# 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.

## 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*):
**DDS HCBS Waiver**

**C.** **Type of Request:new**

**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**

☐ **New to replace waiver**

Replacing Waiver Number:

☐ **Migration Waiver** - this is an existing approved waiver

Provide the information about the original waiverbeing migrated

**Base Waiver Number:**

**Amendment Number**

(if applicable):

**Effective Date:** *(mm/dd/yy)*

**Draft ID:** **AR.41.00.00**

**D.** **Type of Waiver** *(select only one):*

Regular Waiver

**E.** **Proposed Effective Date:** *(mm/dd/yy)*

07/01/14

### 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 Home and Community-Based Services Waiver (HCBS Waiver) is to provide case management and supported employment services for people of all ages who have a developmental disability, meet the institutional level of care, and require support services to live in the community.

The goals of HCBS Waiver are to:
• Support the person in developing a service plan, in coordination with an Interdisciplinary Team,
• Oversee the implementation of the service plan,
• Update the plan as necessary
• Promote community inclusion through integrated employment options, and
• Support the person in all life activities.

Support of the person includes:
• Developing a relationship with the person and maintaining direct contact,
• Determining the person's choices about his life,
• Locating, coordinating and monitoring needed developmental, medical, behavioral, social, educational and other services
• Accessing informal community supports needed by the person,
• Accessing employment services and support individuals in seeking and maintaining competitive employment, and
• Integration into the life and activities of the person's community

The objectives are as follows:

1) To transition eligible persons who choose the HCBS Waiver option from residential facilities to the community;

2) To enhance and maintain community living for all persons participating in the HCBS Waiver program.

Under the organizational structure of the Department of Human Services (DHS), the Division of Medical Services (DMS) is the state Medicaid agency. It has administrative authority for the HCBS Waiver including the items as outlined in the interagency agreement (See Appendix A-2-b). The Division of Developmental Disabilities Services (DDS), also within DHS, is responsible for operation of the HCBS Waiver, including the items as outlined in the interagency agreement. HCBS Waiver services are delivered through private providers who are certified by the DDS Quality Assurance Section. The providers must first meet DDS certification requirements and then enroll with Medicaid as HCBS Waiver provider before the provider can deliver services.

Waiver services are accessed through DDS Intake and Referral units, which include DDS Adult Intake and Referral, DDS Children's Services Intake and Referral, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) intake and referral staff, and the DDS liaison to the Arkansas State Hospital. The intake and referral staff distribute the initial application, assist with completion, explain program options and offer choice of waiver services or ICF/IID services. The completed application packet is transmitted either directly or via the Waiver Application Unit (WAU) to the DDS Psychology Team for a determination of eligibility for institutional level of care services. The WAU tracks applications once eligibility has been determined. The DDS Waiver Application Unit is also responsible for assuring a person meets ICF/IID level of care and Medicaid income eligibility criteria prior to the person receiving waiver services. DDS Specialists offer choice of waiver providers.

Waiver services are delivered by DDS certified providers who have enrolled with DMS. During DDS certification, the providers identify the counties they will serve and, if desired, the maximum number of people they will serve. Providers are 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 persons receiving services from that provider at the time the change is desired. Maximum capacity number will only be reduced through attrition. All services must be delivered based on an individual service plan, which is based on services needs assessments, has measurable goals, specific objectives, measures progress

through data collection, and is overseen and updated by the person's case manager though consultation with the interdisciplinary team (IDT), which includes the individual receiving services.

The provider assures input from the person being served and the IDT in the service plan as to what services are needed and desired, who will deliver the services, desired outcomes for the person, including decisions on the hiring of direct care professionals.

## 3. Components of the Waiver Request

**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

**A. Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

**F. Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

**A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ◉ **Not Applicable**
- ○ **No**
- ○ **Yes**

**C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

**In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:**

**A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D.** Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

**I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

**A. Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B. Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

**C. Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

**D. Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

**E.** **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

**F.** **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

**G.** **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H.** **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

**I.** **Public Input.** Describe how the State secures public input into the development of the waiver:
Arkansas secures public input into the development or revision of the HCBS Waiver through standing communications with the Arkansas Waiver Association (AWA) and DDS websites, convention participation and electronic waiver updates and frequently asked questions segments. In addition, a DDS waiver team, representative of providers and consumers, participates and provides input into all initial waiver applications, any amendments and renewals. The team is comprised of persons from the Arkansas Waiver Association, Arkansas Advocacy for Equal Access, Developmental Disabilities Provider Association, Community Providers of Developmental Disabilities Network, providers at large and DDS staff. Recommendations are made on a consensus basis. It is representative of professionals, persons and families. Additional persons or groups are formed as needed to research or gather information for the team's consideration prior to a final draft being produced. DDS notifies the Arkansas Waiver Association, Arkansas Advocacy for Equal Access, Developmental Disabilities Provider Association, Community Providers of Developmental Disabilities Network, all HCBSW Waiver providers when the draft is completed. Drafts are posted on the DDS websites for general public comment. Subsequent to changes by DMS, DMS approves the application or amendment and submits the final documents to CMS. Upon approval by CMS, implementing the regulations, policies, rules and procedures are promulgated in accordance with the Arkansas Administrative Procedure Act. This Act allows for another opportunity for public comment and changes may occur prior to the final rule submission. After review and advice from the Arkansas Legislative Sub-Committee, the implementing regulations, policies, rules and procedures are adopted into the DMS Medical Services Manual. This manual is available to all providers and the general public via electronic communications at 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:** Higgs

**First Name:** Glenda

**Title:** Waiver Quality Assurance Administrator/Chief Program Administrator

**Agency:** Department of Human Services, Disvision of Medical Services

**Address:** P O Box 1437, Slot S295

**Address 2:**

**City:** Little Rock

**State:** **Arkansas**

**Zip:** 72203-1437

**Phone:** (501) 320-6425 **Ext:** ☐ **TTY**

**Fax:** (501) 682-2480

**E-mail:** glenda.higgs@arkansas.gov

**B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Lansky

**First Name:** Anna

**Title:** Interim Assistant Director of Program Management

**Agency:** Department of Human Services, Division of Developmental Disabilities Services

**Address:** P O Box 1437, Slot N501

**Address 2:**

**City:** Little Rock

**State:** **Arkansas**

**Zip:** 72203-1437

**Phone:** (501) 682-4747 **Ext:** ☐ **TTY**

**Fax:** (501) 682-8687

**E-mail:** james.brader@arkansas.gov

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**Last Name:** Allison

**First Name:** Andy

**Title:** Director

**Agency:** Arkansas Department of Human Services, Division of Medical Services

**Address:** P O Box 1437, Slot S-401

**Address 2:**

**City:** Little Rock

**State:** **Arkansas**

**Zip:** 72203-1437

**Phone:** (501) 682-8292 **Ext:** ☐ **TTY**

**Fax:** (501) 682-1197

**E-mail:** andy.allison@arkansas.gov

## Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The Arkansas Department of Human Services is submitting a State Plan Amendment (SPA) to include the Community First Choice Option (CFCO) program into the Arkansas Medicaid State Plan. DHS plans to transition services currently provided through the HCBS Waiver, with the exception of case management and supported employment services, to CFCO. To that effect, DHS is submitting an HCBS replacement waiver request to reflect the changes. HCBS Waiver services are being moved to CFCO with minimal or no changes to service definitions. Changes in the program do not eliminate or limit any of the services that are now being furnished under the HCBS Waiver. None of the current HCBS Waiver participants will lose eligibility for Medicaid or services that they currently receive due to the transition to CFCO. HCBS Waiver participants will continue to receive case management and supported employment services through the HCBS Waiver.

The CFCO SPA and HCBS Waiver are expected to become effective July 1, 2014. Based on the fact that most HCBS Waiver services, except case management and supported employment, are being transitioned to CFCO without changes, on

the effective date Arkansas Medicaid will consider existing HCBS Waiver individual service plans valid under CFCO and will initiate reimbursement for those services under approved CFCO State Plan. As each individual service plan comes up for annual renewal under the new waiver, each service plan will be revised to reflect the services transitioned to CFCO as non-waiver services utilizing the CFCO guidelines and assessment-based episode payment methodology. Assessment-based payment framework will be used for CFCO. The cornerstone of the assessment-based payment will be the use of standardized assessment tools that determines a participant's level of need and a prospective budget amount, and informs care planning process. Budget amounts will be determined through analysis of costs for individuals at each level of need.

At the point of annual plan of care renewal, participants will be educated regarding any new options available under CFCO (such as the participant-directed delivery model) and will be given an option to request a Fair Hearing if they feel aggrieved by a decision they consider adverse. This will assure seamless and transparent transition of services to the CFCO program.

With implementation of CFCO, individuals currently placed on the HCBS Waiver waiting list may become eligible to receive services upon the CFCO effective date. Arkansas DHS is planning to absorb the waiting list population into the program over the course of 24 months after the start of the CFCO program. Assessment of individuals on the waiting list will begin in October 2013, and will be completed over the course of the calendar year 2014. Individuals will be assessed in order of wait time, with individuals who have been on the wait list the longest assessed first.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

## 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) is the state Medicaid agency and has administrative authority for the HCBS Waiver including the following items as outlined in the DMS/DDS interagency agreement:

1) Development and monitoring of the interagency agreement to assure that provisions specified are executed;

2) Oversight of the HCBS Waiver program through a DMS case record review process that allows for response to all individual and aggregate findings;

3) Review and approval, via Medicaid Manual promulgation process, public policy and procedures developed by DDS regarding the HCBS Waiver and monitors their implementation;

4) Reimbursement of services to eligible Medicaid recipients by certified providers who are enrolled in the Medicaid Program;

5) Promulgation of the DDS HCBS Waiver Provider Manual which provides the rules and regulations for participation in the Arkansas Medicaid Program;

6) Final authority on all functions related to provider participation in the Arkansas Medicaid Program;

7) Training of providers on proper procedures to follow in submitting claims (through the Medicaid fiscal agent)

8) Notification to providers of participative changes in the Arkansas Medicaid Program;

9) Response to provider questions concerning submission of claims (through the Medicaid fiscal agent);

10) Assurance that providers remain in compliance with rules and regulations required for participation in the Medicaid program;

11) Review of provider information and determination whether to enroll the provider into the Arkansas Medicaid Program;

12) Assignment of a unique Medicaid provider number to each new enrolled provider;

13) Notification to DDS of any providers removed from the active Medicaid provider file;

14) Establishes a mechanism to ensure a specified number of service plans are reviewed by DMS or their designated representative;

15) Provision to DDS of relevant information pertaining to the Medicaid program and any federal requirements governing applicable waiver programs;

16) Monitoring of DDS and DMS compliance with the interagency agreement; and

17) Completion and submission of CMS 372 Annual Report.

