DEPARTMENT OF HUMAN SERVICES
FUNCTIONS OF STATE AGENCY **Revised: April 1, 2012**

Division of County Operations

The expanded Division of County Operations (DCO) was created on January 1, 1995, by the merger of the existing division with the Economic Services portion of the past Division of Economic and Medical Services. The merged DCO administers several of the programs offered by the Department of Human Services, including Medicaid eligibility determinations and policy development. Their primary mission is to ensure accessibility of DHS services and to coordinate activities and resources at the local DHS County Offices. This includes assistance to medical providers located in their community.

Division of Services for the Blind

The overall objective of programs in the Division of Services for the Blind is to assist blind and visually **impaired** persons in Arkansas toward the opportunity to live full and productive lives with dignity and self-respect. This involves helping blind people deal with problems directly related to blindness. The Vocational Rehabilitation Program provides a full range of services and training and assistance in finding jobs for blind persons interested in working. The Independent Living Rehabilitation Program makes available counseling and specific training in mobility, communication and activities of daily living. Special emphasis is placed on assisting families of blind children and assisting older blind persons. The Division's Vending Facility Program provides training and licenses qualified blind people who are interested in managing a vending stand or food service facility. Services are provided on a statewide basis. The Division operates under program policies established by the seven-member Board for the Services for the Blind which meets quarterly.

DIVISION OF MEDICAL SERVICES
LONG TERM CARE SECTION
ASSISTANT DIRECTOR **Revised: April 1, 2012**

The Assistant Director, Long Term Care Section, serves as State Licensure Director and Medicaid/Medicare Health Facility Surveyor Director for long term care services. The Assistant Director is responsible for the management and administration of the Long Term Care Program for nursing facilities (NF), intermediate care facilities for the mentally retarded (ICF/MR) and LTC Waiver services in conformity with CMS Medicaid Bureau. As Health Facility Certification Director, the Assistant Director is also responsible for federal survey and certification activities related to Medicare Skilled Nursing Facility (SNF), NFs, and ICF/MR facilities**,** and survey activities related to conditions of participation for Psychiatric Residential Treatment Facilities for Persons under twenty-one (21) in conformity with federal regulations and guidelines of the CMS Health Standards and Quality Bureau. As State Licensure Director, the Assistant Director has responsibility for licensing residential care, adult day care, adult day health care, assisted living and post acute head injury facilities in accordance with Arkansas statutes. The primary functions performed by the Assistant Director's Office as they relate to the Medicaid LTC Program are as follows:

- Directs the development of program goals and objectives, applicable to Long Term Care Medicaid Services to aged and/or **individuals with disabilities** in Arkansas Medicaid certified facilities and waivered services.

- Assists with the preparation of federal and state budget requests for LTC processes.

- Oversees the selection, training and work performance of Long Term Care personnel.

- Oversees the development and monitoring of Medicaid contracts and agreements for long term care necessary to meet federal and state program requirements.

- Serves as liaison to various federal and state committees, groups and organizations.

State Regulated Facilities and Eligibility Determination

- Conducts annual surveys of residential care, assisted living, adult day care and adult day health care facilities, and post-acute head injury facilities
- Processes licensing of the above state regulated facilities
- Establishes the medical necessity for admission and continued stay and the level of care needed by those individuals eligible for medical assistance under Title XIX of the Social Security Act for Medicaid reimbursement
- Prevents unnecessary and inappropriate utilization of care and services available to Medicaid recipients in nursing homes
- Reviews the medical needs of persons applying for Medicaid services under specific Medicaid waiver programs
- Oversees the Nursing Facility preadmission screening and annual resident review (PASRR) for **individuals with mental illnesses** nursing facility applicants and residents

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	**Citation(s)**	**Groups Covered**
A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)		
DCO	1902(e)(4) of the Act	12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.
SOCIAL SECURITY ADMIN (SSA)	42 CFR 435.120	13. Aged, Blind and Individuals **with Disabilities** Receiving Cash Assistance _X_ a. Individuals receiving SSI. This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act. _X_ Aged _X_ Blind _X_ **Individuals with Disabilities**

