Group for CMS in 2006. A systematic random sampling of the active case population is drawn whereby every "nth" name in the population is selected for inclusion in the sample for Individual File Review. The sample size is based on a 95% confidence level with a margin of error of +/-5%. An online calculator is used to determine the appropriate sample size for the Waiver population. To determine the “nth” integer, the sample is divided by the population. Names are drawn until the

sample size is reached. The sample is divided by twelve for monthly review. DMS oversight results are reconciled quarterly with DDS. Where applicable, individual actions are taken with the provider or DDS staff to correct any known non-compliance or questionable practices; sometimes a change in policy or procedure may be necessary when systemic issues are discovered. Corrective action plans are required if indicated by file review. Payment Integrity looks at the circumstances to determine if fraud is suspected If so, Payment Integrity forwards the case to the Office of Medicaid Inspector General. If policy manual or rules change are indicated, a recommendation is made to the Medicaid Program, Planning and Development.

In addition to the annual retrospective review of billing utilization with any underutilization requiring explanation from the provider, DDS Waiver Specialists randomly attend a minimum of 10% of the PCSP meetings for their caseload and conduct visits to the home. DDS billing claims activity compares billing utilization to services approved on the PCSP. DDS Individual File Reviews monitors choice forms, billing, PCSP and level of care. DDS Individual File Reviews are a more complete review as opposed to just a billing review.

OMIG performs regular reviews of Waiver service providers. During the last two state fiscal years, 21% of our audits were devoted to Waiver providers. There are a number of ways in which OMIG selects providers and identifies claims for reviews. They may audit providers due to a complaint, issues identified through data analytics, or follow-ups from previous audits that resulted in findings. When identifying claims selected for review, OMIG considers a number of different factors. In the event that potential issues are identified through complaints and data analytics, the claims identified by those sources will be reviewed. OMIG also may choose to audit a random sampling of claims submitted by that provider from a specified time period. That process is completed by their data analytics department and follows the following process:

There are no generally accepted principles of statistical sampling; however, it is the goal of the data analytics department to ensure that the frames for the planned sample of claims are appropriate for the review and are composed of a representative sample of that provider's population. OMIG does not extrapolate overpayments, they only use statistically valid random sampling as a means to conduct a probe audit of a providers' claims when the sampling frame is too large for a full review.

OMIG utilizes a basic procedure that is reproducible and results in a probability sample. This methodology allows for an unlimited set of distinct samples that could be selected if applied to the target sampling frame. Given the random sampling methodology, it is important to note that each sampling unit has an equal probability of being selected from the sampling frame for review. The basic methodology is as follows:
1. Select a provider for review
2. Select a period to be reviewed
3. Define the claims universe, the sampling unit (number of recipients), and sampling frame (recipients to choose from)
4. Design a sampling plan and select the sample for review

OMIG utilizes a few different sampling techniques, including simple random, stratified, and cluster samples. The application of sampling technique is largely dependent upon data hypothesis and sampling frame. If a provider contains subpopulations that are necessary for review, then a stratified or cluster sample would be most appropriate. If not, the default sampling methodology is a simple random sample.

The recommended sample size based on a defined sampling frame has a 95% confidence interval with a 5% margin of error. However, sample sizes are no less than a 90% confidence interval with 10% margin of error, and this is only in the case of a very large provider with a prohibitively large patient population. This sample size would only be intended to be a probe of that patient population, with the option to drill down and expand the sample size if necessary based on findings.

The sample size is calculated using a sample size calculator by Raosoft. This calculator can be accessed at http://www.raosoft.com/samplesize.html. The calculator provides the desired sample size by prompting for margin of error, confidence interval, population size, and response distribution. Once the desired sample size has been identified, a random number generator is applied to the recipient list for a provider selected for review for a defined time period. The random recipients identified in the sampling frame then constitute the sample for review, and all other recipients' claims are removed from the claims universe; this only leaves the selected sample of recipients' claims for review.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA1: Number and percent of HCBS Waiver claims that were paid using the correct rate as specified in the HCBS Waiver application. Numerator: Number of claims paid at the correct rate; Denominator: Number of claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient Claims History Profile

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
FA2: Number and percent of reviewed claims with services specified in the PCSP. Numerator: Number of claims with services specified in the PCSP; Denominator: Number of claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient Claims History Profile

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA1:Number and percent of HCBS Waiver claims that were paid using the correct rate as specified in the HCBS Waiver application. Numerator: Number of claims paid at the correct rate; Denominator: Number of claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient Claims History Profile

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Developmental Disabilities Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in periodic team meetings to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DDS and DMS have an Interagency Agreement that includes measures related to financial accountability for the HCBS Waiver.