The Division of Developmental Disabilities Services (DDS), also within DHS, is responsible for operation of the waiver including the following items as outlined in the interagency agreement:

1) DDS develops and implements internal, administrative policies and procedures to operate the waiver. DMS does not approve these internal procedures but does review to ensure they are in compliance with State and Federal Regulations. DDS develops and implements public policy and procedures. DMS approves and promulgates public policy in accordance with the state's Administrative Procedures Act;

2) Provides orientation to organizations applying to become providers and provide updates to current providers regarding certification and service requirements set forth by DDS;

3) Certifies qualified providers who apply to provide HCBS Waiver services

4) Provides information on certified providers to DMS;

4) Conducts on-site certification surveys of providers in accordance with current DDS policies and procedures to verify provider compliance with DDS standards;

5) Notifies DMS of any provider for whom DDS revokes certification or otherwise removes from the HCBS Waiver Program; DDS notifies DMS of changes to HCBS Provider Choice List.

6) Establishes and monitors individual service plan requirements that govern the provision of services;

7) Reviews compliance of provider case managers who coordinate the service plan development, oversee implementation and monitor progress;

8) Coordinates data collection and issues reports through MMIS for completion of CMS 372 Annual Report;

9) Provides DMS with the results of monitoring activities;

10) Develops and implements a Quality Assurance protocol that meets criteria as specified in the interagency agreement.

11) Determines waiver participant eligibility according to DMS rules and procedures;

12) Answers questions from providers, participants, and families regarding HCBS Waiver services, requirements, policies, procedures and processes; and

13) Conducts program reviews, investigates service concerns, reviews incident reports from providers; imposes enforcement remedies as warranted.

DMS and DDS staff will meet at least on a quarterly 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 HCBS Waiver.

DMS and DDS will review the interagency agreement prior to July 1 of each year to determine if revisions are required.

DMS Waiver Quality Assurance (WQA) staff use the interagency agreement, Quality Improvement Strategy, case record reviews, report reviews, and meetings with DDS Waiver administrative staff to monitor the operation of the HCBS Waiver and assure compliance with HCBS Waiver requirements. Office of Medicaid

Inspector General (OMIG) Program Integrity also conducts random on site reviews of provider records throughout the year. DMS Waiver Quality Assurance staff review DDS reports, record findings and prioritize any issues that are found as a result of the review process.

DDS sends reports to DMS to facilitate DMS oversight of operations, including reports noted in the Subassurance Performance Measures.

## 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 unduplicated participants served.**

**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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**AA2: Number and percent of active (point-in-time) participants served within approved limits specified in the approved HCBS Waiver. Numerator: Number of active (point-in-time) participants served within approved limits specified in the HCBS Waiver. Denominator: Number of active participants served.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**ACES Report of Active Cases (Point in Time)**

| **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**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Division of County Operations | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**AA3: Number and percentage of LOC determinations completed in the time specified in the agreement with the Medicaid Agency. Numerator: Number of LOC determinations completed in the time specified; 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**AA4: Number and percentage of LOC assessments completed where instruments and processes described in the HCBS Waiver were applied according to the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed where instruments and processes described in the HCBS Waiver were applied; Denominator: Number of LOC assessments 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☑ **Other**<br>Specify:<br>DMS reviews 20% of the charts reviewed by DDS during Individual File Reviews, as a validation review. |

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**AA5: Number and percentage of participant service plans completed by DDS in the time frame specified in the agreement with the Medicaid Agency. Numerator: Number of service plans completed by DDS in the time frame specified; Denominator: Number of service plans 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☑ **Continuously and Ongoing** | ☑ **Other**<br>Specify:<br>DMS reviews 20% of the charts reviewed by DDS during Individual File Reviews, as a validation review. |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**AA6: Number and percentage of participants with delivery of at least one HCBS Waiver service per month as specified in the service plan in accordance with the agreement with the Medicaid Agency. 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** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**AA7: Number and percentage of providers certified by DDS. Numerator: Number of current providers certified by DDS; Denominator: Number of providers participating in the HCBS Waiver program.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Medicaid Quarterly QA Report (Validation Chart Reviews)**

| **Responsible Party for data collection/generation** | **Frequency of data collection/generation** | **Sampling Approach***(check each that applies):* |
|---|---|---|

| *(check each that applies):* | *(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 Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Provider 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:**
**AA8: Number and percentage of policies and/or procedures 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**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Developmental Disabilities Services (the operating agency) and the Division of Medical Services (Medicaid agency) participate in periodic team meetings to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DDS and DMS have an Interagency Agreement for measures related to administrative authority of the HCBS Waiver.

In cases where the numbers of active (point-in-time) participants and 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, as part of the Interagency Agreement. In cases where policy or procedures were not reviewed and approved by DMS, remediation includes DMS reviewing the policy upon discovery, and approving or removing the policy.

In cases where there are problems with level of care determinations completed where instruments and processes were not followed as described in the waiver, or were not completed within specified time frames, additional staff training, staff counseling or disciplinary action may be part of remediation. Similarly, remediation for service plans not completed in specified time frames includes completing the service plan 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 at least one waiver service a month in accordance with the service plan and the agreement with DMS includes closing a case, conducting monitoring visits, revising a service plan 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.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-1: Specification of the Waiver Target Group(s)

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ☐ Aged or Disabled, or Both - General | | | | | |
| | ☐ | Aged | | | ☐ |
| | ☐ | Disabled (Physical) | | | |
| | ☐ | Disabled (Other) | | | |
| ☐ Aged or Disabled, or Both - Specific Recognized Subgroups | | | | | |
| | ☐ | Brain Injury | | | ☐ |
| | ☐ | HIV/AIDS | | | ☐ |
| | ☐ | Medically Fragile | | | ☐ |
| | ☐ | Technology Dependent | | | ☐ |
| ☑ Intellectual Disability or Developmental Disability, or Both | | | | | |
| | ☑ | Autism | 0 | | ☑ |
| | ☑ | Developmental Disability | 0 | | ☑ |
| | ☑ | Intellectual Disability | 0 | | ☑ |
| ☐ Mental Illness | | | | | |
| | ☐ | Mental Illness | | | |
| | ☐ | Serious Emotional Disturbance | | | |

**b. Additional Criteria.** The State further specifies its target group(s) as follows:

Note: Persons with intellectual disability and developmental disability are both 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 he has an intellectual disability.

DDS eligibility is established by Arkansas Code Annotated, Section 20-48-101. The statute applies to Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID) and the HCBS Waiver. DDS interprets a developmental disability to be (a) a categorically qualifying diagnosis and (2) significant adaptive behavior deficits related to this diagnosis.

Cerebral Palsy is established by the results of a medical examination provided by a licensed physician.

Epilepsy is established by the results of a neurological examination provided by a licensed physician.

Autism is 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 is established by the results of a medical examination provided by a licensed physician.

Spina Bifida is established by the results of a medical examination provided by a licensed physician.

Intellectual Disability is 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** | 8668 |
| **Year 2** | 8668 |
| **Year 3** | 8668 |
| **Year 4** | 8668 |
| **Year 5** | 8668 |

**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** | |
| **Year 2** | |
| **Year 3** | |
| **Year 4** | |
| **Year 5** | |

## 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).**

## 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:

Selection for participation is in order of waiver eligibility determination date.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

**Waiver Phase-In/Phase-Out Schedule**
Based on Waiver Proposed Effective Date: 07/01/14

**a. The waiver is being** (select one):

- (●) **Phased-in**
- ( ) **Phased-out**

**b. Phase-In/Phase-Out Time Schedule.** *Complete the following table:*

**Beginning (base) number of Participants:** 4143

**Phase-In/Phase-Out Schedule**

**Waiver Year 1**
**Unduplicated Number of Participants: 8668**

| Month | Base Number of Participants | Change | Participant Limit |
|---|---|---|---|
| Jul | 4143 | 80 | 4223 |

**Waiver Year 2**
**Unduplicated Number of Participants: 8668**

| Month | Base Number of Participants | Change | Participant Limit |
|---|---|---|---|
| Jul | 6037 | 189 | 6226 |

| | | | |
|---|---|---|---|
| Aug | 4223 | 80 | 4303 |
| Sep | 4303 | 140 | 4443 |
| Oct | 4443 | 140 | 4583 |
| Nov | 4583 | 160 | 4743 |
| Dec | 4743 | 160 | 4903 |
| Jan | 4903 | 189 | 5092 |
| Feb | 5092 | 189 | 5281 |
| Mar | 5281 | 189 | 5470 |
| Apr | 5470 | 189 | 5659 |
| May | 5659 | 189 | 5848 |
| Jun | 5848 | 189 | 6037 |

| | | | |
|---|---|---|---|
| Aug | 6226 | 189 | 6415 |
| Sep | 6415 | 189 | 6604 |
| Oct | 6604 | 189 | 6793 |
| Nov | 6793 | 189 | 6982 |
| Dec | 6982 | 189 | 7171 |
| Jan | 7171 | 218 | 7389 |
| Feb | 7389 | 218 | 7607 |
| Mar | 7607 | 238 | 7845 |
| Apr | 7845 | 238 | 8083 |
| May | 8083 | 298 | 8381 |
| Jun | 8381 | 287 | 8668 |

**Waiver Year 3**
**Unduplicated Number of Participants: 8668**

| Month | Base Number of Participants | Change | Participant Limit |
|---|---|---|---|
| Jul | 8668 | 0 | 8668 |
| Aug | 8668 | 0 | 8668 |
| Sep | 8668 | 0 | 8668 |
| Oct | 8668 | 0 | 8668 |
| Nov | 8668 | 0 | 8668 |
| Dec | 8668 | 0 | 8668 |
| Jan | 8668 | 0 | 8668 |
| Feb | 8668 | 0 | 8668 |
| Mar | 8668 | 0 | 8668 |
| Apr | 8668 | 0 | 8668 |
| May | 8668 | 0 | 8668 |
| Jun | 8668 | 0 | 8668 |

**Waiver Year 4**
**Unduplicated Number of Participants: 8668**

| Month | Base Number of Participants | Change | Participant Limit |
|---|---|---|---|
| Jul | 8668 | 0 | 8668 |
| Aug | 8668 | 0 | 8668 |
| Sep | 8668 | 0 | 8668 |
| Oct | 8668 | 0 | 8668 |
| Nov | 8668 | 0 | 8668 |
| Dec | 8668 | 0 | 8668 |
| Jan | 8668 | 0 | 8668 |
| Feb | 8668 | 0 | 8668 |
| Mar | 8668 | 0 | 8668 |
| Apr | 8668 | 0 | 8668 |
| May | 8668 | 0 | 8668 |
| Jun | 8668 | 0 | 8668 |

**Waiver Year 5**
**Unduplicated Number of Participants: 8668**

| Month | Base Number of Participants | Change | Participant Limit |
|---|---|---|---|
| Jul | 8668 | 0 | 8668 |
| Aug | 8668 | 0 | 8668 |
| Sep | 8668 | 0 | 8668 |
| Oct | 8668 | 0 | 8668 |
| Nov | 8668 | 0 | 8668 |
| Dec | 8668 | 0 | 8668 |

| | | | |
|---|---|---|---|
| Jan | 8668 | 0 | 8668 |
| Feb | 8668 | 0 | 8668 |
| Mar | 8668 | 0 | 8668 |
| Apr | 8668 | 0 | 8668 |
| May | 8668 | 0 | 8668 |
| Jun | 8668 | 0 | 8668 |

**c. Waiver Years Subject to Phase-In/Phase-Out Schedule**

| Year One | Year Two | Year Three | Year Four | Year Five |
|---|---|---|---|---|
| ☑ | ☑ | ☐ | ☐ | ☐ |

**d. Phase-In/Phase-Out Time Period**

| | Month | Waiver Year |
|---|---|---|
| Waiver Year: First Calendar Month | Jul | |
| Phase-in/Phase-out begins | Jul | 1 |
| Phase-in/Phase-out ends | Jun | 2 |

# 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)***

- ☑ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional State supplement recipients**
- ☑ **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)**

☑ **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)**

☑ **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.