State: ARKANSAS

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
SSA	1902(a)(10)(A)(i)(II) and 1905(q) of the Act	14. Qualified severely impaired blind and individuals **with disabilities** under age 65, who-- a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must-- (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to **have a disability**; (2) Except for earnings, continue to meet all non-disability-related requirements for eligibility for SSI benefits; (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
DCO	1634 (c) of the Act	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or individuals **with disabilities** who-- a. Are at least 18 years of age; b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility. ☐ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility. ☐ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
DCO	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.
SSA	42 CFR 435.130	17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
DCO	42 CFR 435.132	19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they-- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care.
DCO	42 CFR 435.133	20. Blind and individuals **with disabilities** who-- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and b. Were eligible for Medicaid in December 1973 as blind or **as an individual with a disability**; and c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	**Citation(s)**	**Groups Covered**
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
DCO	1634(d) of the Act	24. Widows **with a disability**, widowers **with a disability**, and unmarried divorced spouses **with a disability** who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A. __ The State applies more restrictive eligibility _ requirements for its blind or **individuals with disabilities** than those of the SSI program. __ In determining eligibility as categorically needy, _ the State disregards the amount of the title II benefits identified in §1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard. __ In determining eligibility as categorically needy, _ the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to be disregarded is specified in Supplement 4 to Attachment 2.6-A. __ In determining eligibility as categorically needy, _ the State chooses not to deduct any of the benefit identified in §1634(d)(1)(A) in determining the income of the individual.

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

DCO — 42 CFR 435.231; 1902 (a)(10)(A)(ii)(V) of the Act

☒ 12. Individuals who are in institutions for at least 30 consecutive days who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

☐ The State covers all individuals as described above.
☒ The State covers only the following group or groups of individuals:

- X Aged
- X Blind
- X **Individuals with Disabilities**
- ___ Individuals under the age of--
  - ____ 21
  - ____ 20
  - ____ 19
  - ____ 18
- X Caretaker relatives
- X Pregnant women

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
N/A	1902(e)(3) of the Act	☐	13. Certain children **with disabilities** age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in an institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of children **with disabilities** at home.
N/A	1902(a)(10)(A)(ii)(IX) and 1902(I) of the Act	☐	14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A. a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and b. Infants under one year of age.

State: ARKANSAS

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
DCO	1902(a)(ii)(X) and 1902(m)(l) and (3) of the Act	☒	16. Individuals-- a. Who are 65 years of age or older or **has a disability**, as determined under section 1614(a)(3) or the Act. Both aged and individuals **with disabilities** are covered under this eligibility group. Only aged individuals are covered under this eligibility group. Individuals **with disabilities** are not covered. b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A. Refer to Supplement 8b to Attachment 2.6-A, Page 3 for more liberal methodologies.

State: ARKANSAS

Agency*	Citation(s)		Groups Covered
		C.	Optional Coverage of Medically Needy (Continued)
DCO	42 CFR 435.310	☒	6. Caretaker relatives.
DCO	42 CFR 435.320 And 435.330	☒	7. Aged individuals.
DCO	42 CFR 435.322 And 435.330	☒	8. Blind individuals.
DCO	42 CFR 435.324 and 435.330	☒	9. Individuals **with disablities**.
N/A	42 CFR 435.326	☐	10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
DCO	435.340		11. Blind and individuals **with disabilities** who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as medically needy in December 1973 as blind or **an individual with a disability**; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

State: ARKANSAS

Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons. a. Aged, blind, **individual with a disability**: Individuals $ 40.00 Couples $ 80.00 For the following persons with greater need: Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b. AFDC related: Children $ 40.00 Adults $ 40.00 For the following persons with greater need: Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B.7. of Attachment 2.2-A $ 40.00

Citation	Condition or Requirement
	7. Resource standard – Medically Needy
	a. Resource standards are based on family size.
1902 (a)(10)(c)(i) of the Act	b. A single standard is employed in determining resource eligibility for all groups.
	___ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for— ___ Aged ___ Blind ___ **Individuals with Disabilities** Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.
1902(a)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B) and 1860D-14(a)(3)(D) of the Act	8. Resource Standard – Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualified Individuals For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualified Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI).
1902(a)(10)(E)(ii), 1905(s) and 1860D-14(a)(3)(D) of the Act	9. Resource Standard – Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

INCOME ELIGIBILITY LEVELS (continued)

3. Aged and Individuals **with Disabilities** (Aged Individuals Only)

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(4) of the Act are as follows (PM 93-5):

Based on **100** percent of the official Federal income poverty line.