The performance measure for number and percent of HCBS Waiver claims paid using the correct rate specified in the HCBS Waiver application will always result in 100% compliance because the rates for services are already set in MMIS; therefore, claims will not be paid at any other rate.

DDS's remediation for claims without specified services includes writing deficiencies to providers based on discovery of their failure to provide services specified in the PCSP, training providers and conducting a face-to-face visit with the participant to determine if there are negative outcomes as a result of the lack of services. DDS also reviews the file to determine if the provider has reported a lapse in services which may have resulted in a failure to provide services.

The tool used for record review captures and tracks remediation in these areas.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Care coordination- The monthly rate for care coordination is $173.33. This rate is consistent with the rate paid for care coordination under the Provider-Led Care Coordination Program, 1915(b) Waiver AR07.00.00. Person-Centered Service Plan Development component-This service component can be billed once per year without documentation of a change in circumstances. The rate is $90.00 per plan development. The rate is based on the current rate paid to behavioral health providers for the development of a treatment plan.

Supportive Living - The maximum daily rate for supportive living is $391.95 (Tier 3) and $184.80 (Tier 2). The budget to support the daily cost of supportive living must include the anticipated hourly rate to be paid each direct service staff, and the associated fringe costs, up to a maximum of 32%. The initial fringe costs associated with the waiver were set in 1990 and were based on the cost of fringe for state employees. A fringe benefit is a form of pay for the performance of services. DDS uses the IRS definition of fringe benefits. Examples of fringe benefits are holidays, annual leave, sick leave, FICA, SUTA, life insurance, retirement, WC, and health and medical insurance. Providers may include up to 20% of the cost of salary and fringe, as indirect, administrative costs. Administrative costs include clerical/bookkeeping support, rent, supervisory support, utilities, salary fringe for supervisory/support staff, supplies/materials, quality assurance and training, advertising for recruiting/employing waiver direct delivery of service staff and other expenses. The salaries of senior executives and cost of general services (such as accounting, contracting, and industrial relations) fall under administrative costs. The budget may also include the costs of non-medical transportation as part of implementation of the PCSP. The rate for transportation is .42 cents per mile and is not subject to the 20% indirect cost charge. Each provider is responsible for independently setting the hourly rate paid for direct service staff. It is basically whatever the labor market pool will tolerate. Providers must be in compliance with Department of Labor relative to minimum wage but other than that DDS only deals with a capitated daily rate.

Respite Care - The prospective rate is developed as described for supportive living, with the exception that transportation costs may not be included. The maximum daily rate is the same. This maximum rate is applied to two waiver services (supportive living and respite) because these waiver services are closely related and can serve as a substitute for one another. Without respite there would be a need for increased supportive living staff/hours to be approved in order to assure health and safety in the absence of the unpaid caregiver. There are many components of supportive living to include transportation, but the waiver recipients would only be approved for the components that they need based on a person centered service plan as approved by a physician and DDS.

Adaptive Equipment, PERS and Environmental Modifications - the rate is prospective based on actual cost with a cost

maximum of $7,687.50 per individual per year. The maximum was based on average consumer needs at the time of limitation setting in 1990. The annual maximum includes Adaptive Equipment, PERS and Environmental Modifications.
Personal Emergency Response System - the rate is prospective based on actual cost of installation, purchase and monthly service fees.

Specialized Medical Supplies, Supplemental Supports, and Community Transition - the rate is prospective based on actual costs with a maximum of $3,690.00 per year. The maximum was based on average consumer needs at the time of limitation setting in 1990. The annual maximum includes Specialized Medical Supplies, Supplemental Support and Community Transition.

Consultation - the annual maximum for an individual is $1320.00. This maximum is increased from the previous 5 years of the waiver.

