ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
Mark Martin
500 Woodlane, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov

For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Developmental Disabilities Services

Contact Elizabeth Pitman E-mail elizabeth.pitman@dhs.arkansas.gov Phone 501-682-4936

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

Rule Title: DDS Community and Employment Supports (CES) Waiver and Medicaid Provider Manual #2-17

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
Legal Notice Published	03/02/2017
Final Date for Public Comment	04/01/2017
Reviewed by Legislative Council	
Adopted by State Agency	08/22/2017

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

Becky Murphy (Contact Person) becky.murphy@dhs.arkansas.gov (E-mail Address) 09/01/2017 (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.)

Signature

(501) 371-2165 (Phone Number) rose.naff@dhs.arkansas.gov (E-mail Address)

Director (Title)

9-8-17 (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.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT 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 DDS Community and Employment Supports (CES) Waiver and Medicaid Provider Manual #2-17

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 Does this proposed, amended, or repealed rule have a financial impact?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		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?

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.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

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
$ 7,943,400

Next Fiscal Year
$ 7,865,400

These numbers represent the amount of money being redirected to the DDS Waiver from the Tobacco Settlement Funds. The total is the state share based on an estimated cost of $54,000 per recipient and the addition of 500 new recipients. We will receive a federal match in the amount of $19,056,600 in this current fiscal year; and $19,134,900 in the next fiscal year.

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;

The waiver is being amended to add 500 slots pursuant to Act 50 of 2017, which redirected $8.7 million of tobacco settlement funds to DHS to reduce the number of people on the waiting list for Waiver services. The waiver is also being amended to require all participants undergo an independent assessment which will be used to assist in determining the appropriate level of services for the client and develop the person centered case plan.

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

There is currently a waitlist for waiver services that has approximately 3000 people on it. Some of these individuals have been waiting for ten years to receive services. The additional funding will help to reduce the number of people on the waitlist by approximately 500 people.

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

The new rule will help to reduce the waitlist by 500 people; also by incorporating the independent assessment, DDS is hoping to ensure that all services provided to Waiver participants are appropriate for the level of need the person has. The purpose of the independent assessment is to have a third party assess the needs of the individual and to require that assessment be used to develop the Person Centered Case Plan, along with other testing.

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

N/A

(4) 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;

Unknown at this time.

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

N/A.

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

The waiver must be renewed every five years, so DDS and DMS reviews the waiver and Provider Manual during that time to ensure that services are being provided to participants in the most cost efficient manner available while still ensuring participant's health and safety.

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.R05.01**

E. **Proposed Effective Date:** *(mm/dd/yy)*
08/21/17
Approved Effective Date: 08/22/17
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:
Purpose of this amendment is to add 500 slots to the program and change the name of the Waiver to "Community and Employment Supports" Waiver.

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	
☐ Appendix A – Waiver Administration and Operation	
☑ Appendix B – Participant Access and Eligibility	B-3-a
☐ Appendix C – Participant Services	
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	

Component of the Approved Waiver	Subsection(s)
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☑ 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:

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.R05.01
Draft ID: AR.006.05.01

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:

NA

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:

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 (the "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 the Waiver are to:
1) Support the person in all major life activities.
2) Promote community inclusion through integrated employment options and community experiences.

Support of the person includes:
1) Developing a relationship with the person and maintaining direct contact,
2) Determining the person's choices about their life,
3) Assisting the person in carrying out those choices,
4) Locating, coordinating and monitoring needed developmental, medical, behavioral, social, educational and other services,
5) Accessing informal community supports needed by the person,
6) Development and implementation of a Person Centered Service Plan (PCSP) in coordination with an interdisciplinary team,
7) Accessing employment services and support individuals in seeking and maintaining competitive employment, and
8) Assisting the person with integrating into the life and activities of his or her community.

The objectives are as follows:
1) To enhance and maintain community living for all persons participating in the Waiver program, and
2) To transition eligible persons who choose the Waiver option from residential facilities to the community.

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 I.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:
DDS secured public input into the amendment of the HCBS Community and Employment Supports Waiver (formerly, the Alternative Community Service Waiver) through the use of an informal workgroup and a formal public notice. The workgroup was made up of Waiver providers. This workgroup met twice while the Amendments were being drafted and reviewed the proposed amendments and made comments. Some changes based off of the workgroup's feedback were made before the draft was officially placed for public comment. Additional feedback received during the public comment period will be considered by DDS and further edits to the waiver will be considered accordingly.

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 DDS contain information about the Waiver amendment. 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 March 29, 2017, at 1:30 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.

During the public comment period, meetings were organized and held for participants and their families to ask any questions and make any comments. These meetings were held on March 29, 2017, at ICM, a provider organization; on April 5, 2017 with Arkansas Support Network, and on April 11, 2017, at Easter Seals. The public comment period was extended until April 7, 2017, to give these families time to submit public comments.

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) 320-6306 **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: Aug 21, 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:
Division 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:

Once this amendment is approved, there will be 500 new slots on the Community and Employment Supports Waiver. New applicants will be enrolled in the Waiver upon the effective date and given an interim service plan (ISP) to begin service delivery.

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 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 Supports (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 case management and direct service providers. The chosen case management provider assesses the person's needs and wants and facilitates the development of the person-centered plan, which is approved by DDS staff. DDS ACS Waiver staff will monitor services through random home visits (minimum 10% per staff caseload). In addition, as part of the DDS certification process, DDS Licensure and Certification staff monitors services in the person's home. DDS ACS Waiver staff and DDS Licensure and Certification staff have been trained on the CMS Final Rule.

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 has revised its HCBS Standards to include the characteristics of Settings which will guide DDS providers as they transition provider settings to those which fully include all the necessary characteristics and traits of a fully compliant HCBS setting. New providers are expected to be compliant with the Final Rule at the time of application.

Assessment of Provider Compliance with Residential and Non-Residential Settings Requirements

As part of the Statewide Transition Plan, the state of Arkansas has developed an inter-agency HCBS Settings working group. The group discusses assessment activities, including provider self-assessment surveys, site visits, and ongoing compliance with the HCBS Settings rule. An inter-agency site review Team is being developed that will review the provider self-assessment surveys, conduct an on-site assessment tool to validate provider self-assessments, and analyze compliance over the coming months.

Provider self-assessment.

DDS is conducting the assessment process outlined in CMS guidance. DDS is analyzing both its residential and day service systems. Residential providers include Group Homes, Apartments, and provider staff homes in which consumers live. Each residential provider has completed and returned a self-study to DDS. The self-study is based on the "Exploratory Questions" document included in the toolkit developed by CMS. It will serve 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. Survey responses are being validated through on-site visits.