Family Size	Income Level
1	$_____
2	$_____
3	$_____
4	$_____
5	$_____

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902 (r) (2) OF THE ACT*

[ ] Section 1902 (f) State [X] Non-Section 1902 (f) State

For Working Individuals with Disabilities – Basic Insurance Group-TWWIIA: Only the income of the individual **with the disability** will be used to determine eligibility. There will be no deeming of spousal income.

*More liberal methods may not result in exceeding gross income limitations under section 1903(f).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902 (r) (2) OF THE ACT

[ ] Section 1902 (f) State [X] Non-Section 1902 (f) State

For aged, blind and individuals **with disabilities**, including Qualified Medicare Beneficiaries, Non-Home Income Producing Property, such as mineral and timer rights, rented farmland, and rented dwellings, will continue to be excluded from resources if it meets the per-5/1/90 SSI $6000/6% rule, which was terminated by Section 8014 of OBRA, 1989. This rule will not apply to cash assistance recipients; to those individuals deemed to be cash assistance recipients; to qualified disabled working individuals (QDWIs) or to COBRA continuation recipients. (Arkansas has not elected to provide coverage to the COBRA continuation recipients.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

(b) a son or daughter of the institutionalized individual who resided in the home for at least two years before the applicant was admitted to the medical institution or nursing facility, and who provided care which enabled the institutionalized individual to remain at home during that period; or

(c) a sibling of the institutionalized individual who had an equity interest in the home for at least one year before the applicant was admitted to the medical institution or nursing facility.

ii. The resources were transferred to (or to another for the sole benefit of) a **child that is** blind or **has a** permanent and total **disability** (as determined by SSI or MRT).

iii. A satisfactory showing is made that the individual intended to dispose of the resources at FMV or for other valuable consideration, or that the resources were transferred exclusively for a purpose other than to qualify for medical assistance.

iv. It is determined that denial of eligibility would work an undue hardship. Undue hardship exists if each condition below is met:

(a) Counting uncompensated value would make an individual ineligible;

(b) Lack of assistance would deprive the individual of food and shelter;

(c) The individual's combined total of gross income and countable resources (no income disregards allowed) do not exceed the applicable federal benefit rate (NF income limit); and

Revision: HCFA-PM-97-3 (CMSO)
December 1997
April 1, 2012

State: **ARKANSAS**

Citation

1843(b) and 1905(a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

X All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); (b) receiving State supplements under title XVI; or (c) within a group listed at 42 CFR 431.625(d)(2).

____ Individuals receiving title II or Railroad Retirement benefits.

____ Medically needy individuals (FFP is not available for this group).

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

X The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and individuals **with disabilities**, entitled to Medicare Part A but not enrolled in Medicare Part B).

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- Rehabilitative Day Service for Persons Ages 18-20
Apply the above definition and requirements (except Staff to Client Ratios, which are outlined below).
Additional information: Use code H2017 with no modifier to claim for services provided to beneficiaries for ages 18-20.

- SERVICE: Adult Rehabilitative Day Service
DEFINITION: Adult Rehabilitative day services provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, and supervision to individuals **with** mental ill**nesses** and who, due to the severity of their impairment, are in need of face to face interventions provided in a structured group program. This service is designed for long-term recovery and self-sufficiency.

  Adult Rehabilitative day services provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the beneficiary in a facility-based program providing specialized rehabilitation.