Crisis Intervention - The maximum rate is $127.10 per hour. The annual maximum is $2640.00. There was no annual maximum for this service in the preceding 5 years of the waiver.

Supported Employment - Supported employment cannot exceed $3.59 per 15 minute unit with a maximum of 32 units a day, 5 days per week for the first year. The service may be provided up to 52 weeks in a year. The resulting maximum is $29,868.00 per year.

The rates included in this waiver were initially set in 1990. The State proposes that within 12 months from the effective date of this waiver renewal, AR will submit an amendment to implement a new rate methodology for all services. AR will consult with CMS during the development of the rate methodology and will comply with all public notice requirements.

Arkansas will submit a timeline for rate methodology amendment, well in advance, but no longer than three months after approval date of this renewal.

Rate Determination Responsibility: DDS is responsible to develop and present all proposed rates to the DMS. The Division of Medical Services is responsible for the approval of rates and methodologies.

Rate Determination Public Comments: Public comments are sought on an informal basis as the State develops the draft waiver document. Public comments are sought on a formal basis as the State promulgates the waiver document according to the AR Administrative Procedures Act. The Act requires advertisement in a newspaper of statewide circulation, and public hearings. the State collects all comments and makes changes as necessary. The Act requires that the document is presented for legislative review and recommendations. After legislative review and advice the document is duly promulgated.

The budget for each individual is determined through the Person Centered Service Plan development process, after completion of the Independent Assessment. The multi-agency team includes the care coordinator, the individual or their legal representative. All other persons attending are at the discretion of the individual or their legal representative and include other professionals as invited. The members of the team will determine services to be provided, frequency of service provision, number of units of service, cost for those services, and ensure the participant's desired outcomes, needs and preferences are addressed. The team members and a physician via a 703 certify the person's condition (level of care) and appropriateness of services initially and at the annual continued stay review date. A person centered services plan revision can be requested at any time that the person's needs change. The waiver services included in the plan of care must be prior approved by DDS.

The rates included in this waiver were initially set in 1990. Arkansas proposed in the last waiver, effective July 1, 2017, that it will submit an amendment to implement a new rate methodology for all services within 12 months. Arkansas also promised to provide a timeline for the new rate methodology within 3 months of the effective date of that amendment. In order to honor that commitment, Arkansas DMS and DDS are working with a third party vendor to conduct a comprehensive rate study of all HCBS Waiver services. AR will consult with CMS during the development of the rate methodology and will comply with all public notice requirements. DHS intends to undergo a rate study within the next year that will not only evaluate HCBS waiver services, but all services provided to clients with developmental disabilities and behavioral health needs. DHS intends to submit this rate study with amendments to both the (c) and concurrent (b) waivers for a target effective date of January 1, 2019.
Rate Determination Responsibility: DDS is responsible to develop and present all proposed rates to the DMS. The Division of Medical Services is responsible for the approval of rates and methodologies.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers bill directly through the state Medicaid Management Information System (MMIS).

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The assessed needs of each person are identified through a functional Independent Assessment. Services to meet assessed needs are authorized by DDS staff prior to the beginning of services through input into the MMIS system. MMIS edits prevent payment of unauthorized services or of amounts above the authorized limit. The provider PCSP developer develops, oversees, and coordinates a written plan, called the Person Centered Service Plan. Providers assure that services are delivered in accordance with the Person Centered Service Plan prior to billing for services. Providers maintain case notes of each service day with the person served. Providers maintain administrative records such as timesheets and payroll records for provider staff. MMIS verifies eligibility of both the person and the billing provider prior to payment for billed services. DDS Waiver staff perform service-to-billing audits annually which include off-site desk review of 100% files and on-site interview with 10% of people served. DDS Quality Assurance staff perform an on-site review of 100% of providers annually using interview, observation, and record review of a random sample of persons served by each provider.
To assure that claims through MMIS are processed correctly and in a timely manner, amounts and codes are compared to MMIS edits and the services and amounts that were prior authorized by DDS. DDS Provider Standards mandate that