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***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*

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○ **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 4)

*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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

**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 *(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 4)

**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:*

  The maintenance needs allowances is equal to the individual's total income as determined under the post-eligibility process which includes income that is placed in a Miller trust.
- **Other**

  *Specify:*

**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 4)

**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 4)

**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-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 ICF/IID requires the same type of evaluations. These include an evaluation of functional abilities that does not limit eligibility to persons with certain conditions, an evaluation of the areas of need for the person, a social history, and psychological evaluation applicable to the category of developmental disability, which are intellectual disability, cerebral palsy, epilepsy, autism, spina bifida, Down syndrome or other condition that causes a person to function as though they have an intellectual disability or developmental disability. The DDS Psychology Team is responsible for determining initial eligibility for the HCBS Waiver. This eligibility process mirrors eligibility for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) institutional care. The same criteria as specified in "B1b" is applied for both HCBS Waiver and ICF/IID initial evaluations and reevaluations, unless CMS determines that annual reevaluations may be waived.

According to 42 CFR 435.1009, Ark. Code Ann. §20-48-101 et seq. and DDS Policy 1035, Eligibility, DDS Psychology Team uses the same criteria to determine eligibility for HCBS Waiver as for ICF/IID. The criteria are: verification of a categorically qualifying diagnosis; age of onset established prior to age 22; substantial functional limitations in activities of daily living (adaptive functioning deficits) are present and are as a result of the categorically qualifying diagnosis; and the disability and deficits are expected to continue indefinitely. Adaptive functioning deficits are defined as an individual's inability to function in 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.

The DDS Psychology Team will consider any standardized evaluation of intellect and adaptive behavior deemed appropriate by the licensed professional completing the evaluation. 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 composed of psychological examiners and psychologists (employed or contracted) 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 licensed 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, unless CMS determines that annual reevaluations may be waived. DDS requires that 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, unless CMS determines that annual reevaluations may be waiver, and before the end of the current plan year, DDS notifies the HCBS Waiver provider of the need for plan renewal and the date for the next full evaluation by the DDS Psychology Team. Prior to the expiration of the current plan, the HCBS Waiver provider must submit a functional evaluation completed by a QDDP, unless CMS determines that annual reevaluations may be waived. The provider must submit a prescription from the person's physician. For a full evaluation by the DDS Psychology Team, the provider must submit IQ testing report, if required, and adaptive functioning test results, based on age.

1) For persons over the age of five, the diagnosis is established as consistently measured by scores of intelligence which fall two or more standard deviations below the mean of a standardized test of intelligence, administered by a licensed professional.
2) For children birth to five, the diagnosis is established as consistently measured by developmental scales, administered by qualified personnel authorized in the manual accompanying the instrument used, which indicate impairment of general functioning similar to that of a person with an intellectual or developmental disability.

For children who have not finished school, initial eligibility will be based upon adaptive functioning testing and IQ testing performed every three years. For persons who have completed school, initial eligibility will be based upon adaptive functioning testing and IQ testing performed once after age twenty-two. Thereafter, a current adaptive behavior evaluation is required every five years. Evaluation may be required by DDS on a more frequent basis if information suggest that adaptive behavior or IQ scores have changed to the degree that eligibility is questioned.

Eligibility for waiver services is presumed when the person is eligible and receiving services in an ICF/IID.

Eligibility for persons with co-occurring diagnoses of intellectual disability or developmental disability and mental illness is established when the DDS Psychology Team has determined that the primary disability for the person is the intellectual or developmental disability, not the mental illness.

DDS reserves the right to require an evaluation of eligibility at any time.

**e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

**f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

DDS evaluates all applicants using the process described in B6d for the initial application for ICF/IID and waiver services. The completed application packet is sent to the DDS Psychology Team who reviews the information, makes a determination of eligibility and documents the determination on Form DDS 704.
DDS requires that, annually, providers send documentation of a standard functional assessment conducted by a QDDP of 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. DDS will discontinue the annual reevaluation process if CMS agrees to waive that requirement.

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, but will not conduct any testing or evaluations themselves.

If an individual disagrees with an eligibility determination, they may appeal to the Assistant Director for Program Management 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:*

Reevaluations of the level of care will be conducted no less frequently than annually; unless, it is determined that there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity. In such cases DDS will permanently waive the annual recertification requirement for these individuals.

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:*

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 Waiver section 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**
   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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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**<br>Confidence Interval = 95% with a +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 B 1: Number and % of participants who received an annual redetermination of LOC eligibility, as required, within 12 months of their initial or last LOC evaluation. Numerator: Number of participants who received an annual redetermination of LOC eligibility within 12 months of their initial or last LOC evaluation. Denominator: Total number of participants due for annual redetermination.**

**Data Source** (Select one):

**Other**
If 'Other' is selected, specify:
**Automated Plan of Care (APC) System**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

c. ***Sub-assurance: The 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 eligibility. Numerator: Number of participants' packets with appropriate process and instruments used to determine eligibility; Denominator: Number of participant's packets reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Report of Utilization of Appropriate Process and Instruments.**

| **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% confidence level +/- 5% margin of error. |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 and flags applications over 90 days old and generates an alert to the Intake Manager. 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 DDS ACS 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 a representative sample (calculated by RaoSoft or similar tool) 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.
(LOC C2)The DDS Psychology Team manager reviews a representative sample (calculated by RaoSoft or similar tool) of all initial HCBS Waiver application determinations after the end of each month for outcome and adjudication accuracy. The sample will include 100% of the denials, with the remainder being approvals. The manager will utilize the Psychology Worksheet Decision form and data generated from EDoctus through an excel spread sheet to determine the number and percentage of accurately adjudicated LOC Determinations. The Psychology manager submits a quarterly report to the QA Assistant Director with an outline of needed corrective procedures.

ii. **Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

***Freedom of Choice.*** *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

*i. informed of any feasible alternatives under the waiver; and*
*ii. given the choice of either institutional or home and community-based services.*

a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Intake and referral for the HCBS Waiver is the responsibility of DDS Children's Services Section for persons birth to 21 if still in high school and of DDS Quality Assurance 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/IID 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/IID placement. For persons residing in an ICF/IID, choice between the programs is offered annually at the time of their annual individual program plan review. Anyone residing in an ICF/IID 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 continued stay review. The choice form provides for minimal tracking identifiers to assure the individual maintains applicable and timely considerations regarding their choices. It also provides for supporting evidence that the options elicit an informed choice as attested to by the signature of the implementing DDS representative. These forms are maintained in the DDS Central Office for applicants and in the case files for HCBS Waiver participants with information entered into the data base.

**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. A copy of the person's file is also maintained by the HCBS Waiver provider chosen by the person. 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 | Supported Employment | | |

## 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:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition** *(Scope):*
Case management services include responsibility for guidance and support in all life activities including locating, coordinating and monitoring the following services. Case management services must be coordinated with the direct service provider. For example, assessment of risks and plan development must, by necessity include the direct service provider. A key component of case management is coordination with all members of the interdisciplinary team, in order to develop a plan based on the needs and desires of the individual. The case manager should ensure that the individual has the opportunity to engage and direct the process to the extent they wish, ensure that those whom the person wishes to attend are provided with adequate notice, ensure that the planning process is timely, that needs are assessed and service meeting the needs and the responsibilities are identified. This does not mean that the case manager has decision-making authority over the services included in the plan.
1. All proposed HCBS Waiver services;

2. Other state plan services such as Community First Choice Program (1915(k));

3. Needed medical, social, educational and other publicly funded services regardless of the fund source,

4. Informal community supports needed by eligible persons and their families.

The intent of case management is to assist persons so that they may access a full range of appropriate services in a planned, coordinated, efficient and effective manner.

Case managers are responsible for the following activities:

1. Attendance at all case planning meetings,
2. Arranging for the provision of services and additional supports;
3. Arranging for Counseling and Financial Management Services, if the person is participating in the Consumer-directed model under the Community First Choice Option (CFCO)
4. Monitoring and reviewing services included in the person's service plan;
5. Monitoring and reviewing services provision in order to assure health and safety of the individual;
6. Conducting risk assessment, identifying backup supports and measures to mitigate the risk, and incorporating risk management strategy into the service plan;
7. Facilitating crisis intervention;
8. Providing guidance and support to obtain generic services;
9. Ensuring that the individual's needs are assessed, with resulting referrals to needed resources;
10. Ensuring that revisions are made to the service plan when the individual's needs change,
11. Monitoring to ensure quality of care and to assess if the person is progressing toward meeting goals and objectives in the service plan;
12. Providing assistance in obtaining and maintaining eligibility for Medicaid HCBS Waiver eligibility and ICF/IID level of care eligibility determination;
13. Assuring the integrity of all case management Medicaid HCBS Waiver billing.
14. Assuring timely submission of behavior and assessment reports, continued service plans, revisions as needs change and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;
15. Arranging for access to advocacy services in the event that case management and direct care supervision are provided by same provider entity. (The case manager and the direct care supervisor can never be the same person when the case manager and the direct care supervisor work for the same (CFCO and HCBS Waiver) provider entity).
16. Ensuring that copies of pertinent documents from DDS and service provider are made available to the individual or their legal representative;
17. Providing assistance with appeals by conducting activities such as arranging for access to advocacy service and providing the individual or his legal representative with applicable documents.

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, CFCO, or State Plan.

When a person is transitioning to HCBS Waiver services from an institution, case management services may be provided to an eligible individual during the last 180 consecutive days of their stay in an institution. The case management activities must be those that are related to the individual's needs as they transition to the community. The person must be approved and in the HCBS Waiver program for case management to be billed retrospectively.