Validation of self-assessment (site visits).

As stated in a previous section, an inter-agency team composed of staff employed by the Division of Aging and Adult Services, Division of Developmental Disabilities Services, and the Division of Medical Services will be identified and assigned to an inter-agency site visit team. This team will conduct the initial review of settings for compliance with CMS setting regulations. . DDS Certification staff have conducted an on-site technical support visit to each group home and provider owned or controlled apartment and are in the process of conducting technical support site visits to each provider who uses staff homes as settings. Of the 151 Residential Settings, 123 settings received an on-site technical support visit. An analysis of the information is being provided to the inter-agency site review team as part of the state provider assessment process.

Ongoing Assessment of Settings

Licensed and certified settings are subject to periodic compliance site-visits by DDS. HCBS settings requirements will be enforced during those visits. Settings found to have deficiencies are required to implement corrective actions and can lose their license or certification when noncompliance continues or is egregious. New providers will also be subject to an assessment of compliance with the HCBS settings requirements prior to licensure and certification.

Remediation

DDS has developed and will promulgate standards that support and promote the belief that individuals must have full access to the benefits of community living and have the opportunity to receive services in the most integrated setting appropriate. The standards specify how services must be offered in settings that are designed specifically for people with disabilities when the individuals in the setting are primarily people with disabilities and on-site staff provide services to them and the setting may have the effect of isolating the individuals who live there from the broader community of individuals not receiving Medicaid-funded HCBS.

The standards require that organizations that own or operate a residential service setting or a day service setting which may be presumed to have institutional qualities to offer services in such a way as to ensure that the characteristics required of an HCBS setting are present. The standards: 1) require assurance of specific individual rights; 2) prescribe certain characteristics of the physical plant; and 3) specify steps which must be taken if any of the required conditions must be modified based on a specific assessed need of an individual.

DDS issues a report to each Organization that owns, operates, or otherwise controls a residential setting of any characteristics at each location that does not appear to be in compliance with the current HCBS settings rule. Each Organization that receives a report identifying practices that require improvement from DDS, responds with an improvement plan and submits relevant policies to assure best practice.

DDS will issue a recommendation of approval to the site development review subcommittee for each residential setting that is in compliance with the HCBS Settings requirements. If a residential setting is not recommended for approval as complying with HCBS Settings requirements, DDS will defer to site subcommittee for final determination. If the HCBS site review subcommittee and the HCBS Settings working group do not feel that a provider is progressing towards compliance, the state will need to implement relocation strategies. The HCBS Settings working group will be developing a relocation plan in the coming months as we work through the on-site assessment process. The relocation remediation strategy will include a detailed relocation plan that provides reasonable notice and due process for residents. The relocation plan will also include a timeframe, a description of the state's process to ensure sufficient services and supports are in place prior to the transition, and assurances that affected residents will receive sufficient information, opportunity, and supports to make an informed choice regarding transition to a new compliant setting.

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.

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.

In cases where DDS asks for heightened scrutiny by CMS for certain settings, the same process as described in the DAAS section will be utilized by DDS.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

This waiver amendment was placed for public comment for at least 30-days and public hearings were held to receive public comment. The following comments were received during the public comment period.

Comment: Please clarify which services are deemed direct and which are deemed indirect. Of those deemed indirect will case management companies be allowed to provide those supports? Will case management companies be allowed to provide direct services under another division or funding source such as Aging or DDTCS?
Response: The Department will take these in consideration as we move forward in designing systems in accordance with CMS regulation in regard to conflict free case management.

Comment: Of those developing the PCSP where the Guardian is related to staff there is a direct interest in financial determinations. How will DDS handle this in the future to assure service planning is not driven by staff hours/pay rather than service need?
Response: DMS/DDS is currently exploring conflict free case management options inclusive of PCSP development.

Comment: As a matter of principle we submit that the waiting list for waiver of 3000 people clearly violates an individual's opportunity for choice. It is not a choice to ask families, individuals, guardians to select an option that is unavailable.
Response: Thank you for your comment.

Comment: At this time one of three main actions occur when an individual with no other support is hospitalized. One, we request GR funding for this support which is fiscally undesirable and often unavailable; two, people go without support which is unsafe and leads to longer hospitalization and often higher reoccurrence of illness; three, the provider eats the cost of staff support which is unsustainable long-term. There needs to be a systemic response to this problem.
Response: The Department will take this under advisement and consult with CMS as this is a statutory requirement under 42 CFR §441.301(b)(1)(ii).

Comment: While we understand the need for DHS to utilize waiver slots to prevent individuals from remaining in more restrictive placements when less restrictive are requested, there is no legitimate basis for this delineation. The state's lack of funding or fear of a Waitlist or Olmstead lawsuit is not sufficient justification to engage in adverse action against community families, let alone adverse action without due process.
Response: Thank you for your comment.

Comment: One commenter noted that the individuals preparing the PCSP cannot be related by blood or marriage, yet the relative box within the waiver is checked on who can provide service. Further the requirement of being conflict free should be added to provider qualifications on the same page within the waiver.
Response: Thank you for your suggestion. Changes will be made within the document.

Comment: Please define clinic, does this refer to doctor's office or is clinic utilization specifying another location?
Response: Clinic is being removed to comply with settings requirements per CMS regulations.

Comment: Under the service of supported employment there are many people who want to work, but need less than 15 hours per week, or need to share a job with another. There is no definition that DDS only provide supported employment under the definition used by ARS and there was a previous agreement to remove the minimum number of hours worked requirement under waiver. By deleting the minimum requirement someone who can only work a few would still be able to work those hours.
Response: The supported employment definition will be revised and an amendment submitted.

Comment: The need for agencies to determine how direct care supervisors will supervise staff is at the agency's discretion and in line with agency personnel policies. The DDS agency should not prescribe how supervision will occur or the timeframe of that supervision. Please remove "maintained weekly." Some agencies review notes daily, others per-pay-period and others on a monthly basis.
Response: Thank you for your comment. Change has been made in document.

Comment: Please change QMRP to QDDP as noted in the rest of the document. Thank you for changing this language.
Response: Thank you for bringing this to our attention. We will make this change.

Comment: Activity fees are limited to individuals who have anger or weight issues. Why?
Response: Supplemental support by definition is used as a response to crisis, emergency or life threatening situations.

Comment: Please clarify who provides choice once the conflict free company is in place, and who is to perform the annual needs assessments. How will Arkansas DDS review those assessments prior to approving an individual's plan of care? Will this slow the plan of care application and approval process?
Response: Thank you for your comment. It will be used in the development of the conflict free process.

