ARKANSAS REGISTER

Proposed Rule Cover Sheet

Secretary of State
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Name of Department Arkansas Department of Commerce

Agency or Division Name Arkansas Division of Workforce Services

Other Subdivision or Department, If Applicable Arkansas Rehabilitation Services

Previous Agency Name, If Applicable N/A

Contact Person Charles Lyford

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Name of Rule ARS Policy and Procedure Manual

Newspaper Name Arkansas Democrat-Gazette

Date of Publishing February 28, 2021

Final Date for Public Comment March 30, 2021

Location and Time of Public Meeting 1 Commerce Way, Little Rock, AR 72202; 10 to 11 a.m.

AMENDED QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Department of Commerce

DIVISION Workforce Services – Arkansas Rehabilitation Services

DIVISION DIRECTOR Joseph Baxter

CONTACT PERSON Charles Lyford, General Counsel

ADDRESS 1 Commerce Way, Suite 206; Little Rock, AR 72202

PHONE NO. 501-682-2286 **FAX NO.** 501-296-1687 **E-MAIL** charles.lyford@arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Charles Lyford

PRESENTER E-MAIL charles.lyford@arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Jessica Sutton
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

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1. What is the short title of this rule? ARS Policy and Procedure Manual

2. What is the subject of the proposed rule? amendments involving medical-provider fee schedules and the agency's small-business program; and a new appendix involving federal performance indicators

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☒ No ☐

If yes, please provide the federal rule, regulation, and/or statute citation. The Rehabilitation Act of 1973, as amended; 34 C.F.R. § 361.50; 34 C.F.R. § 361.20.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒

If yes, what is the effective date of the emergency rule? N/A

When does the emergency rule expire? N/A

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?

Yes ☐ No ☒

5. Is this a new rule? Yes ☒ No ☐

If yes, please provide a brief summary explaining the regulation. The new rule explains the performance indicators required by the federal Rehabilitation Services Administration, and describes the process that ARS follows to track and make use of those indicators. There are also amendments to existing rules on medical fee schedules and the ARS small-business program.

Does this repeal an existing rule? Yes ☐ No ☒

If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. N/A

Is this an amendment to an existing rule? Yes ☒ No ☐

If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."** Please see attached.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation.

Ark. Code Ann. § 20-79-204(b)(1) (authorizing the ARS Commissioner to "prepare rules for promulgation by the appropriate division of the department").

7. What is the purpose of this proposed rule? Why is it necessary? ARS receives a grant from the federal Rehabilitation Services Administration. That grant enables ARS to provide vocational rehabilitation for Arkansans with disabilities. The proposed rules will further the agency's goal of competitive, integrated employment for the Arkansas who receive vocational rehabilitation.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b). https://arcareered.org/publicreview.

9. Will a public hearing be held on this proposed rule? Yes ☒ No
If yes, please complete the following:

Date: March 11, 2021

Time: 10 to 11 a.m.

Place: 1 Commerce Way, Hearing Room 42SG03, Little Rock, AR 72202

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

March 30, 2021

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

May 3, 2021

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice.

Please see attached Legal Notice, to be published Sunday, February 28th through Tuesday, March 2nd in the Arkansas Democrat-Gazette.

13. Please provide proof of filing the rule with the Secretary of State and the Arkansas State Library as required pursuant to Ark. Code Ann. § 25-15-204(e).

Electronic versions of this questionnaire, the financial-impact statement, the proposed revisions, and related documents will be sent to the Secretary of State on February 25, 2021.

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules. Please provide their position (for or against) if known.

Arkansas State Rehabilitation Council; Disability Rights Arkansas.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Commerce

DIVISION Workforce Services - Arkansas Rehabilitation Services

PERSON COMPLETING THIS STATEMENT Charles Lyford, General Counsel

TELEPHONE 501-682-2286 **FAX** 501-296-1687 **EMAIL:** charles.lyford@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 ARS Policy and Procedure Manual

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: N/A

   (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?

   Implementation costs are simply the operating costs already appropriated to ARS.

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

(b) What is the additional cost of the state rule? N/A

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

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.

With regard to the medical fee schedules, medical providers that serve individuals receiving vocational rehabilitation through ARS may be affected. However, any cost would be minimal and is not conducive to an estimate.

Current Fiscal Year	**Next Fiscal Year**
$	$

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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.

Implementation costs are simply the operating costs already appropriated to ARS.

Current Fiscal Year	**Next Fiscal Year**
$	$

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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.

Arkansas Rehabilitation Services, 2020 Rule Revisions – MARK UP

Summary of Substantive Changes:

These amendments focus on three areas of the Arkansas Rehabilitation Services Policy and Procedure Manual: fee schedules for medical providers, the agency's small-business program, and performance indicators for vocational rehabilitation. The fee-schedule provisions, as amended, will allow for payment using Medicare rates, Arkansas Workers' Compensation rates, a percentage of the provider's bill, or a contract between ARS and the provider.

The small-business program will be amended to clarify that the program administrator reviews business plans for overall feasibility, not for financial contributions by ARS. That decision is left to the vocational-rehabilitation counselor for the person submitting the plan.