When a person voluntarily withdraws from HCBS Waiver services, case management may be provided for up to 90 days, to allow for a transition. The transition period will allow for follow up to ensure that the person is referred to other services. It also allows time to assure that the individual understands the implications of withdrawing as well as to determine if the person was coerced or unduly influenced to withdraw. During the transition period, the individual remains enrolled in the waiver program and waiver services will continue to be available until the individual finalizes their intent to withdraw.

The case management HCBS Waiver provider can continue to provide services for up to six months when the individual is in an ineligible setting, in which reimbursement is made by private pay or private insurance and Medicaid is not reimbursing for the care. An ineligible setting is defined as when an individual is receiving services in a hospital, skilled nursing facility, or ICF/IID, or is incarcerated.

During a period of abeyance the case management provider must make face-to-face contact with the individual at least once each month. The case manager must report the status of the individual to the assigned DDS staff.
**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 person served.

The case manager must maintain regular contact with the individual in order to fulfill the responsibilities listed

above. At a minimum, the case manager must make one face-to-face visit with the individual or their legal representative each month at a location that is convenient to the individual. At least once each 12 month period, the case manager must meet with the individual at their place of residence.

**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 manager must hold the following credentials:
   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 as a case manager with individuals with a developmental disability or four years of experience as a case manager in a related field.
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:**

Supported Employment

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition** *(Scope):*

Supported employment is a collaborative service with Arkansas Rehabilitation Services (ARS). All new HCBS Waiver participants receiving supported employment must be prior certified by ARS to ensure the participant is qualified for supported employment and that ARS funding is accessed first. The provider maintains

documentation that is in the file of each participant receiving this service indicating 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 ( Sec. 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 participant'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 may include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include but not be limited to any combination of the following services: vocational/job related discovery or assessment, person-centered planning, job placement, job development, job coaching, benefits support, training and planning and other workplace support that enable the individual to be successful in integrating into the job setting.

Supported employment consists of habilitative and rehabilitative services designed to enable a person to obtain or regain competitive employment in integrated settings, earning minimum wage or above. Services include:

Employment Preparation and Career Planning Services
This service is designed to assist the individual in acquiring paid and meaningful employment. Employment Preparation and Career Planning services include an employment readiness assessment, the development of an employment plan inclusive of self-employment, and employment preparation training. The training may include:

- Attendance and punctuality
- Personal appearance
- Communication and dispute resolution
- Networking
- Completing a job application
- Resume creation
- Obtaining references
- Employer expectations
- Work incentives counseling by a trained specialist to help individuals make informed choice about employment. This may include but not be limited to explaining applicable work incentives (e.g., Ticket to Work, SSDI ); preparation of SSA PASS plans, reporting earnings, financial literacy guidance-budgeting, claiming EITC, etc.

Employment Placement
This service is designed to assist the individual in acquiring paid and meaningful employment. This service may include:

- Continuation of Pre-Employment Training
- Identification of potential jobs and employers that match the individual’s job goals and abilities
- Job search activities
- Negotiation of job creation
- Obtaining and completing job applications
- Accompanying individual to job interviews

Employment and Post-Placement Support
This service is designed to assist the individual in acquiring and retaining paid and meaningful employment. This service includes:

- Orientation to a new job
- Monitoring of job attendance, productivity, and socialization
- Monitoring employer satisfaction
- Assisting the individual with opening and maintaining a bank account
- Follow along long-term supports such as monitoring and interventions to help the individual retain a job including cueing to help the individual manage behaviors, stay focused on employment tasks

Supported employment is available when:

The service provider has determined that a participant may be able to work 15 hours or more a week in an integrated, competitive employment environment which triggers an Arkansas Rehabilitation Services (ARS) eligibility accessment;

The participant works 15 hours or more per week but is not eligible for ARS services due to lack of funding, a medical waiver, or other factors.

The participant's ARS case has reached closure.

Supported Employment cannot exceed a maximum of 32 units a day. Supported Employment provided as long term support requires monitoring at a minimum of two meetings with the participant and one employer contact each month.

**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 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:**
DDS Quality Assurance in conjunction with Arkansas Rehabilitation Services
**Frequency of Verification:**
Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Supported Employment**

**Provider Category:**

Individual

**Provider Type:**

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## 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:

DDS certified case management providers and DDS Staff.

## Appendix C: Participant Services

**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.

“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.

**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):

The AR Department of Human Services maintains two statewide central registries. The DHS Division of Children and Family Services (DCFS) maintains the child registry and the DHS Division of Aging and Adult Services (DAAS) maintains the adult registry. Prior to hiring and every two years thereafter for the child registry and every five years for the adult registry, certified providers must initiate a check of both registries for any staff that has direct, unsupervised contact with individuals served. This includes case managers as well as spouses of employees and any adult over the age of 18 residing in an alternative living arrangement or group home. In the event that a person's name is on either registry, the certified provider may not hire or retain that individual in a position that requires direct, unsupervised contact with HCBS Waiver participants. DDS Quality Assurance staff review evidence of central registry checks for each employee, as appropriate, during the annual on-site review of each provider. If DDS staff find evidence that an ineligible person is in such position, DDS staff require the provider remediate the issue immediately. Additionally, the DDS staff will include a deficiency in the report of the review and require a plan that states how the provider will ensure that no disqualified persons will be employed or remain employed in the future.

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.

## 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 HCBS 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.

Group homes, owned and operated by HCBS 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. DDS has not approved any additional group homes since July 1, 1995.

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Supported living arrangement apartments owned and operated by HCBS Waiver providers

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| Case Management | ☑ |
| Supported Employment | ☑ |

**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:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Group Homes

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|

| | |
|---|---|
| **Case Management** | ☑ |
| **Supported Employment** | ☑ |

**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:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| **Case Management** | ☐ |
| **Supported Employment** | ☐ |

**Facility Capacity Limit:**

**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:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| **Case Management** | ☐ |
| **Supported Employment** | ☐ |

**Facility Capacity Limit:**

**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:**

## 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.*

  Providers will not be reimbursed for services provided by adoptive or natural parents, step-parents or legal representatives or legal guardians of person less than 18 years old. Providers will not be reimbursed for services provided by a spouse or a legal representative of a person 18 years of age or older. "Legal representative" means an individual who has the official authority to act on behalf of another individual, and includes an attorney in fact or any other person acting in a fiduciary capacity for the HCBS Waiver participant. For any service provider, all DDS qualifications and standards must be met before the person can be approved as a paid service provider. Qualified relatives, other than as specified in the foregoing, can provide any service. 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 service plan goals and objectives. Further, reimbursement for services provided by qualified family members may not exceed payment for 40 hours per week.
- **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 a HCBS Waiver provider. DDS provides continuous open enrollment for certification as a 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. Once an organization completes an application and prepares all pertinent attachments, DDS Certification and Licensure Administrator assigns staff to review the application and provide technical assistance 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 Provider Enrollment Unit. The provider's transition from temporary to regular certification is dependent upon the provider's demonstration of compliance with DDS standards 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**

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 providers 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**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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**<br>Confidence Interval = |
| ☐ **Other** | ☐ **Annually** | ☐ **Stratified** |

| | | |
|---|---|---|
| Specify: | | 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 non-licensed/non-certified providers to assure adherence to waiver requirements.***

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:**
**NOT APPLICABLE; There are no non-certified providers.**

**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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 who complied with Standard 301.1,Eh,i; 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**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 301 5.4; 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 that providers meet and adhere to promulgated state standards regarding HCBS Waiver

providers, and identifies and rectifies situations where providers do not meet DDS requirements. Standard 301.1.E. h & i (QP C1)
301.1 All personnel shall receive initial and annual competency-based training to include, but not limited to:
E. Legal
h. Ark. Code Ann. §§5-28-101 – 5-28-109; --Abuse of Adults
i. Ark. Code Ann. §§12-12-501 – 12-12-515; --Arkansas Child Maltreatment Act
Standard 301.5.4 (QP C2)
301.5. Training Requirements for direct care staff
4. Prior to beginning service delivery, direct care staff must receive a minimum of six of the required 12 training hours in the individual's plan of care and specific health and safety needs (medication, positive behavior programming, etc.).
Standard 507 (SP A1)
507. A service needs assessment must be completed on every individual seeking services.
Standard 508.1B.3.a. 1-6 (SP A2)
508.1 The Individualized Plan of care:B.Shall Identify:
3.Long-range goals (addressing a period of 3-5 years) and annual goals
a.Individuals shall have a person-centered plan of care. The planning process shall support the individual in decision making and choosing options…
Standard 507.A (SP A3)
507. A service needs assessment must be completed on every individual seeking services. A. A Health and Safety Assurances Assessment shall be included as a component of the needs assessment in order to safeguard the individual against physical, mental and behavioral risks.
Standard 508-508.2.D (excluding 1.B.3-5) (SP B1)
508 Every individual shall have a written Individualized Plan of care
A. The organization shall include the person served and/or legal guardian as an active participant giving direction in all aspects of the planning and revision processes. The person may have other representatives present as desired.
B. Services shall be provided based on the choices of the individual/parent/guardian (as appropriate) and on the strengths and needs of the individuals to be served by the organization
C. Individual choice shall be determined by a comprehensive assessment… psychological information

508.1 The Individualized Plan of care:A. Shall be developed and implemented with the input of the person served and/or their legal guardian.
B. Shall Identify:
1. Most appropriate environment
2. Barriers
6. A Back up plan to ensure continuity of care and health and safety of the individual.
508.2 Short-term objectives (3-6 months) may be either habilitative in nature or service related objectives. Short-term objectives shall be developed and implemented, as needed, for each annual goal. Objectives describe sequential steps and expected outcomes needed to reach the annual goal.
Standard 509 B (SP C1)

509 Continued Stay Review Service Objectives
B. The organization shall develop and implement a new plan annually and submit to DDS for approval.
Standard 509 A (SP C2)
509 Continued Stay Review
Service Objectives A. Shall be reviewed on a regular basis with respect to expected outcomes.
Standard 510 (SP C2)
510 Every 90 days of service delivery, the service provider shall complete a quarterly report on the goals/objectives of the plan of care.
Standard 508.1.B.4 & 5 (SP D1)
508.1 The Individualized Plan of care:
B. Shall Identify:
4. Specific measurable objectives.
5. Daily schedule of direct service hours
Standard 508.2.E.1-3 (SP D1)
508.2 E. Target dates (for habilitation goals).

DDS issues a Temporary Certificate to a prospective provider after the submission of required documents, such as Articles of Incorporation, by-laws, and policies and procedures which comply with promulgated state standards. Upon notification of service provision from the "temporarily certified" provider, DDS Certification and Licensure staff conducts an onsite review to determine compliance with standards. DDS Certification and

Licensure staff also conduct annual onsite reviews of every certified provider.