providers report any 30 consecutive day interruptions in the provision of services to a person. These processes ensure that services are paid at the correct rate, billing does not exceed maximum approved amounts, and gaps in services are reported and investigated. When a provider becomes aware of errors, the provider performs remediation through adjusting the claim in error in future billings. DDS refers issues that were not or cannot be remediated through adjusted provider billing to the Medicaid audit unit for recoupment and other remedies.
DDS Quality Assurance unit performs an on-site review of 100% of providers annually. When issues related to scope, frequency, or duration of services are discovered during this review or as the result of a complaint investigation, DDS refers issues to the Medicaid audit unit for adjusted billing, recoupment and other remedies and notifies the DDS Waiver unit of the referral.
The MMIS system also edits for qualified providers by requiring an active certification date in the system. DDS Quality Assurance works with the Medicaid MMIS contractor to insure timely and correct dates are entered into the system. The DDS Medicaid Income Eligibility Unit, a part of DDS Quality Assurance, verifies that each person receiving waiver services has a valid code (W1) in the MMIS system before the first service can be billed. This assures that the person is approved for Medicaid prior to the delivery of services. MMIS requires that prior authorization data to be entered by the DDS Waiver unit prior to the provider billing for services. Data fields include beginning and ending dates, total plan amount, and procedure codes. Adjustments may be made for a service set that includes more than one service, such as supportive living and respite.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ◉ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

○ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

◉ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

DDS has established an Organized Health Care Delivery System (OHCDS) option as per 42 CFR 447.10 (b) for certified HCBS Waiver providers. This is incorporated into the DDS CES Waiver Provider Manual at 201.200. Providers agree in writing to guarantee that the services of a subcontractor will comply with Medicaid regulations. The OHCDS provider assumes all liability for contract non-compliance. The OHCDS provider must provide at least one HCBS Waiver service directly utilizing its own employees. The OHCDS provider must also have a written contract that specifies the services and assures that work will be completed in a timely manner and be satisfactory to the person served. OHCDS is optional.

DDS Quality Assurance reviews compliance with DDS Standards annually during an on-site visit. DDS reviews 10% of OHCDS files, up to 10 files.

When OHCDS is used, the enrolled provider is required to have a duly executed sub-contract in place and must review and assure financial accountability. The provider must ensure that services were delivered and proper documentation was submitted for services delivered under OHCDS.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

○ **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The □1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Developmental Disabilities Services receives state funding that is used for Medicaid HCBS Waiver match. The money is transferred to DMS through an interagency agreement.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Supplemental Security Income (SSI)/personal accounts are used to cover room and board costs and are maintained separately from HCBS Waiver reimbursements. Providers are prohibited from including room and board as any part of HCBS Waiver direct/indirect expense formulations.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	49537.28	15678.00	65215.28	115475.00	15811.00	131286.00	66070.72
2	44465.51	16148.00	60613.51	118939.00	5986.00	124925.00	64311.49
3	43483.04	16632.00	60115.04	122507.00	6165.00	128672.00	68556.96
4	43484.28	17131.00	60615.28	126182.00	6350.00	132532.00	71916.72
5	43527.81	17645.00	61172.81	129968.00			

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Arkansas Department of Human Services

DIVISION Division of Developmental Disabilities Services

PERSON COMPLETING THIS STATEMENT Elizabeth Pitman

TELEPHONE 501-682-4936 **FAX** 501-682-8380 **EMAIL:** Elizabeth.pitman@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Certification Standards for First Connections

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	0	Total	0

   (b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	($669,378)	General Revenue	($139,774)
Federal Funds	($1,628,521)	Federal Funds	($340,056)
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	($2,297,899)	Total	($479,830)

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	Next Fiscal Year
$ 0	$ 0

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	Next Fiscal Year
$ (2,297,899)	$ (479,830)

Because the PASSE will begin performing care coordination services for all Waiver participants once they are attributed, we expect to see a savings on each participant once they become attributed. This savings will be a total of $217.00 per month, per attributed participant. The $217.00 is derived from stopping care coordination under the waiver ($117.00/month) and from taking the care coordination fee out of the supportive living payment ($100.00/month). There will be a new fee of $90.00 per year for the development of the PCSP by the supportive living provider. All care coordination services will be provided by the PASSE once a participant becomes attributed.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

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

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

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

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

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

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

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

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.