  Services may include:

  A. Goal compliance,

  B. Problem solving,

  C. Patient Safety

  D. Task completion

  E. Pharmaceutical supervision and/or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:
Medicaid **beneficiaries** age twenty-two and older who are diagnosed as **individuals with** developmental disabilit**ies such as** mental **illnesses**, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental **illnesses** because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental **illnesses** or require treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

D. Definition of Services (Continued):

Targeted Case Management Services are limited to 104 hours per SFY.

The following are targeted case management service descriptions:

- Assessment/Service Plan Development: Face to face contact with the beneficiary and contact with other professionals, caregivers, or other parties on behalf of the beneficiary. Assessment is performed for the purpose of collecting information about the beneficiary's situation and to determine functioning and to determine and identify the beneficiary's problems and needs. Service Plan Development includes ensuring the active participation of the Medicaid-eligible beneficiary. The goals and actions in the care plan must address medical, social, education and other services needed by the Medicaid-eligible beneficiary. The maximum units allowed for this service may not exceed twelve (12) units per assessment/service plan visit with beneficiaries age 22 and over.

- Service Management/Referral and Linkage: Activities and contacts that link Medicaid-eligible beneficiaries with medical, social, education providers and/or other programs and services that are capable of providing needed services. Functions and processes that include contacting service providers selected by the beneficiary and negotiation for the delivery of services identified in the service plan. Contacts with the beneficiary and/or other professionals, caregivers, or other parties on behalf of the beneficiary may be a part of service management.

- Service Monitoring/Service Plan Updating: Activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the Medicaid-eligible beneficiary. Verifying through regular contacts with service providers at least every other month that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the beneficiary, at least monthly, that the beneficiary continues to participate in the service plan and is satisfied with services. The

maximum units for this service may not exceed four (4) units per monitoring visit when providers are dealing with beneficiaries age 22 and over.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

Medicaid **beneficiaries** age twenty-two and older who are diagnosed as **individuals with** developmental disabilit**ies such as** mental **illnesses**, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental **illnesses** because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental **illnesses** or require treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

D. Definition of Services (Continued):

Refer to Attachment 4.19-B, Page 7a, C. for the definition of a unit of service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

Medicaid **beneficiaries** age twenty-two and older who are diagnosed as **individuals with** developmental disabilit**ies such as** mental **illnesses**, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental **illnesses** because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental **illnesses** or require treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

E. Qualification of Providers:

Providers of targeted case management services for recipients as described above must be a Division of Developmental Disabilities Services Certified Case Manager who must maintain the following information

(1) Documentation of a high school diploma or GED.
(2) Documentation of the successful completion of the DDS Certified Case Management Training.
(3) Documentation of two years of experience of working with individuals with disabilities.
(4) Documentation of a successful completion of a criminal background check and adult and child maltreatment registry checks.
(5) In addition, the individual must provide two letters of reference and sign a Code of Ethics agreement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

Medicaid **beneficiaries** age twenty-two and older who are diagnosed as **individuals with** developmental disabilit**ies such as** mental **illnesses**, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental **illnesses** because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental **illnesses** or require treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

(1)Eligible recipients will have free choice of the providers of case management services.
(2)Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Targeted case management services under the plan are not integral to the administration of another non-medical program and do not duplicate other services made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Program of All-Inclusive Care for the Elderly (PACE) Reimbursement Methodology

The PACE rates are based on the Upper Payment Limit methodology. The historical fee-for-service population data is extracted for claims and eligibility for a PACE eligible populations for more than one fiscal period. Data for recipient aged, blind and **individuals with disabilies** aid categories for those 55 or greater is used in the UPL and rate calculations. The level of care codes are limited to nursing facility level of care eligible or Waiver level of care eligible (waivers included are the ElderChoices Waiver and the Adults with Physical Disabilities Waiver).

The data includes both those that are eligible only for Medicaid and those that are eligible for both Medicaid and Medicare. In addition, this data includes only QMB-Plus and SLMB-Plus populations. The claims data includes all categories of service. The UPL and base rate information is also inclusive of patient liability.