There is also a new appendix that addresses the performance indicators used by the federal Rehabilitation Services Administration to assess agencies such as ARS. The appendix describes each indicator and defines the process that ARS follows to track and evaluate the indicators.

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SURGICAL AND HOSPITAL INSURANCE

Insurance benefits must be used first in paying for surgical and medical services. ARS will pay the billed amount after comparable services, similar benefits and insurance are applied. The authorized payment will be based on ~~80% of~~ the most current ~~Blue Cross Blue Shield~~ Medicare Fee Schedule. If the service is not covered by Medicare, payment will be based on the current Arkansas Workers' Compensation Fee Schedule (Medical or Laboratory). For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total charges billed for the surgical or medical services. For hospitals or clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount without regard to Medicare or Workers' Compensation-based fee schedules.

[VI-16]

PROCEDURES - ASSISTIVE TECHNOLOGY SERVICES/ REHABILITATION ENGINEERING

- ARS will issue payment for assistive technology/rehabilitation engineering services according to the price indicated in the current ~~Blue Cross Blue Shield~~ Medicare or Arkansas Workers' Compensation fee schedule, beginning with Medicare, ~~(current as of the date of the invoice)~~ for a given HCPCS line item. ~~ARS will pay 80% of the price indicated in the Blue Cross Blue Shield~~ Medicare ~~Fee Schedule.~~

- For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total charges billed for the assistive technology or rehabilitation technology.

- For individuals with insurance coverage for assistive technology/rehabilitation engineering services, ARS will issue payment after that coverage has been applied. ~~In no event will ARS pay an amount greater than 80% of the price indicated in the Blue Cross Blue Shield fee schedule for a given HCPCS line item.~~

[VI-49 to 50]

Payment for Hearing Aids

- ARS will issue payment for new hearing aids and related devices according to the ~~price indicated in the~~ current ~~Blue Cross Blue Shield~~ Arkansas Workers' Compensation fee schedule ~~(current as of the date of the invoice)~~ for the appropriate L or V code. ~~ARS will pay 80% of the price indicated in the Blue Cross Blue Shield fee schedule for the appropriate L or V code.~~

- For used hearing aids and related devices, ARS will pay 70% of the price indicated for the appropriate L or V code in the Arkansas Workers' Compensation fee schedule.

- For hearing aids and related devices (new or used) not covered by Arkansas Workers' Compensation, ARS will pay up to 50% of the total charges billed.

- ~~•~~ For individuals with insurance coverage for hearing aids and related devices, ARS will issue payment after that coverage has been applied. ~~In no event will ARS pay an amount greater than 80% of the price indicated in the Blue Cross Blue Shield fee schedule for a given HCPCS line item.~~

[VI-53]

ARS MEDICAL FEES

~~ARS Fee Schedule is referenced in Section VI. Descriptions~~ The applicable cost of procedures, devices, and other ~~related~~ medical services ~~along with the associated fees are~~ may be found in the fee schedules maintained by Medicare or the Arkansas Workers' Compensation Commission. Links to these schedules ~~Arkansas Health Information Network's annual Blue Cross/Blue Shield Physician Fee Schedule, Hospital Fee Schedule and Outpatient Fee Schedule to determine the agency's cost for Physical/Mental Restoration or other medical services. This Fee Schedule can be~~ are located on the ARS network. Before applying the fee schedules, ARS counselors must ~~are~~ first ~~to~~ determine if ~~C~~ comparable ~~B~~ benefits are available, including all health insurance plan coverages.

[Appendix I-1]

3. RATES OF PAYMENT

When determining ~~model~~ rates ~~for~~ of payment to third party vendors, ~~reimbursement~~, ARS first requires that the vendors be properly licensed or accredited. ~~utilizes approved standards of compensation that are recognized authorities or accrediting bodies in the applicable field and establishes that rate for its certified vendors providing goods or services~~. For example, ~~licensure~~

by the state is recognized by ARS as a criterion for approval of all health care providers. medical providers must be in good standing with the applicable State of Arkansas licensing board or agency. Rates of payment for licensed physician or other authorized health care professionals are set at 80% of the Arkansas Blue Cross Blue Shield rate of pay If properly licensed, medical providers will be paid using the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the medical provider. Similarly, ARS recognizes national accreditation for the approval of colleges and universities as providers. For hospitals or clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount without regard to Medicare or Workers' Compensation-based fee schedules.

[Appendix I-4]

5. MEDICAL REHABILITATION SERVICES

The rate of payment for physician services, dental treatment, glasses, optical aids, and artificial eyes, hearing aids, hospitalization, nursing services, orthotic devices, physical and occupational therapy, prosthetic devices, psychotherapy, speech and hearing therapy, and surgical implants/ appliances are based on at 80% of the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider. the Arkansas Blue Cross and Blue Shield fee schedule. Arkansas Blue Cross and Blue Shield uses the Resource Based Relative Value System (RBRVS) as a guide for establishing fees. The RBRVS was developed with input from thousands of providers, and has become industry standard for establishing physician payments. ARS utilizes health care professionals and facilities that have agreed to accept the Arkansas Blue Cross and Blue Shield fee schedule as their maximum payment, and cannot collect amounts greater than the schedule for covered services to those insured by Arkansas Blue Cross and Blue Shield. With hospitals, Arkansas Blue Cross and Blue Shield determines hospital payment rates using the Diagnosis Related Groups (DRGs) classification system which groups hospital patients according to similar diagnostic criteria and other characteristics.