Comment: Please remove the line from page 82 that requires approval from DDS authority on hiring eligible relatives.
Response: Thank you for your comment. This has been removed from the document.

Comment:DDS has previously denoted that the level of care is functional qualification, not a funding level. However, the funding is reviewed annually and listed in the waiver itself on page 90. The previous correction to this was announced a year ago at AWA where the DDS representative announced that the levels of care in the waiver were agreed to be arbitrary and would be removed.
Response: Thank you for your comment.

Comment: In the last waiver renewal, the agency agreed to a 10% cost of living adjustment per year, as it was agreed that rates were far removed from the cost necessary to provide quality supports. This occurred once.
Response: Thank you for your comment.

Comment: The risk assessment area of the plan of care should rest with the case management entity. If a number of providers are eligible to be selected, the coordination of assessing risk will need to cross agency lines.
Response: Thank you for your comment. We will utilize your comment as we move forward on developing conflict free case management.

Comment: Most long term care programs have absentee rates. Keeping beds/slots full spreads the overhead costs of the program and keeps from continual staff turnover. Further, absentee rates help retain employees who might need leave, and lowers the cost of replacement and retraining. In our current workforce crisis, any mechanism to staff, and retain staff are necessary. An absentee rate under waiver could assist the staffing of these programs.
Response: Thank you for your comment.

Comment: One commenter noted that DDS policy does not include spina bifida and Down Syndrome as a qualifying diagnosis. Both diagnoses were added to the Statute by Act 68 of 2011.
Response: Thank you for your comment. Revision is forthcoming to align with DDS policy.

Comment: One commenter wrote in great detail their concerns about participant access and eligibility, level of care criteria, procedure for offering opportunity to request a fair hearing and the availability of additional dispute resolution process.
Response: Thank you for your comment. This information will be considered in future amendments.

Comment: One commenter recommended that the State accept the Community First Choice Option and additional federal funds to increase the number of HCBS Waiver slots available to persons with development disabilities in Arkansas who desire to live in the community. In the alternative, the state should immediately increase the number of HCBS Waiver slots to cover all of those who have been on the waiver waiting list for more than 5 years and increase the number of slots available annually by at least 200 slots for the next five years.
Response: Thank you for your comment. This information will be considered in future amendments.

Comment: One commenter recommended that the State address the need for conflict free case management by increasing rates available for providers of case management services.
Response: Thank you for your comment. This information will be considered in future amendments.

Comment: One commenter wrote in great detail their multiple concerns with what they considered as inadequacies of the Transition Plan.
Response: Thank you for your comment. This information will be considered in future amendments.

Comment: The State should revise the list of incidents that are designated as critical and require follow-up by DDS.
Response: Thank you for your comment. This information will be considered in future amendments.

Comment: The State should revise the Participant Rights section of the Request to align it with federal law regarding a beneficiary's access to services during the pendency of the appeal. The State should also make changes to either the request or the State policy regarding appeals to ensure that both are consistent with each other and should implement a mechanism to ensure that both are carried out with fidelity. In addition, DDS should consider providing simple, plain language guidance to explain the appeals process to an ordinary consumer.
Response: Thank you for your comment. This information will be considered in future amendments.

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;
9) Provide to DMS the results of monitoring activities;
10) 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.*:

   ◉ **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:

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:

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
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	☑	☑
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**

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:
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**

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:
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)*:
☑ 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:

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:

Responsible Party for data aggregation and analysis *(check each that applies)*:	Frequency of data aggregation and analysis*(check each that applies)*:

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	☐ Annually

Responsible Party for data aggregation and analysis *(check each that applies)*:	Frequency of data aggregation and analysis*(check each that applies)*:
Specify:	
	☐ 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)*:

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)

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:

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 (DDS, the operating agency) and the Division of Medical Services (DMS, the State 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 measures related to administrative authority of the HCBS Waiver.

In cases where the numbers of unduplicated participants 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. 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 timeframes, 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 participants not receiving monthly monitoring of at least one waiver services 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 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			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☑		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 (2) 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	4683
Year 3	4703
Year 4	4723
Year 5	4743

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:

☑ **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:

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 with Intellectual or Developmental Disabilities (ICF/IDD) 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/IDD 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/IDD, as defined by 42 CFR § 440.150; and
(2) Would be institutionalized in an ICF/IDD in the near future (that is, in a month or less), 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/IDD. 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 participant's case manager 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/IDD 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 individual. 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.

If an individual disagrees with an eligibility determination, they may appeal to the Assistant Director for Quality

Assurance for an administrative review of the findings. Individuals 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 for the person to the provider case manager who is responsible for assuring timely evaluation. 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 case managers.

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 will remain 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**
☐ **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):*
☐ **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):*

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	☐ Annually

Responsible Party*(check each that applies)*:	**Frequency of data aggregation and analysis** *(check each that applies)*:
Specify:	
	☐ **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).

Intake and referral for the HCBS Waiver is the responsibility of intake and referral staff with the DDS Children's Services Section for persons birth to 21 if still in high school or of DDS Adult Services Section for persons age 18 and over if the person has completed high school. The DDS staff person explains the service options of HCBS Waiver or ICF/IDD to each person or their legal guardian by phone, personal visit, email, or mail. The individual or legal guardian completes the HCBS Choice Form and selects either the HCBS Waiver program or ICF/IDD placement. For persons residing in an ICF/IDD, choice between the programs is offered annually at the time of their annual PCSP review. Anyone residing in an ICF/IDD can request HCBS Waiver services at any time by contacting the transition coordinator. The transition coordinator works with the HCBS Waiver Applications Unit Administrator and assigned DDS HCBS Waiver Specialist. Annual choice is offered by the assigned DDS Specialist 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.

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 HCBS Waiver application packets including the choice form are maintained in an electronic format during the application process. Person's electronic case file is maintained by the assigned DDS Specialists who are located in designated DHS county offices. Documentation of annual choice following initial HCBS Waiver program participation 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 for need is obtained 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.

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	Case Management		
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		
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):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope)*:
Services that assist participants in gaining access to needed waiver and other state plan services; as well as, medical, social, educational and other generic services, regardless of the funding source for the services to which access is available.

Case management includes responsibility for guidance and support in all life activities including locating, coordinating and monitoring the following:

1) All proposed waiver services;

2) Other state plan services;

3) Needed medical, social, educational and other publicly funded services (regardless of funding source);

4) Informal community supports needed by eligible participants and their families.