**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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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.*

- [ ] **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 D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**

**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:*

  Safeguards-full disclosure: DDS states in several documents that DDS allows entities that develop the service plan to also provide other direct services. These documents include the Waiver Application; forms explained to and signed by the person served, at the start of services and at least annually; and in informational documents located on the DDS and the Arkansas Waiver Association (AWA) websites.
  Safeguards-people are supported in exercising their right to free choice of providers: The Waiver Handbook posted on the DDS, the DDPA and the AWA website explains the right to free choice of providers. The Rights and Choice Form provided to each person initially, annually and as requested states, "I have the right to change providers at any time I may choose without fear of retaliation". People with complaints regarding the exercise of their right to free choice may call DDS QA section, which will investigate the complaint in compliance with DDS Policy 1010, Service Concern Investigation. DDS Waiver Section staff and the DDS Ombudsman also support people in exercising their right to freedom of choice.
  Safeguards-provision of information about the full range of HCBS Waiver services: The documents noted above

provide information about the full range of HCBS Waiver services, not just the services that are offered by the entity that is responsible for the person's service plan development. DDS staff offers choice when a person is initially approved for services, annually, and upon request, including choice of a different entity or individual to develop the person's service plan. People with complaints about information regarding the full range of HCBS Waiver services may call DDS QA, which will investigate the complaint. DDS section conducts an on-site review of each provider annually and cites deficient practices in the area of free choice. DDS conducts Adult Satisfaction Surveys under the National Core Indicator (NCI) Project with a random sample of people served, which provides data on the level of satisfaction with freedom of choice.
Safeguards-option to choose a different entity or individual to develop the plan: DDS prohibits the same person from serving as the person's case manager and their direct service staff. DDS Waiver Section offers choice when a person is initially approved for services, annually, and upon request. This includes the choice of a different entity or individual to develop the person's service plan. People with complaints about the person or entity which provides service plan development may call DDS QA, which will investigate the complaint.
Safeguards-direct oversight of the process or periodic evaluation by a state agency: DDS Waiver Section offers choice of provider when a person is initially approved for services, annually, and upon request. DDS Quality Assurance conducts an on-site review of each provider annually and cites deficient practices in the area of free choice of the entity or individual who develops each person's service plan. People with complaints about the process may call DDS QA, which will investigate the complaint.
Safeguards-restricting the entity that develops the plan from providing services without the direct approval of the state: DDS Quality Assurance must certify each entity that provides services, prior to the entity's enrollment with Medicaid and the provision of services. Case managers who assist in the development of service plans must meet criteria established by DDS standards and verified by the certified provider.
Safeguards-the agency that develops the plan must administratively separate the plan development function from the direct service provision function: DDS prohibits the same person from serving as the person's case manager and their direct service staff. DDS standards specify criteria for individuals who serve as case managers and for individuals who provide direct services and prohibit one person from serving in both capacities. DDS QA verifies compliance with this prohibition during an on-site review of each provider annually and cites deficient practices when necessary.
Safeguards-controlling content of plan: Independent assessment of the person served sets a service need level and an annual budget for each person. The service plan is developed by the case manager, in conjunction with the person served and an interdisciplinary team of the person's choosing, which may include DDS staff. A copy of the plan is sent to DDS to be available for retrospective quality review by DDS and DMS. DDS QA conducts an on-site review of each provider annually and cites deficient practices when the person's plan does not address needs, is not being implemented, or is not updated as required. People with complaints about the content of the plan may call DDS QA to investigate. DDS conducts Adult Satisfaction Surveys under the NCI Project with a random sample of people served, which provides data on the level of satisfaction with the service plan.

## 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 Quality Assurance starts the flow of information about the person's direction of and engagement in service plan 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 Waiver Section 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 service plan 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 service plan, provider choice, and rights and responsibilities.

The person served may invite any person they choose to participate at any step of the service plan development process. DDS Waiver Section staff and the chosen provider inform the person and invited advocates about any confidentiality and conflict of interest issues. DDS prohibits a provider from participating or advocating for a person served by a different provider.

The case manager is mandated to participate as the person who will develop, oversee implementation, and update the

service plan. DDS Waiver Section 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, direct support persons (paid and unpaid) may accompany the individual to all or part of planning conferences to help assure that the person understands the discussion and can make their desires understood. The chosen case manager must attend planning conferences to help assure that the person served expressed their needs and desires and these are accounted for in the plan. Advocates chosen by the individual may also assist the person.

If the case manager fails to include the person served and any legal representative in the service plan development process, the plan is not a valid service plan. DDS Waiver Section staff provide information to the person served regarding their direction of and engagement in the service plan development process. People with complaints about a person's direction of, engagement in, or satisfaction with the outcome of the service plan 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 service plan development process.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a. Temporary Service Plan (TSP):

DDS has provisions in place so that when a person accesses HCBS Waiver services for the first time, an interim service plan may be developed in order to initiate services in advance of the finalization of a full service plan. After an individual has chosen both his/her case management and direct service providers, DDS issues an Interim Service Plan that authorizes the provision of case management for up to three months and if the person chooses support services through CFCO. The provider may develop and submit the full plan at any time during the three month period.

DDS waiver staff track the expiration dates of TSPs and ensure that a full service plan is complete before the temporary plan expires. The area manager may grant an extension of the three month timeframe if the case manager submits an acceptable justification for why the extension is necessary.

b. Service Plan:
1. Development, Participation and Timing
The case manager is responsible for scheduling and coordinating the plan development meeting, including inviting other participants and making sure that the location and the participants are acceptable to the HCBS Waiver participant. If the HCBS Waiver participant objects to the presence of any individual, that person may not attend the meeting. Aside from any objections from the HCBS Waiver participant or his/her 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 HCBS Waiver participant may attend the meetings. DDS waiver staff will attend if the HCBS Waiver participant invites them.

2. Assessment Types, Needs, Preferences, Goals and Health Status
Prior to development of the service plan, 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 determine 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 a risk assessment. Licensed therapists conduct applicable assessments. Other assessments which do not required a licensed person, are conducted by persons who are most familiar with the individual.

3. Information regarding availability of services
The DDS Waiver staff informs the participant of available waiver services at the time of initial application and again when they offer choice. The case manager has the responsibility to present information regarding service availability during the service plan development process.

4. Addressing goals, needs and preferences and assignment of responsibilities
DDS prescribes the use of a format that requires that plan developers address how the team discussed, planned for and incorporated the individual's goal, needs (including health care needs), and preferences. The form also requires that the developers designate who is responsible for implementation of and monitoring the plan. During the oversight process conducted by DDS, each entity reviews the plan to make sure that the plans include the necessary information. Additionally, during the onsite review of each provider, Certification and Licensure staff review plans to make sure all elements are included.

5. Service Coordination
The case manager has the responsibility for coordinating and monitoring the implementation of all services identified in the service plan, including waiver, state plan and generic services. The case manager must coordinate with the direct service providers to ensure quality service delivery.

6. Updating plans
The case manager is responsible for making sure that the plan is updated at least annually. They are also responsible for making sure that the plan is reviewed quarterly so that the team may identify goals that may need to be added, removed or revised. The team uses the data gathered by the implementer of the service plan as they work with the individual to determine if goals should change. The team also relies on input from the individual regarding whether they want to work on new or revised goals.

7. Participant Engagement
From the time an individual first makes contact with DDS to apply for HCBS Waiver services, they are informed of their rights to make choices about each aspect of the services that are available. It is the responsibility of every person at the state and the provider level to make sure that the individual is aware of and exercises his/her rights. During the planning meeting, every person present is responsible for supporting and encouraging the individual to express his/her wants and desires and to then incorporate those into the plan.

## 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 service plan 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 plans 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 plan 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 service plan. Each provider must specify the type of back-up arrangements that are employed, and make sure that each plan 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.

Annually, DDS Waiver Section 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/IID. DDS Waiver Section staff also offer a choice of a different provider initially as services begin, annually, and upon request. DDS Waiver Section 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. 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):

DDS establishes and promulgates standards for the development, implementation, and revision of service plans. DDS Quality Assurance conducts an on-site review of each provider annually to determine compliance with these Standards and cites deficient practices in the area of service plan development. Provider case managers, in coordination with the person served and service providers, are responsible for the development of the service plan and must include all components of an acceptable service plan as described in Appendix D.1.d and D.1.e. The provider may implement a service plan without prior approval from DDS, provided the plan is based on the person's assessed needs, input, service need level, and annual budget.

DMS retains responsibility for service plan approval and reviews a sample of service plans retrospectively. To provide plans for this review, DMS requires providers to submit an electronic copy of the service plan, 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.

DDS Waiver Section staff determine compliance with HCBS Waiver assurances by performing a retrospective review of a representative sample of files. DDS Waiver Section staff collects data, aggregates the data, and takes remediation action as needed.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case management provider, DDS staff, DDS Certification and Licensure staff and DMS Quality Assurance staff are responsible for monitoring the implementation of the service plan and participant health and welfare.

The case management provider is charged with the first-line responsibility for monitoring the implementation of the service plan and the participant health and welfare. They must maintain regular contact with the individual, making one face-to-face contact with the individual or their legal representative each month at a location that is convenient to the individual. 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 plan.

DDS Standards also require that the case manager, along with the team, must review the plan 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 plan.

DDS staff conducts a file review and a random on site review of service plans. 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 service plan as it is renewed but may be conducted more frequently when problems requiring remediation are identified.

DDS Quality Assurance staff conduct annual onsite reviews of every certified provider. 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 service plan and the health and welfare of the individual. If any of the processes reveal a problem with implementation of the plan, 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 service plans 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:*

Safeguards to ensure that those monitoring the implementation of the service plan and the health and welfare of each person act in the best interests of the person served:

DDS staff provide choice of the entity that develops and implements the service plan and monitors the person's health and welfare to persons served. DDS provides people with the opportunity to choose a provider initially when services begin and to change their provider at any time they choose. DDS staff asks people why they have requested a change of providers. When the person says they are dissatisfied with the provider's monitoring of the implementation of the person's service plan or monitoring of the health and welfare of the person, DDS staff refer to DDS Quality Assurance as a service concern.

People with complaints about the implementation of a person's service plan or the monitoring of a person's health and welfare 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 how the provider monitors the implementation of the service plan and how the provider monitors the health and welfare of each person served. DDS can impose enforcement remedies, including revocation of the provider's certification, if deficiencies are not corrected by the provider in a manner and timeframe acceptable to DDS.

When a person complains to the provider about how its staff have monitored the implementation of the service plan or monitored the health and welfare of the person, DDS standards require the provider to offer the person an internal grievance process to attempt to settle the complaint. When the outcome of the provider complaint process is not satisfactory to the person, the person may appeal to DDS under DDS Policy 1076, Appeals.