5.01 Physician Services

Rates of payment for medical services provided by physicians are based on set at 80% of the Arkansas Blue Cross/ Blue Shield rate fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission, as of July 1st of each year, updated annually. Services are identified by CPT code and reimbursed using the fee schedule set by Arkansas Blue Cross/ Blue Shield where possible. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.02 Dental Treatment

Rates of payment for dental services are based on set at 80% of the Arkansas Blue Cross/ Blue Shield rate fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission, as of July 1st of each year, updated annually. Services are identified by CPT code and reimbursed using the fee schedule set by Arkansas Blue Cross/ Blue Shield where possible.

For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider. ~~If no qualified vendor agrees to accept the rate established for dental services, the counselor may, with the written permission of the district manager that is entered into the client case file, negotiate a reasonable fee based on the lowest of three competitive estimates from vendors in the local area.~~

Insurance benefits must be used first in paying for surgical and medical services. The amount ~~allowed~~ authorized by ~~the~~ ARS ~~Fee Schedule~~ will be ~~authorized~~ followed by the statement "Rehabilitation Services will pay only that part of the authorized amount not covered by the insurance policy up to the maximum amount allowed by the ARS Fee Schedule." (See Appendix I-1.)

The file must document the rational use in price decision: previously proposed prices, contracted prices, market research for the same items.

5.03 Glasses, Optical Aids, and Artificial Eyes

Rates of payment are based on ~~set at 80% of~~ the ~~Arkansas Blue Cross/ Blue Shield rate~~ fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission for prescription glasses, optical aids, and artificial eyes. For devices covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

Rates of payment are set at the published list price for a non-prescription item, e.g., closed circuit television, magnifiers, etc. The ARS assistive technology team, here and after referred to as Access and Accommodations, reviews purchases to ensure the price is reasonable in the market. If no qualified vendor agrees to accept the published rate of payment, the counselor may, with the written permission of the district manager that is entered into the client case file, negotiate a reasonable fee based on the lowest of three competitive estimates from vendors in the local area.

5.04 Hearing Aids

Invoices for hearing aids must be itemized. Each line item must correspond to the recommendations for the individual in the audiology/hearing aid evaluation.

Line items for devices not recommended for the individual in the audiology/hearing aid evaluation may be rejected if inconsistent with the individual's Employment Plan. Non-itemized or bundled invoices will be rejected and returned to the vendor.

Each line item for a hearing aid or related device must include the appropriate billing code from the "L" or "V" sections of the Health Care Common Procedures Coding System (HCPCS). ARS may request further documentation to support a given L or V code, and may refuse payment if the vendor cannot provide the documentation requested.

Used devices, if provided, must be disclosed on the invoice as "refurbished," "used," or "rebuilt." Failure to disclose a refurbished device or to follow the FDA procedures may result in removal of the vendor from the ARS Approved Vendor List.

Counselor will verify that the individual received the device and is able to use it. Document in the ECF. Counselor will key required information into the case management system for ARS Purchase Authorization.

ARS will issue payment for new hearing aids and related devices according to the price indicated for the appropriate L or V code in the ~~Blue Cross Blue Shield~~ fee schedule established by the Arkansas Workers' Compensation Commission ~~(current as of the date of the invoice) for the appropriate L or V code. ARS will pay 80% of the price indicated in the Blue Cross Blue Shield Medicare fee schedule for the appropriate L or V code.~~ For used hearing aids and related devices, ARS will pay 70% of the price indicated for the appropriate L or V code, using the Arkansas Workers' Compensation Fee Schedule.

For hearing aids and related devices (new or used) not covered by Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.05 Hospitalization

Rates of payment for the first day of inpatient hospital services are based on the ~~set at 80% of the Arkansas Blue Cross Blue Shield Hospitalization per diem~~ fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For first-day hospital services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

For hospital services beyond one day, ARS will pay up to 50% of the total amount billed by the provider.

For hospitals with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount. ~~for that facility. The rate of payment for surgery is set at the Medicaid rate~~.

5.06 Nursing Services

Rates of payment for nursing services are based on the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For nursing services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider. For hospitals or outpatient clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount.

~~provided in in-home or outpatient settings are included in the Arkansas Blue Cross Blue Shield physician fee schedule or the outpatient fee schedule~~.