Case Management services include the following activities:

1) Arranging for the provision of services and additional supports;

2) Monitoring and reviewing of services included in the participants PCSP;

3) Monitoring and reviewing of services to assure health and safety of the participant;

4) Facilitating crisis intervention;

5) Guidance and support to obtain generic needs;

6) Case planning;

7) Needs assessment and referral for resources;

8) Monitoring to assure quality of care and case reviews which focus on the participants progress in meeting goals and objectives established through the PCSP;

9) Providing assistance relative to the obtaining of waiver Medicaid eligibility and ICF/IDD level of care eligibility determinations;

10) Assuring the integrity of all case management Medicaid waiver billing in that the service delivered must have DDS prior authorization, must meet required waiver service definitions, and must be delivered before billing can occur;

11) Assuring submission of timely (advance) and comprehensive behavior and assessment reports, continued plans of care, revisions as needs change and information and documents required for ICF/IDD level of care and waiver Medicaid eligibility determinations;

12) Arranging for access to advocacy services as requested by participant.

13) Upon receipt of DDS approvals and denials, ensures that a copy is provided to the participant or their legal

representative;

14) Provides assistance with appeals when appeal is chosen.

The State of Arkansas adheres to CMS regulations as it relates to conflict free case management. Case Management Services may not include the provision to the individual of direct services that are typically or otherwise covered as a service under HCBS Waiver or State Plan. The organization may not provide case management services to any person to whom they provide any direct services without adhering to the appropriate firewalls and protections outlined in the case management section. Appendix C-1-b.

DDS will continue to implement the following firewalls and mitigation strategies to assure adherence to conflict-free case management:
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 participant'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 participants;
4) DDS will perform utilization reviews;
5) DDS will review and approve/deny participants' PCSPs at the annual time of renewal or with any submitted amendment/modification;
6) Participants 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.

Case Management services may be available during the last 180 consecutive days of a Medicaid eligible person's institutional stay to allow case management activities to be performed related to transitioning the person to the community. The person must be approved and in the Waiver program for case management to be billed.

Case Management 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 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 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.

Case management 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 participant 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 participant 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 case management provider must conduct a monitoring contact and report the status to the applicable DDS Specialist. If the case management 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:

There is a maximum reimbursement limit of $117.70 per month and $1,412.40 annually for each beneficiary.

Service contacts minimum requirement is at least one face-to-face contact per month.

3) For Clients in abeyance – a minimum of one visit or contact a month by the Case Manager 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 increements, not to exceed one year) placed in a licensed or certified treatment program for purposes of behavior, physical or health treatment or stabilization.

This waiver service is only provided to individuals age 21 and over. All medically necessary case management 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 Case Management Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency

Provider Type:
Certified Case Management Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
DDS certification as a case management provider.

DDS certified case management providers must demonstrate evidence of the following personnel requirements for persons who are designated as case managers:
1. Case managers 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 individuals with developmental disabilities, or
c. Have two years of verified experience working with individuals with developmental disabilities 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.
e. Not be related by blood or marriage to the individual or to any paid caregiver, are not financially responsible for the individual or would benefit from the provision of direct services.

2. Case managers 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 certified case management organization's policies and procedures.

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	99011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	99012 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) Group Home:

5) Licensed respite facility; or

6) 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.

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, or
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	93010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	93021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**

03 Supported Employment	93022 ongoing supported employment, group

Category 4: **Sub-Category 4:**

03 Supported Employment	93030 career planning

Service Definition *(Scope):*
Supported employment services consist of intensive, ongoing supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, or who because of their disabilities need on-going supports to perform in a competitive work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities. Coverage does not include payment for the supervisory activities rendered as a normal part of the business setting. The employer is responsible for making reasonable accommodations in accordance with the Americans with Disabilities Act. Supported employment is a collaborative service with Arkansas Rehabilitation Services (ARS). All new waiver participants receiving supported employment must be prior certified by ARS to assure the individual is qualified for supported employment and that ARS funding is accessed first.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2) Payments that are passed through to users of supported employment programs; or

3) Payments for training that is not directly related to an individual's supported employment program.

Transportation between the participant's place of residence and the employment site is included as a component of supported employment services. The cost for transportation is included as a part of the supported employment rate paid to providers.

Supported employment does not include sheltered workshops or other similar types of vocational services furnished in specialized facilities. Supported employment provides integrated work settings where there is frequent, daily social interaction among people without disabilities. Integration requires the person to work in a place where no more than 8 persons with disabilities work together. Further, co-workers without disabilities are to be present in the work setting or immediate vicinity thereof.

Supported employment services may be furnished by a co-worker or other job site personnel provided that the services which are furnished are not part of the normal duties of the co-worker or other personnel and these individuals meet the pertinent qualifications to be a provider of service.

Personal assistance may be a component part of supported employment services but may not comprise the entirety of the service.

Supported employment may include services and supports that assist the participant in achieving self-employment through the operation of a business. However, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include:

1) Aiding the participant to identify potential business opportunities;

2) Assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;

3) Identification of the supports that are necessary for the participant to operate the business; and

4) Ongoing assistance, counseling and guidance once the business is launched.

Individuals receiving supported employment services may also receive educational, prevocational and day habilitation services. A participant's service plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.

Supported Employment includes:

1) Activities needed to sustain paid work by waiver individuals, including supervision and training.

2) Re-Training, job retention, or job enhancement

3) Job site assessments - The job coach, after consultation with each person in supported employment, can determine on a case by case basis how to best acquire current information relevant to assessing job stability and the individual's needs.

4) Job maintenance visits with the employer for purposes of obtaining, maintaining and retaining current or new employment opportunities. If on site monitoring is not necessary to assess stability, alternative methods of gathering information for the twice monthly assessment may be permitted. This may take a variety of forms including telephone calls with supervisors and off site meetings with the individual participating in supported employment as well as visits to the work site.

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 case manager 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 case manager 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
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.
Qualified providers must be currently licensed as a vendor by the Arkansas Rehabilitation Services (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 organization is certified to provide supported employment services. Providers must maintain documentation of certification on file.

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 plan of care 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 case manager 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;
9) Reviewing the person's records & 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.

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 beneficiary'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

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. Must have at least one of the following:
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.;
5. Not be listed on either the adult or child maltreatment registry;
6. Have satisfactorily completed a drug screen in accordance with the Organization's policies; and
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	T4032 supplies
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	T1060 prescription drugs
Category 3:	**Sub-Category 3:**
17 Other Services	T7990 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:

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.

Additional supply items are covered as a waiver service when they are considered essential for home and community care. A physician must order all items. 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 leaves the institutional setting and enters the waiver. 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**
- ☑ **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 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:	**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):*
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	T0030 crisis intervention
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	T0040 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. Requests that fall within the category of general home repairs or modifications will not be allowable. 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.