The base rates are calculated using calendar year base data. The base year data is trended forward using the historical claims and eligibility information extracted for the fee-for-service population. The recent trend rates are compared to linear regression model trend rates to determine comparability, and to determine if any adjustments are necessary. The trend rates for future periods are expected to be consistent with historical rate changes rather than the more recent experience.

The following rate category groupings were developed for Arkansas: Pre-65 Medicaid Only, Pre-65 Dual Eligible, Post-65, and QMB Only. The UPL for QMB Only is based on actual expenditures for co-payments and deductibles for the base year period trended forward for inflation, and adjusted for investment income and administration expense. Due to the limited size population in the post-65 age group that was not Medicare eligible, it was determined that a Medicare eligibility rate for those over 65 would not improve predictability. The data did not reflect a necessity for a rate grouping for either geographic region or gender.

Claims completion factors are developed from the fee-for-service paid claims experience with the most recently available paid dates. Claims completion factors were developed for fourteen (14) primary groupings with comparable categories of service grouped for improved predictability. The completion factors were adjusted to exclude low and high outliers for each specific lag month.

The following adjustments are necessary in the development of the rates:

- Prescription Drug (PD) Rebate – Reduce PD expenditure data to reflect the rebate received by Arkansas.
- Investment Income – Reduce expenditure data by 0.2% for all Categories of Services (COS) to reflect an average payment lag of 2.49 months.
- Administration Expense – Increase expenditure data for all COS by 0.3% to reflect the cost

of administration of the fee-for-service program.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- Rehabilitative Day Service for Persons Ages 18-20
  Apply the above definition and requirements (except Staff to Client Ratios, which are outlined below).
  Additional information: Use code H2017 with no modifier to claim for services provided to beneficiaries for ages 18-20.

- SERVICE: Adult Rehabilitative Day Service
  DEFINITION: Adult Rehabilitative day services provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, and supervision to individuals **with** mentally ill**nesses** and who, due to the severity of their impairment, are in need of face to face interventions provided in a structured group program. This service is designed for long-term recovery and self-sufficiency.

  Adult Rehabilitative day services provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the beneficiary in a facility-based program providing specialized rehabilitation.

  Services may include:

  A. Goal compliance,

  B. Problem solving,

  C. Patient Safety

  D. Task completion

E. Pharmaceutical supervision and/or

G. Health monitoring.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) Non-Emergency

(a) Public Transportation

Effective for dates of service on or after December 1, 2001, the following reimbursement applies to public transportation services:

Taxi/Wheelchair Van - Reimbursement is based on the lesser of billed charges or the Title XIX maximum allowable. The billed charges must reflect the same charges made to all other passengers for the same service as determined by the local municipality which issues the permit to operate or by the Interstate Commerce Commission. The Title XIX maximum was established utilizing the 1991 Taxicab Fact Book issued by the International Taxicab and Livery Association. The calculations are as follows:

Taxi - The cost per mile of 1990 plus Market Basket Index of 1991 plus Market Basket Index of 1992 plus 25% = $1.13 per mile (unit).

Wheelchair Van - Must transport 6 or more passengers comfortably.

The cost per mile of 1990 plus Market Basket Index of 1991 plus Market Basket Index of 1992 plus 65% = $1.50 per mile (unit). An additional 40% was added to the reimbursement per mile due to the added cost of wheelchair van adaptation for wheelchair accessibility and for additional provider compensation for physically assisting **individuals with disabilities**.

The State Agency will negotiate with the affected provider group representative should recipient access become an issue.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CATEGORICAL DETERMINATIONS

Arkansas applies categorical determinations in PASRR to individuals with the following conditions: 1. Terminally Ill, Comatose, 2. Ventilator Dependent, 3. Severely Ill , 4. the short term convalescence resident, the individual being admitted from a hospital for convalescent care not to exceed 120 days and is not a danger to self or others, and Mental **Illness** with a concurrent diagnosis of dementia. The individual, to whom the previous conditions apply, has an impairment so severe that the individual could not be expected to benefit from specialized services.