5.07 Orthotic Devices

Rates of payment for orthotic devices are based on ~~set at 80% of~~ the ~~Arkansas Blue Cross/ Blue Shield rate~~ fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For orthotics covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.08 Physical and Occupational Therapy
Rates of payment for physical and occupational therapy services are based on ~~set at 80% of~~ the ~~Arkansas Blue Cross Blue Shield Physician Fee Schedule as of July st of each year, updated annually~~ fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For physical and occupational therapies covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

[Appendix I-5 to 8]

5.10 Prosthetic Devices
Rates of payment for prosthetics are based on ~~set at 80% of~~ the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. All prosthetic requests are reviewed by the Access and Accommodations physical therapist to ensure the prosthesis and its components are consistent with the client's expressed vocational goal. As part of the report, the physical therapist will document ~~80% of~~ the allowable ~~Arkansas Blue Cross Blue Shield~~ rate for the device. For prosthetics covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.13 Surgical Implants/Appliances
Rates of payment for surgical implants/appliances are based on the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For implants or appliances covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider. For hospitals or outpatient clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount. ~~reimbursed 80% of the Arkansas Blue Cross Blue Shield rate as of July 1st of each year, updated annually. Services are identified and reimbursed by CPT code. If no qualified vendor agrees to accept the rate established for surgical implants/appliances, the counselor may, with the written permission of the district manager that is entered into the client case file, negotiate a reasonable fee based on the lowest of three competitive estimates from vendors in the local area.~~

[Appendix I-10]

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Small Business Program

The role of the Consultant includes, but is not limited to, ~~providing~~ the following ~~assistance to the client as follows~~:

1. Recommendation of training and technical assistance from appropriate organizations consisting of subjects such as exploring entrepreneurship, small business development, business plan development, small business management, accounting for business, and business financing.

2. Referral of the client to an appropriate resource as it relates to the development of a business plan defining the concept of the business and the business market and competition analysis.

3. Assistance in identifying resources for the capitalization of the business.

4. ~~The Consultant will d~~ Development of a report ~~upon completion of these activities. The report will~~ that summarizes the Consultant's findings and provides recommendations as it relates to the operation of a new or existing business. The Consultant's report will be written prior to development of an approved IPE by the VR counselor and the client ~~developing an approved IPE~~.

5. Determination of whether the client's business plan is feasible. ~~The Small Business Consultant only approves the plan. He/she~~ The Consultant does not approve funding assistance ~~amounts or allotments~~ for a client's small business. The VR Counselor will review ~~proposed~~ the Consultant's report, together with the funding assistance requested in the client's business plan. The VR Counselor will then recommend an amount of funding to be authorized in the IPE. If funding for a small business is approved, comparable benefits and services will be taken into consideration, as well as the client's ability to contribute. ~~and approve amount ARS can assistance with along with client participation and/or comparable benefits.~~"

[Appendix A-2]

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WIOA Common Performance Measures

Section 116 of Workforce Investment and Opportunity Act (WIOA) requires Arkansas Rehabilitation Services to assess how well the Vocational Rehabilitation program performs each quarter, and annually, based on the following 6 indicators:

1. Employment Rate - 2nd Quarter After Exit	The percentage of participants who are working in the community during the second quarter after exit from the program. A VR client must work 90 days before their case can be closed. Once the 90- day timeframe is complete and the case is closed, the client has "exited" the program. The client's work record will be validated 6 months (2 quarters) after they exit the program. In order to verify that the client is employed at that time, ARS staff will obtain supporting documents such as: • Direct Unemployment Insurance (UI) wage match - I Wage (applies to status 26 and status 28 closures) • Federal or military employment records • Paystub • W2 or tax record • Verification from the client in writing using an agency form or a letter from the client, signed and dated from the client and counselor • Verification using an agency out-of-state wage form

	• Verification from the Employer on letterhead with employment start date and justification • Verification Form for Self-Employment Income and Expenses The "employment rate" for this indicator is essentially the number of clients who are employed 2 quarters after exiting the program, divided by the total number of clients who exited during the same reporting period. Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.
2. Employment Rate - 4th Quarter After Exit	The percentage of participants who are working in the community during the fourth quarter after exit from the program. A VR client must work 90 days before their case can be closed. Once the 90- day timeframe is complete and the case is closed, the client has "exited" the program. The client's work record will be validated 12 months (4 quarters) after they exit the program. In order to verify that the client is employed at that time, ARS staff will obtain supporting documents such as: • Direct Unemployment Insurance (UI) wage match - I Wage (applies to status 26 and status 28 closures) • Federal or military employment records • Paystub • W2 or tax record • Verification from the client in writing using an agency form or a letter from the client, signed and dated from the client and counselor • Verification using an agency out-of-state wage form • Verification from the Employer on letterhead with employment start date and justification • Verification Form for Self-Employment Income and Expenses The "employment rate" for this indicator is essentially the number of clients who are employed 4 quarters after exiting the program, divided by the total number of clients who exited during the same the reporting period.

	Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.
3. Median Earnings 2nd Quarter After Exit	The median quarterly earnings for participants who are working in the community 6 months after they exit the program, as validated through direct UI wage match, federal or military employment records, or supplemental wage information like the Verification Form for Self-Employment Income and Expenses. The median wage is determined by listing participants' quarterly wages from the lowest to the highest value. The wage in the middle of the list is the median quarterly wage. If there are an even number of participants in the list, the median is the average of the middle two wages. Generally, participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE. **However, the following clients are not included:** • Clients who have exited but are not employed in the 2nd quarter after exit. • Clients who have exited and are employed, but for whom earnings are not yet available. • Clients who have exited and are working, but have no income (e.g., unpaid family workers) • Clients who have exited but are in subsidized employment. • Clients who have exited, but one or more of the "Exclusions" apply. See section on Exclusions, below. Note that there is a two-quarter lag in reporting wages. If a participant's wages are not available after two quarters, the wage must be reported as $0, and the person is not considered employed for purposes of Median Earnings – 2nd Quarter. A median wage reported as $0 will negatively impacts Employment Rate – 2nd Quarter.
4. Credential Attainment	The percentage of program participants enrolled in an education or training program (excluding on-the-job training and customized training) who attain a **recognized postsecondary credential or a**

	secondary school diploma, or its recognized equivalent, during participation in, or within one year after exit from, the program. A high-school school diploma or GED can count for purposes of credential attainment, but only if the client becomes employed within one year after exit, or enrolls in an education or training program leading to a recognized postsecondary credential within one year after exit. Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.
5. Measurable Skill Gains	The percentage of program participants who, during a program year, are enrolled in an education or training program that leads to a recognized postsecondary credential or employment and gain a skill that counts as "documented progress" towards the credential or employment. Progress can be academic, technical, occupational, or other, depending on the type of education or training program: 1. Documented achievement of at least one educational functioning level of a participant who is receiving instruction below the postsecondary education level; 2. Documented attainment of a secondary school diploma or its recognized equivalent; 3. Secondary: Transcript or report card showing passing grades for 1 semester; 4. Postsecondary, full-time (12 or more hours): Transcript showing passing grades for 1 semester. Postsecondary, part time (less than 12 hours): Transcript must show passing grades for a total of 12 hours, over 2 consecutive semesters; 5. Satisfactory or better progress report towards established milestones, such as completion of OJT or completion of one year of an apprenticeship program or similar milestones, from an employer or training provider; or 6. Successful passage of an exam that is required for a particular occupation or progress in attaining technical or occupational skills as evidenced by trade-related benchmarks such as knowledge-based exams. • Measurable Skill Gains are reported on a yearly basis and are not an exit-based measure.

	• Clients are generally given credit for 1 Measureable Skill Gain per year, even if they earn more than 1 during a program year. • Record all Measurable Skill Gains in the case management system—the reporting system will count them appropriately. Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.
6. Effectiveness in Serving Employers	There are three approaches to measuring this indicator. The core partners are required to report on two of the three following measures. The core programs for the Combined State Plan in Arkansas, including VR, are in the pilot phase of choosing a common approach: • Approach 1 - Retention with the same employer - addresses the programs' efforts to provide employers with skilled workers; • Approach 2 - Repeat Business Customers - addresses the programs' efforts to provide quality engagement and services to employers and sectors and establish productive relationships with employers and sectors over extended periods of time; and • Approach 3 - Employer Penetration Rate - addresses the programs' efforts to provide quality engagement and services to all employers and sectors within a State and local economy.

Clients Counted in the Performance Measures

A "participant" for VR purposes is someone who is eligible for services, has an individualized plan for employment, and is receiving services. These policies apply to all cases in the case-management system involving clients who meet the definition of participant.

Exit Wage Calculations

All earnings are reported before deductions of Federal, State and local income taxes and Social Security payroll tax. The entire amount received for the quarter is reported. Wages for salespersons, consultants, self-employed individuals, and other similar occupations are based on their adjusted gross income. Estimates of in-kind payments, such as meals and lodging, cannot be reported.

Exclusions

Things may happen in clients' lives that exclude them from certain performance measures. These exclusions occur due to:

• Incarceration in a correctional institution, or becoming a resident of an institution or facility providing 24-hour support (such as hospital or treatment center) for 90 days or longer, which is considered enough time to prevent the client from participation in a workforce program;

• Medical treatment where the treatment is expected to last longer than 90 days and precludes entry into unsubsidized employment or continued participation;

• Death; or

• Membership in the National Guard or other reserve military unit of the armed forces, and being called to active duty for at least 90 days.

Data Validation Generally

Under WIOA section 116(d), the U.S. Departments of Education and Labor have established data-validation guidelines in order to ensure that information included in program reports is valid and reliable. For ARS, this means the data supporting our performance indicators (and reported to RSA) must first meet internal, quality-assurance standards. Ultimately, data validation will improve ARS's performance accountability and help achieve better outcomes for our clients. ARS complies with all State and Federal laws applicable to performance-measure collection and reporting.

Quality-Assurance Standards for Data Validation

1) Data Collection for Effective and Efficient Operations. ARS counselors will be provided a monitoring tool, based on the 911 report and technical assistance from RSA, in order to review case data and supporting documentation. Using the monitoring tool, counselors will enter information into the electronic case management system the appropriate clients. The monitoring tool may also be used by managers each quarter to review cases for accuracy.