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 Registries of substantiated cases of abuse and neglect. The DHS Division of Children and Family Services (DCFS) maintains the child abuse registry and Adult Protective Services (APS) maintains the adult abuse registry. All DDS certified Waiver 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 employee's spouses. This check will provide documentation that the prospective employee's name and any adult family members' who reside with Waiver participants, 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 to comply with DDS Licensure Standards. DDS Quality Assurance staff reviews 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
Respite	☐
Community Transition Services	☐
Adaptive Equipment	☑
Crisis Intervention	

Waiver Service	Provided in Facility
	☑
Supplemental Support	☐
Supportive Living	☑
Case Management	☑
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

Waiver Service	Provided in Facility
Respite	☐
Community Transition Services	☐
Adaptive Equipment	☑
Crisis Intervention	☑
Supplemental Support	☐
Supportive Living	☑
Case Management	☑
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; case managers 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.I & 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) Pervasive - maximum daily rate is $391.95 with a maximum of $143,061.75 annually.

2) Extensive - maximum daily rate is $184.80 with a maximum of $67,452.00 annually.

3) Limited - maximum daily rate is $176.00 with a maximum of $38,544.00 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 Pervasive Level 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.

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.

☐ **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:

☐ **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 person'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 person and any legal representative. DDS staff provide the same information after the person has been determined eligible and is approved for HCBS Waiver services when the person chooses a provider. The entity chosen by the person for PCSP development (case manager) 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 person served 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 case manager must participate as the person who will develop, oversee implementation, and update the PCSP. DDS staff and the case manager inform the person served 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 person served 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 consumer may accompany the individual 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 individual, must sign the PCSP, the

case manager ensures that the plan is distributed to the person served and other people involved in the implementation of HCBS services included in the plan.

If the case manager fails to include the person served and any legal representative in the PCSP development process, the PCSP is not a valid PCSP. DDS staff provide information to the person served 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):

CES Waiver services are accessed through DDS Intake and Referral units, which include DDS Adult Intake and Referral, DDS Children's Services Intake and Referral, and Intermediate Care Facilities for Intellectual or Developmental Disabilities (ICF/IDD) Intake and Referral staff. The Intake and Referral staff distribute the initial application, assist with completion of the application, explain program options and offer choice of waiver services or ICF/IDD services. The application packet can be obtained on DDS's website at http://humanservices.arkansas.gov/ddds/Pages/waiverServices.aspx.
The completed application packet is transmitted to the Waiver Application Unit (WAU) who tracks the application and documents eligibility determinations. The DDS Psychology Team determines whether the applicant is ICF/IDD eligible. The Medicaid Income Eligibility Unit is responsible for determining if the individual is Medicaid eligible. After an applicant has been determined eligible and enrolled in the Waiver, a DDS Specialist offers him or her a choice of waiver providers.

All Waiver services are delivered by DDS certified providers who have enrolled with DMS as Medicaid Providers. During the DDS certification process, the providers identify the services they will provide, the level of services they will offer, the counties they will serve and, if desired, the maximum number of people they will serve. Providers are currently permitted to change these criteria and may do so by contacting the DDS Certification Unit. However, change cannot be made if the change will adversely impact any person receiving services from that provider at the time the change is desired.

Providers must request in writing and receive written permission from DDS before reducing numbers of participants served by 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 persons they have most recently begun serving. Providers are responsible for continuing to provide services until transition of persons to another provider is complete.

All services must be delivered based on an individual person-centered service plan (PCSP), which is based on all psychological and functional assessments. The PCSP is developed by the case manager with input from the Participant, the Participant's guardian, the direct service providers, and any other advocates the participant may choose. The PCSP must have measurable goals and specific objectives, measure progress through data collection, been overseen and updated by the participant's case manager through consultation with the team, which includes the person receiving services.

The Direct Care Coordinator assures that the person being served and the team has input into the development of the PCSP, including services needed and desired outcomes for the person, and decisions on hiring direct care professionals.

A. Before the Person Centered Case Plan (PCSP)

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 (ISP) for up to 60 days. The ISP may include case management and supportive living for direct case supervision. DDS staff track the expiration dates of ISPs and ensure that a PCSP is complete before the ISP expires.

B. Developing the PCSP:

1. Development, Participation and Timing

The case manager is responsible for scheduling and coordinating the Person Centered Case Plan (PCSP) development meeting, including inviting all parties and making sure that the location and the attendees are acceptable to the Waiver participant. If the Waiver participant objects to the presence of any individual, that person may not attend the meeting. Aside from any objections from the Waiver participant 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. DDS staff will attend if the participant invites them. The case manager 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, DDS requires that the case manager secures a functional assessment and any evaluations that are specific to the needs of the individual. In addition to psychological testing to include a measure of IQ and the adaptive behavior assessments conducted to establish eligibility, the case manager may secure social histories, medical, physical and mental histories, a current physician evaluation, an assessment of educational needs, physical, speech and occupational therapy evaluations, as well as 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 individual.

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 pervasive level participant, it must be documented that the participant's health and safety require one on one staffing, twenty-four hours a day.

3. Information regarding availability of services

The DDS staff informs the participant of available Waiver services at the time of initial application. After the case manager has completed the functional assessment and met with the individual to discuss which services are needed based on the assessment. DDS meets with the individual 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 case manager 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 individual's goal, needs (including health care needs), and preferences, as well as any cultural considerations. DDS requires that the developers designate who 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 case manager has the responsibility for coordinating and monitoring the implementation of all services identified in the PCSP, including waiver, state plan and needed services not reimbursed by Medicaid. The case manager must coordinate with the direct service providers to ensure quality service delivery.

6. Updating the PCSP

The case manager is responsible for making sure that the PCSP is updated at least annually. They are also responsible for making sure that the PCSP is reviewed quarterly so that the team may identify goals that may need to be added, removed or revised and that there are no unnecessary or inappropriate services and supports. The team uses the data gathered by the implementer of the PCSP as they work with the participant to determine if goals should change. The team also relies on input from the participant regarding whether they want to work on new or revised goals. The participant may request an update of their PCSP at any time.

7. Participant Engagement

From the time an individual first makes contact with DDS to apply for Waiver services, they are informed of their rights

to make choices about each aspect of the services that they receive. It is the responsibility of every person at the state and the provider level to make sure that the participant is aware of and exercises their rights and to ensure that the process is driven to the maximum extent possible by him or her. During the person-centered planning meeting, every person present is responsible for supporting and encouraging the participant 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 participant during the PCSP development process. In conjunction with the participant 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 PCSP with individualized mitigation strategies. The strategies must be designed to respect the needs and preferences of the participant. 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. Additionally, the case manager must make sure that the team analyzes the risk management strategies and how effective those strategies are. The analysis must occur at least quarterly as part of the quarterly PCSP review.