## 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**

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 who complied with Standard 507 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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 who complied with Standard 508.1B, 3a1-6 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>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 who complied with Standard 507A Denominator: Total number of provider agencies reviewed or investigated.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Report of Service Plan Risk Factor Deficiencies**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| | | |

| | | |
|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**b.** ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 B1: Number and percentage of providers who developed service plans in accordance with procedures described in the HCBS Waiver application. Numerator: Number of provider agencies who complied with Standard 508 – 508.2.D (excluding 508.1.B.3-5) Denominator: Total number of provider agencies reviewed or investigated.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Report of Service Plan Procedure 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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 who complied with Standard 509B 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>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 who complied with Standard 509A or 510. 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 and duration specified in the service plan. Numerator: Number of provider agencies who complied with Standard 508.1.B.4,5 and 508.2.E.1-3. 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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 E1: 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 institutional care or HCBS Waiver services. Numerator: # of participants who were offered choice documented by signed freedom of choice form specifying institutional care or waiver services; Denominator: # 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**<br>Confidence Interval = 95% with a +/- 5% margin of error |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**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** | ☐ **Weekly** | ☐ **100% Review** |

| | | |
|---|---|---|
| **Agency** | | |
| ☑ **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 service plan 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 service plans 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 plans address assessed needs, personal goals, risk factors, and were developed according to established procedures. They also review to determine if plans are updated annually or when needs change.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If deficiencies are cited based on any of the deficiencies relative to the performance measures stated above as a result of an annual onsite certification review of a certified provider, DDS gives the provider an opportunity to develop a plan of correction. The plan of correction must address how individual problems have been resolved as well as what processes the provider will put in place to assure the deficiencies do not occur again in the future. After receipt of an acceptable plan of correction, depending on the severity of the cited deficiencies, DDS staff either issues a Certificate, or returns for a follow-up onsite review. If the follow-up review reveals that the provider has not successfully corrected the deficiencies, DDS may impose an array of enforcement remedies, and may ultimately revoke the certification of the provider.

DDS maintains investigative staff so that, on an ongoing basis, they may investigate any complaints regarding the provider. Utilizing a process similar to certification, DDS requires a plan of correction, referred to in this case as an Assurance of Adherence to Standards, and may impose enforcement remedies and revoke certification if the provider does not comply with requirements.

When DDS determines, during a certification review or an investigation, that the provider has not met the requirements in any of the standards mentioned above, the provider is cited and must submit an acceptable plan of correction. The plan must include an attestation that the deficiency has been corrected for the specific individuals on which the deficiency was written, as well as a description of the processes the provider will put in place to assure the deficiencies do not occur again in the future.

Ninety days prior to the end of the service plan year, DDS sends Choice Forms which offer the participant choice 1) between institutional care and HCBS Waiver services and 2) among qualified providers who serve the area in which they reside. DDS will mail another set of forms to the individual if they have not returned the appropriately completed and signed forms 60 days prior to the end of the service year. If DDS has not received the forms within 45 days prior to the plan year end, the case manager will meet with the individual to obtain the forms.

**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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 program denial of ICF/IID 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;

3) Service denials;

4) Chosen providers non-acceptance of the case; and

5) Case closure.

The right to change choice 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 re-education at each annual continued stay 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 the provider in accordance with DDS Appeals Policy 1076 . A copy of the policy is enclosed with the notice to the individual or the legal representative. The notice with the enclosure is sent both through regular and certified mail. A copy of the notice is also forwarded to the individual's chosen case manager. This policy provides for resolution by the applicable DDS Assistant Director or designee and specifies, "If a participant is not satisfied with the result of the administrative review a fair hearing may be requested." Within ten working days of receiving the decision of the administrative review, an appeal may be filed with the Office of Policy and Legal Services (OPLS), Office of Appeals and Hearings.

Requests for fair hearing shall include:

1) The name, address, and telephone number of the person filing the appeal;

2) The relationship of the person who is filing the appeal to the individual requesting or receiving waiver services;

3) The decision that is being appealed;

4) The reasons the decision is being appealed;

5) The desired outcome of the appeal;

6) The law or facts that are being relied upon in the filing of the appeal;

7) The person who will present the appeal; and

8) Whether the person will be represented and, if so, the name, address and telephone number of the representative. This is not limited to legal representation.

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 may continue during the appeal process if a fair hearing is requested and the service provider agrees to assume the risk of nonpayment for services delivered during this time. If the HCBS Waiver participant does not request a fair hearing during the time allowed the case will be closed.

## 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 the person making the complaint. The investigator must begin the fact finding process within one day of initiation of the investigation and must complete the investigation within 30 days, unless granted an extension for cause. The investigator may conduct an onsite visit to conduct face-to-face interviews with involved parties as well as reviewing pertinent documents and records. The investigator provides a written report to the certified provider and to the individual making the complaint. If the investigator substantiates the complaint, they issue a deficiency to the certified provider and request an Assurance of Adherence to Standards which must explain how they will remedy the situation with the individual involved as well as how they will prevent similar situations from occurring in the future.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Arkansas Child Maltreatment Act, Ark. Code Ann. §12-18-101 et seq., and the Arkansas Adult Maltreatment Act, Ark. Code Ann. §12-12-1701 et seq. defines the acts that are considered abuse or neglect. The acts define who is a mandated reporter and includes employees of DDS Certified HCBS Waiver Providers. Failure on the part of a mandated reporter to report suspected abuse or neglect is a criminal offense. The AR Department of Human Services (DHS), Division of Children and Family Services and the Arkansas State Police, Crimes Against Children Division (CACD) are responsible for investigation of allegations regarding children. The DHS Division of Aging and Adult Services is responsible for investigation of allegations regarding adults.

DHS Incident Reporting Policy 1090 and DDS Certification Standards for HCBS Waiver Services, Section 406 describe the incidents that the certified providers must report to DHS, DDS. The certified providers must report incidents, using automated form DHS 1910 via secure e-mail, to the DDS Quality Assurance Certification and Licensure section within two working days following the incident. In instances that might be of interest to the media, the incident must be immediately reported to the DHS Communication Director. Providers must also report suicide, death from adult abuse or child maltreatment, or a serious injury within one hour of occurrence, regardless of the hour.

The following is a list of the incidents which must be reported and are tracked by DDS. However, the State does not require follow-up or investigation of each listed incident. A description of how DDS makes the determination that follow-up action is required and by whom is described in Item G-1-d. Specifically, DDS has designated the following incidents as critical and sufficiently serious as to require follow-up; 1)attempted suicide, 2)suspected abuse or neglect, 3)elopement, 4)use of restrictive interventions, 5)death, and 6) arrest.

Incidents which must be reported (but are not necessarily considered critical):
1. Adult abuse, maltreatment, and exploitation Ark. Code Ann. §12-12-1701 et seq.;
2. Child maltreatment and severe maltreatment Ark. Code Ann §12-18-101 et seq.;
3. Disturbance, meaning any situation in which a person, served by DHS, employee or member of the general public engage in threatening or disruptive behavior of such a nature that it causes fear of imminent injury or destruction of property;
4. Serious or significant injuries;
5. Incidents which include:
a. Significant injury or death;
b. Serious injury to a person;
c. Threatened or attempted suicide of a person in DHS custody;
d. Arrest or conviction of a person in DHS custody or a DHS employee while on duty;
e. Any situation where the location of any person in DHS custody is unknown and cannot be determined within two hours;
f. Any crime committed at a DHS office, institution or facility;
g. Any communicable disease resulting in quarantine or closing of a DHS facility;
h. Any condition or event that prevents the delivery of DHS services for more than two hours.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DDS provides training and information to participants and legally responsible persons in the form of the "Arkansas Guide to Services for Children with Disabilities" and the "Arkansas Guide to Services for Adults with Disabilities",

The DDS Waiver Handbook, and the DDS website. DDS Quality Assurance investigations staff will provide training to providers regarding the reporting requirements contained in the Certification Standards for HCBS Waiver Services. Additionally, the Certification Standards require that certified providers provide training to all staff regarding the prevention of adult and child maltreatment, reporting adult and child maltreatment and DHS and DDS requirements for reporting incidents. The requirement stipulates that the provider conduct this training each year. The HCBS Waiver Certification Standards also require that certified providers inform all participants of their rights and provide support and training to them so that participants may recognize attempts to exploit them.

The DHS Division of Children and Family Services (DCFS) provides statewide training on child abuse and neglect prevention, as well as how to report suspected abuse or neglect. The DHS Division of Aging and Adult Services provides statewide training regarding adult maltreatment.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The DHS Division of Aging and Adult (DAAS), Adult Protective Services, (APS) receives reports of critical events designated as adult abuse or neglect and investigates those allegations. The methods to evaluate the reports and the time-frames for responding are defined at Ark. Code Ann.§ 12-12-1711(b)(1). The law requires that, if the APS staff who receives the report believes that the act described by the reporter constitutes criminal behavior, they must contact the appropriate law enforcement agency. If the APS staff believes the individual to have an immediate need, the staff must treat it as an emergency and report it to 911 services. The APS investigator must see the individual within 24 hours of the report. In non-emergency situations, investigation staff must see the individual who is the subject of concern within three working days and must complete the investigation with 60 days. Based on information provided in the Case Summary Report and the recommendation of the APS staff, the APS Field Manager determines if the allegations are unfounded, founded or incomplete. If founded, the case summary report must contain details of how the APS staff met their responsibility to protect the person and to remedy the circumstances found to exist.

The DHS Division of Children and Family Services (DCFS) receives reports of critical events designated as child abuse or neglect and investigates those allegations. The method to evaluate the report and the time-frames for responding are defined at Ark. Code Ann. § 12-18-102. The Arkansas Child Maltreatment Hotline accepts reports of alleged maltreatment and determines if the report constitutes an event defined as abuse or neglect and if the report constitutes a Priority I or Priority II offense. A Priority I offense is sexual abuse, death, broken bones, head injuries, exposure to poison and noxious chemicals and substances and other critical injuries or events. A Priority II offense is one that involves serious issues, but those that are not life threatening.

Generally, DHS DCFS investigates allegations designated as Priority II and the Arkansas State Policy, Crimes Against Children Division (CACD) investigates Priority I allegations. If the nature of a child maltreatment report suggests that a child is in immediate risk, DCFS or CACD initiates an investigation immediately or as soon as possible. DCFS maintains primary responsibility for ensuring the health and safety of children regardless of whether the investigation is conducted by CACD or DCFS. DCFS and CACD complete investigations and make an investigative determination within thirty days. If the circumstances of the child present an immediate danger, the DCFS may take the child into protective custody for up to 72 hours.

When a DDS certified provider reports an incident to the Adult or Child Hotline, they must also submit an incident report (DHS 1910) to the DDS QA investigation unit. The DDS Quality Assurance investigator reviews and evaluates the incident reports to determine if correct procedures and time frames are followed. If the certified provider staff did not report the incident according to proscribed timeframes, the investigative staff will issue a deficiency to the certified provider and request an Assurance of Adherence of Standards which describes how the provider will ensure future compliance with the required reporting time frames.