ARS staff responsible for monitoring will provide counselors and managers a written report of errors and missing data, with a request for corrections. Monitoring staff will also provide ongoing training and technical assistance. By the quarter prior to the due date for the next 911 report, counselors will provide a written response to their managers, showing that the errors identified by monitoring staff have been corrected. This statement will be forwarded to the monitoring staff, with a copy to the Chief of Field Services.

After receiving the statement from counselors, ARS monitoring staff will screen the electronic case files again for errors. At this time, any corrections still needed will be made by the monitoring staff or manager prior to the report's due date. Remedial training will be provided to counselors with recurring error corrections, as needed.

2) Retention. The ARS case management system maintains clients' full record of services, including assessments, evaluations, reports, financial records, and supporting documents. These records are kept electronically for the life of the case on the counselor's caseload. With the

exception of certain files in Status 00, ARS will continue to keep all records of services for a period of seven (7) years. See 34 C.F.R. § 361.47; ARS Policy & Procedure Manual, sec. X; Ark. Code Ann. § 25-18-604; and current Arkansas Record Retention Schedule.

3) Timely Reporting to RSA. On a quarterly basis within each program year, the ARS Data Analyst will compile performance-indicator data to prepare 911 Reports, which are submitted to RSA as required by the Rehabilitation Act. The 911 Report collects case-service data, with a focus on performance indicators. As the 911 Reports are prepared, the Data Analyst will make note of errors and missing data from the counselors' caseloads. The Data Analyst will distribute summaries of the errors and omissions, along with a correction guide, to each counselor prior to the close of the quarter. Any errors will be addressed using the correction guide. This is intended to supplement the written report/correction/screening process involving ARS monitoring staff, described above.

The Data Analyst's summaries and correction guides will be distributed on the following timeline:

Q1: July 1 to September 30
Q2: October 1 to December 31
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4) Reliability of Performance Indicators. Generally speaking, any information entered into the case management system must be verified using the supporting documents identified in TAC 19-01 (RSA) and TEGL 7-18 (U.S. Departments of Labor and Education). Allowable supporting documentation is listed for each performance indicator in the table following Attachment I of the TEGL, Source Documentation for WIOA Core Programs.

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[Appendix J, WIOA Common Performance Measures]

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Arkansas Rehabilitation Services, 2020 Rule Revisions – CLEAN

1. Fee Schedules for Payment to Medical Providers

SURGICAL AND HOSPITAL INSURANCE

Insurance benefits must be used first in paying for surgical and medical services. ARS will pay a portion of the billed amount after comparable services, similar benefits and insurance are applied. The authorized payment will be based on the most current Medicare Fee Schedule. If the service is not covered by Medicare, payment will be based on the current Arkansas Workers' Compensation Commission Fee Schedule (Medical or Laboratory). For services covered by neither Medicare nor the Arkansas Workers' Compensation Commission, ARS will pay up to 50% of the total charges billed for the surgical or medical services. For hospitals or clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount without regard to Medicare or Workers' Compensation-based fee schedules.

[VI-16]

PROCEDURES - ASSISTIVE TECHNOLOGY SERVICES/ REHABILITATION ENGINEERING

- ARS will issue payment for assistive technology/rehabilitation engineering services according to the price indicated in the current Medicare or Arkansas Workers' Compensation fee schedule, beginning with Medicare, for a given HCPCS line item.

- For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total charges billed for the assistive technology or rehabilitation technology.

- For individuals with insurance coverage for assistive technology/rehabilitation engineering services, ARS will issue payment after that coverage has been applied.

[VI-49 to 50]

Payment for Hearing Aids

- ARS will issue payment for new hearing aids and related devices according to the current Arkansas Workers' Compensation fee schedule for the appropriate L or V code.

- For used hearing aids and related devices, ARS will pay 70% of the price indicated for the appropriate L or V code in the Arkansas Workers' Compensation fee schedule.

- For hearing aids and related devices (new or used) not covered by Arkansas Workers' Compensation, ARS will pay up to 50% of the total charges billed.

- For individuals with insurance coverage for hearing aids and related devices, ARS will issue payment after that coverage has been applied.

[VI-53]

ARS MEDICAL FEES
The applicable cost of procedures, devices, and other medical services may be found in the fee schedules maintained by Medicare or the Arkansas Workers' Compensation Commission. Links to these schedules are located on the ARS network. Before applying the fee schedules, ARS counselors must first determine if comparable benefits are available, including all health insurance plan coverages.

[Appendix I-1]

3. RATES OF PAYMENT
When determining rates of payment to third party vendors, ARS first requires that the vendors be properly licensed or accredited. For example, medical providers must be in good standing with the applicable State of Arkansas licensing board or agency. If properly licensed, medical providers will be paid using the fee schedules established by (1) Medicare, or (2) the Arkansas Workers' Compensation Commission. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the medical provider. For hospitals or clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount without regard to Medicare or Workers' Compensation-based fee schedules.