DDS does not require a specific risk assessment tool, but does require that providers document practices and decisions regarding risk assessment and the ongoing management of risks. Providers must specify the tool they use. HCBS Waiver participants, 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 case management providers in conjunction with the direct service provider 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 case management and direct service provider minimize certain personal safety risks by imposing certain "physical plant" requirements without compromising the natural, home-like atmosphere in any setting in which the individual 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 individual.

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 person and any legal representative. When desired by the person and any legal representative, DDS provides information by phone, mail, or email. The 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 person 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 person and any legal representative an opportunity to change their choice of setting of service from community (HCBS Waiver) services to services in an ICF/IDD. DDS staff also offer a choice of a different provider initially as services begin, annually, and upon request. DDS staff supports the person to make a choice of provider without any specific recommendations that could sway the person's choice. DDS prohibits providers from soliciting persons 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 person'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 persons served. 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**

- [x] **Operating agency**
- [x] **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 case management 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 participant health and welfare.

The case management provider is charged with the first-line responsibility for monitoring the implementation of the PCSP and the participant health and welfare. They must maintain regular contact with the individual, making at least one contact with the individual or their legal representative each month. During the contact, the case manager must discuss issues related to HCBS Waiver and non-waiver services and whether or not the individual 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 individual. If they identify problems, they must take action to remediate the issue. The case manager 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 case manager, along with the team, must review the PCSP at least quarterly. The team must review the participant's objectives and determine if they are accomplished, to be continued, or should be modified or discontinued. The team must use participant'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 persons served 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 participants 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
☑ 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)*:
	☐ 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:

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**
	☐ **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**
	☐ **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 participant. The system focuses on participant-centered service planning and delivery, participant rights and responsibilities, and participant outcomes.

During onsite provider certification reviews, DDS Certification and Licensure staff review PCSP for 10% of the population 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 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, it 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 or all of the standards mentioned above, the provider is cited and must submit an acceptable plan of correction. The plan must include an attestation that any deficiencies have 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 all participants which offer the participant choice

1) Between institutional care and HCBS Waiver services and 2) among qualified providers who serve the county in which the person resides and offers the services that the person needs. If the person has not returned the appropriately completed and signed Choice forms within 30 days, DDS will call the person to discuss the forms and will conduct a visit if the person needs assistance to complete the forms. If the person requests provider staff, either direct care or case management to assist with choice forms, the provider staff will call DDS to relay this information. DDS will contact the individual to inform them that DDS will assist them with the choice process, rather than the provider.

Revocation of provider certification will only occur after the provider has been given the opportunity for a fair hearing in accordance with the Arkansas Administrative Procedures Act.

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 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)

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 individuals. 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).

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – DDS Alternative Community Services Waiver (DDS ACS) – 1915 (c) Waiver

EFFECTIVE DATE: August 22, 2017

SUBJECT: Provider Manual Update Transmittal DDSACS-2-17

REMOVE		INSERT	
Section	Effective Date	Section	Effective Date
200.000	—	200.000	—
201.000	10-8-10	201.000	8-22-17
201.100	3-1-10	201.100	8-22-17
201.200	3-1-10	201.200	8-22-17
202.000	3-1-10	202.000	8-22-17
202.100	3-1-10	202.100	8-22-17
202.200	9-1-16	202.200	8-22-17
211.000	9-1-16	211.000	8-22-17
211.200	9-1-16	211.200	8-22-17
212.000	3-1-10	212.000	8-22-17
213.000	9-1-16	213.000	8-22-17
213.300	9-1-16	213.300	8-22-17
214.000	7-15-12	214.000	8-22-17
214.100	3-1-10	214.100	8-22-17
215.000	3-1-10	215.000	8-22-17
215.100	3-1-10	215.100	8-22-17
215.200	3-1-10	215.200	8-22-17
215.300	3-1-10	215.300	8-22-17
216.000	3-1-10	216.000	8-22-17
216.100	1-1-16	216.100	8-22-17
216.200	3-1-10	216.200	8-22-17
216.300	3-1-10	216.300	8-22-17
—	—	216.400	8-22-17
217.000	3-1-10	217.000	8-22-17
217.100	3-1-10	217.100	8-22-17
217.200	3-1-10	217.200	8-22-17
218.000	3-1-10	218.000	8-22-17

218.100	3-1-10	218.100	8-22-17
219.000	3-1-10	219.000	8-22-17
219.100	3-1-10	219.100	8-22-17
219.200	3-1-10	219.200	8-22-17
220.000	9-1-16	220.000	8-22-17
220.100	3-1-10	220.100	8-22-17
220.200	3-1-10	220.200	8-22-17
221.000	9-1-16	221.000	8-22-17
221.100	3-1-10	221.100	8-22-17
222.000	3-1-10	222.000	8-22-17
223.000	3-1-10	223.000	8-22-17
223.100	3-1-10	223.100	8-22-17
230.000	9-1-16	230.000	8-22-17
230.100	3-1-10	230.100	8-22-17
230.200	9-1-16	230.200	8-22-17
230.210	3-1-10	230.210	8-22-17
230.211	3-1-10	—	8-22-17
230.212	3-1-10	—	8-22-17
230.213	3-1-10	—	8-22-17
230.300	3-1-10	230.300	8-22-17
230.400	9-1-16	230.400	8-22-17
230.410	9-1-16	230.410	8-22-17
240.000	3-1-10	240.000	8-22-17
241.000	9-1-16	241.000	8-22-17
251.000	3-1-10	251.000	8-22-17
261.000	3-1-10	261.000	8-22-17
262.000	3-1-10	262.000	8-22-17
262.210	9-1-14	262.210	8-22-17

Explanation of Updates8-22-17

Section 200.000, DDS Alternative Community Services (ACS) Waiver General Information, has been updated to reflect the name change to DDS Community Employment Supports (CES)

Section 201.000, Arkansas Medicaid Program Participation Requirements for DDS CES Waiver Program, has been updated to reflect the name change and to add information on reduction of provider's maximum number of persons served.

Section 201.100, Providers of DDS ACS Waiver Services in Arkansas and Bordering States Trade Area Cities, has been updated to reflect the name change.

Section 201.200, Organized Health Care Delivery System Provider, has been updated to reflect the name change and to add information about subcontract financial accountability.