DDS has designated the following incidents as critical and sufficiently serious as to require follow-up; 1) attempted suicide; 2) suspected abuse or neglect; 3) elopement; 4) use of restrictive interventions, and; 5) death. Certified providers are required to report an array of incidents, including the five listed above. When investigative staff receive reports of the five designated events, they evaluate the information contained in the report to determine if the incident requires an investigation or possible follow up at the next annual review of the provider.

If the investigator reviewing the incident report determines that the incident should have been reported to a hotline and was not, the investigator will immediately report the incident to the appropriate hotline. Additionally, the investigative staff will issue a deficiency to the certified provider and request an Assurance of Adherence of Standards which describes how the provider will ensure future compliance with the required hotline reporting requirements.

If an incident warrants investigation, the DDS Quality Assurance investigator will initiate an investigation according to DDS Policy 1010 "Service Concern Resolution." The policy requires that investigative staff complete an investigation within 30 days, unless the Certification and Licensure Administrator grants an extension for cause.

DDS has designated the death of an individual as a critical incident. DDS Policy 1018, Mortality Review of Deaths guides the process to conduct a review of each death in order to identify issues and trends related to deaths in order to improve division and provider practices by identifying issues, recommending changes, influencing development of excellent policies and to gather data in order to identify and analyze trends. The purpose is to facilitate Continuous Quality Improvement by gathering information to identify systemic issues that may benefit from scrutiny and analysis in order to make system improvements and to provide opportunities for organizational learning

DDS maintains an investigatation unit which investigates complaints and concerns, which may or may not constitute a "critical incident". 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 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 provides a written report to the certified provider and to the individual making the complaint. If the investigator substantiates the complaint, they issue a deficiency to the certified provider and requests an Assurance of Adherence to Standards which must explain how they will remedy the situation with the individual involved as well as how they will prevent similar situations from occurring in the future.

**e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHS DDS Quality Assurance Certification and Licensure section is responsible for overseeing the reporting of and response to critical incidents regarding HCBS Waiver participants. There are three primary facets to the oversight process. One part of the process occurs during the annual onsite review of the certified provider to ensure that the provider is following applicable policies and procedures and that necessary follow up is conducted on a timely basis. The second occurs as the investigative staff reviews and responds as appropriate to reports of incidents that certified providers submit to DDS Investigative Unit. Thirdly, DDS Certification and Licensure unit maintains a database of incidents in order to facilitate the identification of trends and patterns in the occurrence of critical incidents in order to identify opportunities for improvements and support the development of strategies to reduce the occurrence of incidents in the future.

DDS Certification Standards require that certified providers develop and implement policy that requires reporting adult abuse, maltreatment or exploitation, or child maltreatment to the Child Abuse or Adult Maltreatment Hotline. Standards also require that certified providers develop and implement policy that requires that program staff report certain incidents that occur within the program. The policy must:
1. Include all incidents described as "critical" by DDS,
2. Include any other incidents determined reportable by the program, and
3. Require notification to the parent or guardian of all children age birth to 18 or adults who have a guardian, each time the provider submits an incident report to DDS or according to the provider's Internal Incident Reporting policy.
Standards also require that the provider develop and implement policy regarding follow-up of all incidents.
During the annual onsite review, Certification and Licensure staff review the documentation maintained by the provider which supports compliance with these requirements. Staff review documentation of incidents to determine if the incident constitutes a reportable incident and confirm that a report was submitted. Certification and Licensure staff interview provider staff to determine if they are familiar with the requirements of incident reporting.

DDS investigative staff receive and review incident reports that certified providers submit according to guidelines described in d. above. They review the report to determine if the provider responded appropriately to the incident, if they reported timely, if they reported to the appropriate hotline if necessary and it the incident requires investigation by the DDS investigative unit.

DDS Certification and Licensure unit maintains a database of incidents that includes the type of incident, the name of the provider, the name of the HCBS Waiver participant, and the date of occurrence. Certification and Licensure staff review the information on a quarterly basis to determine if there are trends that are relative to specific providers at a system-wide level or within the waiver population. If trends are identified, the information is provided to the DDS Quality Assurance Committee which meets quarterly.

DDS Certification and Licensure Administration maintains oversight of investigative activities. Investigative staff maintains
a database that includes timeframes regarding initiation and resolution, including notification to the parties

involved. Staff generate monthly reports and administrative staff analyzes data on a quarterly basis. Systemic issues, when identified, are presented to the DDS Quality Assurance Committee which meets on a quarterly basis.

# Appendix G: Participant Safeguards

## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

**a. Use of Restraints.** *(Select one)*:

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS permits the use of physical restraints or seclusion when the challenging behavior exhibited by the HCBS Waiver recipient threatens the health or safety of the individual or others. DDS standards stipulate that medications may not be used to modify behavior or for the purpose of chemical restraint. DDS does not permit the use of mechanical restraints.
Definitions:
"Seclusion" means the sequestration by placement of a recipient alone in a room which he has no means of leaving. The restriction of an individual to a given area or room as part of a behavior modification program which has been authorized in his service plan does not constitute seclusion, provided that the restriction does not exceed any continuous period in excess of two hours nor any periods which total more than four hours in any twenty−four hour period and that the duration, nature and purposes of each restriction are promptly documented in the individual's record.
"Mechanical Restraint" means any physical apparatus or equipment used to limit or control challenging behavior. This apparatus or equipment cannot be easily removed by the person and may restrict the free movement, or normal functioning, or normal access to a portion or portions of a person's body, or may totally immobilize a person.
"Challenging behaviors" are behaviors defined as problematic or maladaptive by others who observe the behaviors or by the person displaying the behaviors. They are actions that:
1. Come into conflict with what is generally accepted in the individual's community,
2. Often isolate the person from their community, or
3. Can be barriers to the person living or remaining in the community, and
4. Vary in seriousness and intensity.
"Chemical Restraint" means the use of medication for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition
"Physical intervention" means the use of a manual technique intended to interrupt or stop a behavior from occurring. Physical intervention includes using physical restraint to release or escape from a dangerous or potentially dangerous situation.
"Physical restraint" means manually holding all or part of a person's body in a way that restricts the person's free movement; also includes any approved controlling maneuvers, such as Therapeutic Options holds. This does not include briefly holding, without undue force, a person in order to calm the person, or holding a person's hand to escort the person safely from one area to another.

DDS requires that, before a provider may use physical restraint or seclusion, they must have developed alternative strategies to avoid the use of restraints or seclusion by developing a behavior management plan which incorporates the use of positive behavior support strategies as an integral part of the plan.

The plan must:
1. Be designed so that the rights of the individual are protected,
2. Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or puts the individual at medical risk,
3. Identify the behavior to be decreased,
4. Identify the behavior to be increased,
5. Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior,
6. Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person,
7. Identify the event that likely occurs right before a behavior of concern,
8. Identify what staff should do if the event occurs,
9. Identify what staff should do if the behavior to be increased or decreased occurs, and
10. Involve the fewest interventions or strategies possible.

A behavior management plan must be written, implemented and supervised by a qualified professional who is, at a minimum, a Qualified Developmental Disabilities Professional. The provider must provide training to all persons who implement the behavior management plan. Training requirements include Introduction to Behavior Management, Abuse and Neglect and any other training as necessary.

The provider must collect data and review the plan. Since the success of a behavior management plan is measured by reductions in challenging behaviors, performance of alternative behaviors and improvements in quality of life, the provider is required to:
1. Develop a simple, efficient and manageable method of collecting data,
2. Collect data regarding the frequency, length of time of each use, the duration of use over time and the impact of restraint and seclusion,
3. Review the data regularly, and
4. Revise the plan as needed if the interventions do not achieve the desired results.
DDS Standards require that the provider report to DDS the use of seclusion or restraint. The DDS investigative staff review each report to determine if the use of the technique was authorized or misapplied. Additionally, in an effort to detect the unauthorized use of or misapplication of restraints, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider.

DDS Standards stipulate that providers prohibit maltreatment or corporal punishment of individuals. DDS Standards also require that providers guarantee an array of rights which includes the right to be free from the use of a physical or chemical restraint, medications, or isolation as punishment for the convenience of the provider except when a physical restraint is necessary for the health and safety of the individual.

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DDS Quality Assurance Certification and Licensure section is responsible for overseeing the use of restraint and restrictive interventions. DDS Standards require that the provider report to DDS the use of seclusion or restraint. The DDS investigative staff review each report to determine if the use of the technique was authorized or misapplied. Additionally, in an effort to detect the unauthorized use of or misapplication of restraints, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider. DDS also maintains an investigative unit, whose staff investigates any complaints or concerns regarding the possible misuse of restraints or interventions.

DDS investigative staff collect data from provider incident reports. The data includes the frequency, length of time of each use, the duration of use over time and the impact of restraint and seclusion. The staff produces a report on a monthly basis and reviews the data to detect any trends specific to individuals or providers that may emerge. On a quarterly basis, the Certification and Licensure Administrator presents a quarterly report of the data to the DDS Quality Assurance Committee. If a trend is identified, DDS may initiate an investigation to identify root causes and require corrective action to reduce or eliminate the inappropriate use of restraints or seclusion.

DDS investigative staff also collect data from deficiencies cited by the Certification and Licensure staff based on their annual onsite provider reviews as well as deficiencies cited by investigative staff based on

complaints or concerns. This data is analyzed as described in the above paragraph.

# Appendix G: Participant Safeguards

## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

DDS Standards prohibit the use of restrictive interventions that restrict an individual's movement, access to individuals, locations or activities, restrict their rights or employ aversive methods. Restrictive interventions are further defined as procedures that restrict an individual's freedom of movement, restricts access to their property, prevents them from doing something they want to do, requires an individual to do something they do not want to do, or removes something they own or have earned. Restrictive interventions include the use of time-out (exclusionary and non-exclusionary),the use of any mechanical restraining device with the intent to modify or control challenging behavior, the use of medication for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition.

Time-out is a restrictive intervention in which a person is temporarily removed from positive reinforcement or denied the opportunity to obtain positive reinforcement and during which the person is under constant visual and auditory contact and supervision. Time-out interventions include: placing a person in a specific time-out room, commonly referred to as exclusionary time-out and removing the positively reinforcing environment from the individual, commonly referred to as non-exclusionary time-out.

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DDS QA is responsible for detecting the unauthorized use of restrictive interventions. DDS Standards require that the provider report to DDS the use of any restrictive intervention. The DDS investigative staff review each report to determine why the use of the technique occurred and what corrective action the provider took to prevent the reoccurrence of the use of the restrictive intervention. Additionally, in an effort to detect the unauthorized use of restrictive intervention, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider. DDS also maintains an investigative unit, whose staff investigates any complaints or concerns regarding the possible use of restrictive interventions.