[Appendix I-4]

5. MEDICAL REHABILITATION SERVICES
The rate of payment for physician services, dental treatment, glasses, optical aids, and artificial eyes, hearing aids, hospitalization, nursing services, orthotic devices, physical and occupational therapy, prosthetic devices, psychotherapy, speech and hearing therapy, and surgical implants/appliances are based on the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.01 Physician Services
Rates of payment for medical services provided by physicians are based on the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission, updated annually. Services are identified by CPT code where possible. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.02 Dental Treatment
Rates of payment for dental services are based on the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission, updated annually. Services are identified

by CPT code where possible. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.
Insurance benefits must be used first in paying for surgical and medical services. The amount authorized by ARS will be followed by the statement "Rehabilitation Services will pay only that part of the authorized amount not covered by the insurance policy up to the maximum amount allowed by the ARS Fee Schedule." (See Appendix I-1.)

The file must document the rational use in price decision: previously proposed prices, contracted prices, market research for the same items.

5.03 Glasses, Optical Aids, and Artificial Eyes
Rates of payment are based on fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission for prescription glasses, optical aids, and artificial eyes. For devices covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

Rates of payment are set at the published list price for a non-prescription item, e.g., closed circuit television, magnifiers, etc. The ARS assistive technology team, here and after referred to as Access and Accommodations, reviews purchases to ensure the price is reasonable in the market. If no qualified vendor agrees to accept the published rate of payment, the counselor may, with the written permission of the district manager that is entered into the client case file, negotiate a reasonable fee based on the lowest of three competitive estimates from vendors in the local area.

5.04 Hearing Aids
Invoices for hearing aids must be itemized. Each line item must correspond to the recommendations for the individual in the audiology/hearing aid evaluation.

Line items for devices not recommended for the individual in the audiology/hearing aid evaluation may be rejected if inconsistent with the individual's Employment Plan. Non-itemized or bundled invoices will be rejected and returned to the vendor.

Each line item for a hearing aid or related device must include the appropriate billing code from the "L" or "V" sections of the Health Care Common Procedures Coding System (HCPCS). ARS may request further documentation to support a given L or V code, and may refuse payment if the vendor cannot provide the documentation requested.

Used devices, if provided, must be disclosed on the invoice as "refurbished," "used," or "rebuilt." Failure to disclose a refurbished device or to follow the FDA procedures may result in removal of the vendor from the ARS Approved Vendor List.

Counselor will verify that the individual received the device and is able to use it. Document in the ECF. Counselor will key required information into the case management system for ARS Purchase Authorization.

ARS will issue payment for new hearing aids and related devices according to the price indicated for the appropriate L or V code in the fee schedule established by the Arkansas Workers'

Compensation Commission. For used hearing aids and related devices, ARS will pay 70% of the price indicated for the appropriate L or V code, using the Arkansas Workers' Compensation Fee Schedule.

For hearing aids and related devices (new or used) not covered by Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.05 Hospitalization
Rates of payment for the first day of inpatient hospital services are based on the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For first-day hospital services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

For hospital services beyond one day, ARS will pay up to 50% of the total amount billed by the provider.

For hospitals with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount.

5.06 Nursing Services
Rates of payment for nursing services are based on the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For nursing services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider. For hospitals or outpatient clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount.

5.07 Orthotic Devices
Rates of payment for orthotic devices are based on fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For orthotics covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.08 Physical and Occupational Therapy
Rates of payment for physical and occupational therapy services are based on fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For physical and occupational therapies covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

[Appendix I-5 to 8]

5.10 Prosthetic Devices
Rates of payment for prosthetics are based on the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. All prosthetic requests are reviewed by the Access and Accommodations physical therapist to ensure the prosthesis and its components are consistent with the client's expressed vocational goal. As part of the report, the physical therapist will document the allowable rate for the device. For prosthetics covered by neither Medicare nor

Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.13 Surgical Implants/Appliances
Rates of payment for surgical implants/appliances are based on the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For implants or appliances covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider. For hospitals or outpatient clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount.

[Appendix I-10]

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2. ARS Small Business Program

The role of the Consultant includes, but is not limited to, the following:

1. Recommendation of training and technical assistance from appropriate organizations consisting of subjects such as exploring entrepreneurship, small business development, business plan development, small business management, accounting for business, and business financing.

2. Referral of the client to an appropriate resource as it relates to the development of a business plan defining the concept of the business and the business market and competition analysis.

3. Assistance in identifying resources for the capitalization of the business.

4. Development of a report that summarizes the Consultant's findings and provides recommendations as it relates to the operation of a new or existing business. The Consultant's report will be written prior to development of an approved IPE by the VR counselor and the client.

5. Determination of whether the client's business plan is feasible. The Consultant does not approve funding assistance for a client's small business. The VR Counselor will review the Consultant's report, together with the funding assistance requested in the client's business plan. The VR Counselor will then recommend an amount of funding to be authorized in the IPE. If funding for a small business is approved, comparable benefits and services will be taken into consideration, as well as the client's ability to contribute.