Section 202.000, Documentation Requirements, has been updated to reflect the name change.

Section 202.100, Documentation in Beneficiary's Case Files, has been updated to reflect the name change.

Section 202.200, HCBS Settings Requirements, has been updated to change HCBS to CES.

Section 211.000, Scope, has been updated to reflect the name change and to add/remove other information.

Section 211.200, Risk Assessment, has been updated to add and remove information.

Section 212.000, Description of Services, has been updated to reflect the name change.

Section 213.000, Supportive Living, has been updated add and remove information and clarify existing information.

Section 213.300, Benefits to Supportive Living, has been updated to add and remove information and clarify existing information, particularly, with regard to levels (tiers) of support.

Section 214.000, Respite Services, has been updated to remove some information.

Section 214.100, Benefit Limits for Respite Services, has been updated to add, delete, and change information, with particular regard to levels (tiers) of support and maximum daily and annual rates.

Section 215.000, Supported Employment, has been updated to add new information and remove old information.

Section 215.100, Supported Employment Exclusions, has been updated to reflect the name change.

Section 215.200, Documentation Requirements for Supported Employment, has been updated to add information on Discovery Career Planning, Employment Path Services, and Extended Services.

Section 215.300, Benefit Limits for Supported Employment, has been updated to add details on Discovery/Career Planning, Employment Support Job Development, Employment Supports Job Coaching and Extended Services, and to remove old information.

Section 216.000, Adaptive Equipment, has been updated to add details on adaptive equipment and to clarify what the waiver covers regarding such. The Note has been removed.

Section 216.100, Adaptive Equipment: Vehicle Modifications, has been updated to remove old information and to clarify exclusions.

Section 216.200, Adaptive Equipment: Personal Emergency Response System (PERS), has been updated to remove old information, add new information, and clarify existing information.

Section 216.300, Benefit Limits for Adaptive Equipment, has been updated to include new information and remove old information regarding the maximum annual expenditure for adaptive equipment.

Section 216.400, Required Documentation for Adaptive Equipment, has been added regarding documentation of bids on modifying adaptive equipment.

Section 217.000, Environmental Modifications, has been updated to include information on sole-source funding of environmental modifications.

Section 217.100, Environmental Modifications Exclusions, has been updated to remove the Conditions note.

Section 217.200, Benefit Limits for Environmental Modifications, has been updated to add and remove information regarding annual expenditure limits.

Section 218.000, Specialized Medical Supplies, has been updated to prioritize the physician's role in documenting or ordering specialized medical equipment and to add that the most cost-effective item will be considered first.

Section 218.100, Benefit Limits for Specialized Medical Supplies, has been updated to clarify the maximum annual allowance.

Section 219.000, Supplemental Support Service, has been updated to remove old information and replace "emergencies" with "unforeseen problems."

Section 219.100, Supplemental Support Service Exclusions, has been deleted. This section is now marked Reserved.

Section 219.200, Supplemental Support Service Benefit Limits, has been updated to clarify the maximum annual allowance.

Section 220.000, Case Management Service, has been updated primarily to replace "levels" of support with "tiers" of support and to define the minimum requirement for service contacts.

Section 220.100, Traditional Case Management, has been updated to remove information.

Section 220.200, Benefit Limits for Case Management, has been updated primarily to add information on abeyance and clarify the age limits.

Section 221.000, Consultation Services, has been updated to add behavior analyst and to change references to "person" to "beneficiary."

Section 221.000, Benefit Limits for Consultation Service, has been updated to clarify the maximum per-hour benefit limit.

Section 222.000, Crisis Intervention Services, has been updated primarily to define the maximum annual limit and clarify the age limits.

Section 223.000, Community Transition Services, has been updated primarily to clarify the point of eligibility and remove certain information regarding exclusions.

Section 223.100, Benefit Limits for Community Transition Services, has been updated to clarify the overall maximum annual allowance.

Section 230.000, Eligibility Assessment, has been updated to include an independent assessment as part of the comprehensive diagnosis and evaluation.

Section 230.100, Categorical Eligibility Determination, has been updated to reflect the name change of the waiver program.

Section 230.200, Level of Care Determination, has been updated to further define the level of care determination.

Section 230.210, Tiers of Support, has been updated to replace the term "levels" with "tiers" and to further define the areas of assessment.

Section 230.211, Pervasive Level of Support, has been removed/deleted.

Section 230.212, Extensive Level of Support, has been removed/deleted.

Section 230.213, Limited Level of Support, has been removed/deleted.

Section 230.300, Comprehensive Diagnosis and Evaluation, has been updated to reflect the name change of the waiver program.

Section 230.400, Person-Centered Service Plan, has been updated primarily to include information regarding independent assessment and monitoring of risk level and risk management strategies.

Section 230.410, Person-Centered Service Plan Required Documentation, has been updated to include information regarding independent assessment.

Section 240.000, Prior Authorization, has been updated to include to reflect the name change of the waiver program.

Section 241.000, Approval Authority, has been updated primarily to reflect the name change of the waiver program and replace references of "level" to "tier."

Section 251.000, Method of Reimbursement, has been updated to reflect the name change of the waiver program.

Section 261.000, Introduction to Billing, has been updated to reflect the name change of the waiver program.

Section 262.000, DDS CES Waiver Procedure Codes, has been updated to reflect the name change of the waiver program and in some instances replace units of service "month" to "package."

Section 262.210, Completion of CME-1500 Claim Form, has been updated to reflect the name change of the waiver program.

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 Hewlett Packard Enterprise 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.

Rose M. Naff
Director

TOC required

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

201.000 Arkansas Medicaid Program Participation Requirements for DDS CES Waiver Program 8-22-17

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 8-22-17

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 8-22-17

The DDS CES waiver allows a provider who is licensed and certified as a DDS CES case management 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 8-22-17

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 8-22-17

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 8-22-17

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 8-22-17

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.

211.200 Risk Assessment 8-22-17

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: case manager 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, plan of care 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 8-22-17

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. Case Management Services

I. Consultation Services

J. Crisis Intervention Services

K. Community Transition Services

213.000 Supportive Living 8-22-17

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, case management 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 case management 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 case manager at least monthly.
   g. If psychotropic medications are being used for behavior, the direct care supervisor and case manager 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 case manager 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 case manager 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 case manager. Retainer payments may be made to providers of habilitation while the waiver participant is hospitalized or absent from his/her home.

213.300 Benefit Limits for Supportive Living 8-22-17

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 8-22-17

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.