[Appendix A-2]

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3. Performance Measures (Appendix J)

WIOA Common Performance Measures

Section 116 of Workforce Investment and Opportunity Act (WIOA) requires Arkansas Rehabilitation Services to assess how well the Vocational Rehabilitation program performs each quarter, and annually, based on the following 6 indicators:

1. Employment Rate - 2nd Quarter After Exit	The percentage of participants who are working in the community during the second quarter after exit from the program. A VR client must work 90 days before their case can be closed. Once the 90- day timeframe is complete and the case is closed, the client has "exited" the program. The client's work record will be validated 6 months (2 quarters) after they exit the program. In order to verify that the client is employed at that time, ARS staff will obtain supporting documents such as: • Direct Unemployment Insurance (UI) wage match - I Wage (applies to status 26 and status 28 closures) • Federal or military employment records • Paystub • W2 or tax record • Verification from the client in writing using an agency form or a letter from the client, signed and dated from the client and counselor • Verification using an agency out-of-state wage form • Verification from the Employer on letterhead with employment start date and justification • Verification Form for Self-Employment Income and Expenses The "employment rate" for this indicator is essentially the number of clients who are employed 2 quarters after exiting the program, divided by the total number of clients who exited during the same reporting period. Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.
2. Employment Rate - 4th Quarter After Exit	The percentage of participants who are working in the community during the fourth quarter after exit from the program. A VR client must work 90 days before their case can be closed. Once the 90- day

	timeframe is complete and the case is closed, the client has "exited" the program. The client's work record will be validated 12 months (4 quarters) after they exit the program. In order to verify that the client is employed at that time, ARS staff will obtain supporting documents such as: • Direct Unemployment Insurance (UI) wage match - I Wage (applies to status 26 and status 28 closures) • Federal or military employment records • Paystub • W2 or tax record • Verification from the client in writing using an agency form or a letter from the client, signed and dated from the client and counselor • Verification using an agency out-of-state wage form • Verification from the Employer on letterhead with employment start date and justification • Verification Form for Self-Employment Income and Expenses The "employment rate" for this indicator is essentially the number of clients who are employed 4 quarters after exiting the program, divided by the total number of clients who exited during the same the reporting period. Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.
3. Median Earnings 2nd Quarter After Exit	The median quarterly earnings for participants who are working in the community 6 months after they exit the program, as validated through direct UI wage match, federal or military employment records, or supplemental wage information like the Verification Form for Self-Employment Income and Expenses. The median wage is determined by listing participants' quarterly wages from the lowest to the highest value. The wage in the middle of the list is the median quarterly wage. If there are an even number of participants in the list, the median is the average of the middle two wages. Generally, participants counted for this indicator include clients whose record of services is closed successfully after development of

	an IPE, and clients whose record is closed unsuccessfully after development of an IPE. **However, the following clients are not included:** • Clients who have exited but are not employed in the 2nd quarter after exit. • Clients who have exited and are employed, but for whom earnings are not yet available. • Clients who have exited and are working, but have no income (e.g., unpaid family workers) • Clients who have exited but are in subsidized employment. • Clients who have exited, but one or more of the "Exclusions" apply. See section on Exclusions, below. Note that there is a two-quarter lag in reporting wages. If a participant's wages are not available after two quarters, the wage must be reported as $0, and the person is not considered employed for purposes of Median Earnings – 2nd Quarter. A median wage reported as $0 will negatively impacts Employment Rate – 2nd Quarter.
4. Credential Attainment	The percentage of program participants enrolled in an education or training program (excluding on-the-job training and customized training) who attain a recognized postsecondary credential or a secondary school diploma, or its recognized equivalent, during participation in, or within one year after exit from, the program. A high-school school diploma or GED can count for purposes of credential attainment, but only if the client becomes employed within one year after exit, or enrolls in an education or training program leading to a recognized postsecondary credential within one year after exit. Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.
5. Measurable Skill Gains	The percentage of program participants who, during a program year, are enrolled in an education or training program that leads to a recognized postsecondary credential or employment and gain a skill that counts as "documented progress" towards the credential or employment.

	Progress can be academic, technical, occupational, or other, depending on the type of education or training program: 1. Documented achievement of at least one educational functioning level of a participant who is receiving instruction below the postsecondary education level; 2. Documented attainment of a secondary school diploma or its recognized equivalent; 3. Secondary: Transcript or report card showing passing grades for 1 semester; 4. Postsecondary, full-time (12 or more hours): Transcript showing passing grades for 1 semester. Postsecondary, part time (less than 12 hours): Transcript must show passing grades for a total of 12 hours, over 2 consecutive semesters; 5. Satisfactory or better progress report towards established milestones, such as completion of OJT or completion of one year of an apprenticeship program or similar milestones, from an employer or training provider; or 6. Successful passage of an exam that is required for a particular occupation or progress in attaining technical or occupational skills as evidenced by trade-related benchmarks such as knowledge-based exams. • Measurable Skill Gains are reported on a yearly basis and are not an exit-based measure. • Clients are generally given credit for 1 Measureable Skill Gain per year, even if they earn more than 1 during a program year. • Record all Measurable Skill Gains in the case management system—the reporting system will count them appropriately. Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.
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[Appendix J, WIOA Common Performance Measures]

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