. 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 8-22-17

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 8-22-17

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 8-22-17

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 8-22-17

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 8-22-17

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 8-22-17

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 8-22-17

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) 8-22-17

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 8-22-17

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 8-22-17

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 8-22-17

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 case manager. 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 8-22-17

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 8-22-17

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

218.000 Specialized Medical Supplies 8-22-17

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 8-22-17

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 8-22-17

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 8-22-17

219.200 Supplemental Support Service Benefit Limits 8-22-17

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 Case Management Services 8-22-17

Case management services assist beneficiaries in gaining access to needed waiver services and other Arkansas Medicaid State Plan services, as well as medical, social, educational and other generic services, regardless of the funding source to which access is available.

Case management services include responsibility for guidance and support in all life activities. The intent of case management services is to enable waiver beneficiaries to receive a full range of appropriate services in a planned, coordinated, efficient and effective manner.

These activities include locating, coordinating and assuring the implementation of and monitoring:

A. All proposed waiver services

B. Other Medicaid state plan services

C. Needed medical, social, educational and other publically funded services, regardless of the funding source

D. Informal community supports needed by beneficiaries and their families

Case management services consist of the following activities:

A. Arranging for the provision of services and additional supports

B. Monitoring and reviewing beneficiary services included in the person-centered service plan

C. Facilitating crisis intervention

D. Guidance and support to obtain generic services and supports

E. Case planning

F. Needs assessment and referral for resources

G. Monitoring to assure quality of care and case reviews that focus on the beneficiary's progress in meeting goals and objectives established through the case plan

H. Providing assistance relative to obtaining waiver Medicaid eligibility and ICF/ID/DD level-of-care eligibility determinations

I. Assuring the integrity of all case management Medicaid waiver billing in that the service delivered must have prior authorization and meet required waiver service definitions and must be delivered before billing can occur

J. Assuring submission of timely (advance) and comprehensive behavior and/or assessment reports, continued person-centered service plans, revisions as needs change, and information and documentation required for ICF/IID level of care and waiver Medicaid eligibility determinations

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

L. Monitoring and reviewing services to assure health and safety of the beneficiary

M. Upon receipt of DDS approvals or denials of requested services, ensuring that a copy is provided to the beneficiary or legal representative

N. Providing assistance with the appeals process when the appeal option is chosen by the beneficiary or legal representative

O. Planning meetings are scheduled by the case manager on behalf of the beneficiary, at a time and in a location that is convenient for the beneficiary or legal representative. The planning meeting will only include the case manager, the beneficiary or legal representative and other persons invited by the beneficiary.

Case Management will be provided up to a maximum of a 90-day transition period for all beneficiaries who seek to voluntarily withdraw from waiver services unless the beneficiary does not want to continue to receive the service. 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 ensure 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. Case Management 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 case management 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. The beneficiary should be encouraged to advocate or have an advocate present during all planning meetings

C. Providers will administratively separate case management functions and staff and direct-care functions and staff

Case management services are available at two tiers of support. They are:

A. Tier 3: Requiring care 24 hours per day, seven (7) days per week; and

B. Tier 2: Requiring care of less than 24 hours per day, seven (7) days per week.

The minimum requirement for service contacts is one face-to-face contact per month:

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. On a monthly basis, the case manager must conduct a monitoring contact and report the status to DDS.

See Section 260.000 for billing information.

220.100 Transitional Case Management 8-22-17

Case Management services may be available during the last 180 consecutive days of a Medicaid eligible person's institutional stay to allow case management activities to be performed related to transitioning the person to the community. The person must be approved and in the waiver program for case management to be billed.

220.200 Benefit Limits for Case Management 8-22-17

The maximum reimbursement limit per beneficiary is $117.70 per month and $1,412.40 annually.

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.

Case management is provided only through the waiver to beneficiaries who are age 21 and over. All medically necessary case management services are provided to children under the age of 21 through the Medicaid State Plan EPSDT benefit.

221.000 Consultation Services 8-22-17

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 8-22-17

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 8-22-17

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 8-22-17

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 8-22-17

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.

230.000 ELIGIBILITY ASSESSMENT 8-22-17

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 8-22-17

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 8-22-17

Based on intellectual and behavioral assessment submitted by the provider, the ICF/ID/DD level of care determination is performed by the Division of Developmental Disabilities. The ICF/ID/DD 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/ID/DD.

B. Need institutionalization in an ICF/ID/DD 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/ID/DD level of care.

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

230.210 Tiers of Support 8-22-17

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

Tier 3: Institutional level of care

Tier 2: Institutional level of care less than 24/7

Tiers will be determined through an independent assessment conducted by a third-party vendor that will assess the participant in the following areas:

1. Individual areas, including
    a. Medical history, current medical conditions, or conditions observed by the assessor or self-reported by the beneficiary
    b. Behavioral
    c. Home living activities
    d. Community activities
    e. Employment
    f. Health and safety assessment
    g. Social functioning
2. Caregiver (natural supports) areas, including
    a. Physical/behavioral (health)
    b. Involvement
    c. Social resources
    d. Family stress
    e. Safety
3. Current Risk Assessment Review, including
    a. Safety Plan, if available
    b. Behavior Plan
    c. Physical Plan
    d. Medical Plan

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 8-22-17

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 case management 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 8-22-17

During the initial sixty (60) days of DDS CES waiver services, a beneficiary receives services based on a DDS pre-approved initial person-centered service plan that provides for case management 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 case management 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 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 case manager, 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 case manager 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.

230.410 Person-Centered Service Plan Required Documentation 8-22-17

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 MR/DD 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 case management provider, case manager, 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 8-22-17

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 8-22-17

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

A. The DDS prior authorization process requires that all pervasive level-of-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 case manager.

2. The DDS Plan of Care 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 participant 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 case management provider, with cooperation from the procurement source, to satisfy the request(s) within the prescribed time frames.

H. It is the responsibility of the case management 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 case management 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 case management, the sixty (60)-day interim plan begins with the date of discharge.

1. At any time during the initial sixty (60) days or transitional case management period, the case manager 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.

251.000 Method of Reimbursement 8-22-17

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.

261.000 Introduction to Billing 8-22-17

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 8-22-17

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	Case Management 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 Case Management	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

262.210 Completion of CMS-1500 Claim Form 8-22-17

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.

Field Name and Number		Instructions for Completion
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.
	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:	

Field Name and Number		Instructions for Completion
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.
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.

Field Name and Number	Instructions for Completion
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.
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.

Field Name and Number	Instructions for Completion
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 ORIGINAL REF. NO.	Reserved for future use. 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.
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.

Field Name and Number	Instructions for Completion
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.
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.

Field Name and Number	Instructions for Completion
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.