DDS investigative staff collect data from provider incident reports. The data includes the frequency, length of time of each use, the duration of use over time and the impact of the restrictive intervention. The staff produces a report on a monthly basis and reviews the data to detect any trends specific to individuals or providers that may emerge. On a quarterly basis, the Certification and Licensure Administrator presents a quarterly report of the data to the DDS Quality Assurance Committee. If a trend is identified, DDS may initiate an investigation to identify root causes and require corrective action to reduce or

eliminate the use of restrictive interventions.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one)*:

- **The State does not permit or prohibits the use of seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

- **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

  **i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  **ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The direct care service provider has on-going responsibility for second-line monitoring of participant medication regimens. While the provider may not actually provide services to a person on a 24/7 schedule, the provider is responsible at all times to assure that the service plan identified and addressed all needs with other supports as necessary to assure the health and welfare of the participant.

The provider must develop and implement a Medication Management Plan for all persons receiving prescription medications. The plan must describe;

1. How that direct service staff will, at all times, remain aware of the medications being used by the individual,

2. How the direct service staff will be made aware of the potential side effect effects of the medications being used by the individual,
3. How the program staff will ensure that the individual or their guardian will be made aware of the nature and the effect of the medication,
4. How the program staff will ensure that the individual or their guardian gives their consent prior to the use of the medication, and
5. How the program staff will ensure that administration of the medication will be performed in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

The provider staff providing direct services must maintain medications logs that document at least the following:
1. Name and dosage of the medication given,
2. Time the medication was given,
3. Day and date the medication was given,
4. Initials of the person administering the medication,
5. Any side effects or adverse reactions, and
6. Any errors in administering the medication.

The direct service provider must ensure that a supervisory level staff monitors the administration of medications at least monthly by reviewing medication logs to ensure that;
1. The individual consumed the medications accurately as prescribed,
2. The medication is effectively addressing the reason for which they were prescribed,
3. Any side effects are being managed appropriately,

When medication is used to treat specifically diagnosed mental illness, the medication has been prescribed and is being managed by a psychiatrist who is periodically provided information regarding the effectiveness of and any side effects experienced from the medication. The prescription and management may be by a physician, if a psychiatrist is not available, or when requested and agreed to by the person or the person's guardian and when based upon the documented need of the person. Medications may not be used to modify behavior in the absence of a specifically diagnosed mental illness, or for the purpose of chemical restraint.

DDS standards recognize that prescription PRN medications are appropriate in the use of treating specific symptoms of illnesses. The Provider must keep data regarding:
1. How often the medication is used,
2. The circumstances in which the medication is used,
3. The symptom for which the medication was used, and
4. The effectiveness of the medication.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DDS is responsible for overseeing the second-line medication management process to ensure that participant medications are managed appropriately. The DDS Quality Assurance Certification and Licensure staff conduct an onsite review of every provider every year. During the onsite review, Certification and Licensure review records, conduct interviews and observe interactions between staff and HCBS Waiver participants. Staff review medication management plans and medication logs. They also review internal incident reports as well as those incident reports that the provider submitted to DDS to detect any potentially harmful practices. If they find errors, Certification and Licensure staff cite the provider with a deficient practice and require a plan of correction. When warranted, Certification and Licensure staff perform a follow-up review of providers to determine if they have implemented the practices described in their plan of correction.

DDS maintains an investigative unit that will investigate complaints or concerns regarding how providers manage medications. The investigative staff cite the provider with a deficient practice and require a plan of correction if they identify a harmful or potentially harmful practice.

Prescription drugs are a state plan Medicaid service. The DMS Drug Utilization Review (DUR) Committee and the DUR Board monitors how prescription drugs are prescribed. Their monitoring includes checking the number of medications prescribed and the possible concurrent use of contraindicated medications.

# Appendix G: Participant Safeguards

## Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

- (●) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
  **Do not complete the rest of this section**

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**iii. Medication Error Reporting.** *Select one of the following:*

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  *Complete the following three items:*

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- ( ) **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

# Appendix G: Participant Safeguards

## Quality Improvement: Health and Welfare

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Health and Welfare**
***The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**HW1 : Number and percentage of participants or legal guardians who received information about how to report abuse, neglect, and exploitation as documented on the applicable form. Numerator: Number of participants who received information about how to report abuse, neglect, and exploitation as documented on the applicable form; Denominator: Number of files reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Individual File Review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% with a +/- 5% margin of error |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| |
|---|
| ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**HW2: Number and percentage of critical incidents that were reported within required time frames. Numerator: Number of critical incidents that were reported within required time frames; Denominator: Total number of critical incidents reported to DDS.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Report of Critical Incidents Reported to DDS**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | |
|---|---|
| ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**HW3: Number and percentage of critical incidents reported to APS or CPS within required time frames. Numerator: Number of critical incidents reported to APS, CPS within required time frames; Denominator: Total number of critical incidents required to be reported to APS or CPS.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Report of Critical Incidents Reported to APS or CPS**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**HW4: Number and percentage of critical incidents where the provider took corrective actions to protect the health and welfare of the individual. Numerator: Number of critical incidents where the provider took corrective actions to protect the health and welfare of the individual; Denominator: Number of critical incidents requiring protective actions.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Report of Corrective Actions**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |

| | | |
|---|---|---|
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**HW5: Number and percentage of criminal background checks completed by DDS on a timely basis. Numerator: Number of criminal background checks completed by DDS on a timely basis; Denominator: Total number of criminal background checks due.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Report of Criminal Background Check Determinations**

| | | |
|---|---|---|

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**HW6: Number and percentage of complaint investigations that were completed on a timely basis. Numerator: Number of complaint investigations that were completed on a**

**timely basis; Denominator: Number of complaint investigations.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Report of Timely Completed Complaint Investigations**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

| | |
|---|---|
| | |

**Performance Measure:**
**HW7: Number and percentage of reported deaths which were reviewed by the Mortality Review Committee Numerator: Number of reported deaths which were reviewed timely by the Mortality Pre-Review Committee; Denominator: Number of deaths reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Data Source Report of Timely Mortality Reviews**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**HW8: Number and percentage of individuals for whom providers adhered to DDS requirements for the use of restrictive interventions. Numerator: Number of individuals for whom providers adhered to DDS requirements for the use of restrictive interventions as documented on an incident report; Denominator: Number of individuals for whom the provider utilized restrictive intervention.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Report of Restrictive Interventions**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
(HW 1) The case management provider is responsible for issuing a training guide for reporting abuse, neglect and exploitation which was developed by DDS to all participants or their guardians. The case manager is responsible for obtaining documentation of receipt and providing that documentation to DDS.

(HW4) Prior to initiation of an annual onsite provider certification review, Certification and Licensure (C&L) staff gathers incident reports which the provider has submitted throughout the year. C&L staff identifies reports that describe incidents which require protective actions, such as behavior management plans, changes in staffing levels, or changes in goals. During the onsite review, the reviewers will determine, through the use of interviews, observations and file reviews, if the provider has taken necessary action to protect the individual in question.

(HW 5) DDS investigative staff reviews criminal background checks which are provided to DDS by the Arkansas State Police on a secure website, "The Online Criminal Background System." Staff accesses the system each Friday and provides a written response to the provider who requested the background check. If a disqualifying conviction appears on the background check, DDS staff includes a determination that the prospective employee is disqualified from employment. The staff must provide the response to the provider within 14 calendar days.

(HW 6) DDS Policy 1010, "Service Concern Resolution," requires that DDS investigative staff completes investigations within 30 calendar days of receipt of the concern.

(HW 8) DDS requires that providers submit incident reports each time they utilize a restrictive intervention. DDS investigative staff reviews each report and determines if the methods described in the incident report adhere to the requirements for the use of the type intervention used. DDS staff may contact the provider to obtain additional information, if necessary.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
(HW 1) During service plan development, if the provider does not include the signature page indicating receipt of the abuse, neglect, and exploitation training guide in the DDS-703 submitted to DDS, the DDS Specialist will complete a POC Review Sheet and send to the provider to allow for submission of the required documentation.

(HW 2) When DDS determines, during an investigation, or based on Incident Reports submitted by the provider, that the provider has consistently not complied with reporting time frames, or has not complied with reporting requirements with regard to critical incidents, the investigation manager cites a deficiency and requires that the provider submit an Assurance of Adherence to Standards. The Assurance must include a

description of the processes the provider will put in place to assure the deficiencies do not occur again. (HW3) Additionally, when the DDS staff reviews an Incident Report and determines that the described incident is reportable to APS or CPS and has not been reported by the provider, the DDS staff immediately calls the appropriate hotline to report the incident.

(HW4) Prior to initiation of an annual onsite provider certification review, Certification and Licensure (C&L) staff gathers incident reports which the provider has submitted throughout the year. C&L staff identifies reports that describe incidents which require protective actions, such as behavior management plans, changes in staffing levels, or changes in goals. During the onsite review, the reviewers will determine, through the use of interviews, observations and file reviews, if the provider has taken necessary action to protect the individual in question.

(HW6) If DDS staff consistently does not complete investigations within required time frames, or if DDS staff does not provide timely responses to providers requesting criminal background checks, the Certification and Licensure Manager counsels the staff and utilizes the DHS Minimum Conduct Standards for Employees and DHS Employee Discipline policy to ensure compliance.

(HW8) If DDS staff determines that a provider did not adhere to regulations regarding the use of restrictive interventions, the DDS staff issues a deficiency and requires an Assurance of Adherence to Standards from the provider. DDS investigative staff may conduct an onsite investigation if determined necessary.

(HW 7) The Death Review Coordinator prepares an annual report that addresses any trend identified by the Committee as well as the identification of any prevention activities proposed because of any review. The report contains recommendations regarding specific actions such as:

1. Revision of provider or Division policy or forms,
2. Development of new provider or Division policy to address systemic issues discovered in the review process,
3. Training, either on a statewide or individual provider basis,
4. Facilitation of best practice, including new risk-prevention practices, through dissemination of recommendations for development of or modification to provider policies, or
5. Issuance of a statewide safety alert.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-

operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

# Appendix H: Quality Improvement Strategy (2 of 2)

## H-1: Systems Improvement

**a. System Improvements**

**i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

**ii. System Improvement Activities**

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Quality Improvement Committee** | ☑ **Annually** |
| ☐ **Other** Specify: | ☐ **Other** Specify: |

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

**ii.** Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DDS and DMS will review the Quality Improvement Strategy annually. Review consists of analyzing reports and progress toward stated initiatives, resolution of individual and systemic issues found through discovery and notating of desired outcomes. When change in the strategy is indicated, a collaborative effort between DMS and DDS is set in motion to complete a revision to the Quality Management Strategy that may include changes for submission as an amendment of the HCBS Waiver to CMS. The collaborative process includes participation by the section or unit who has specific strategy responsibility with open discussion opportunity prior to a strategy change of direction.

# Appendix I: Financial Accountability

## I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

MMIS claims data are audited periodically for program policy alignment, and claims processing worksheets are audited, processed and returned on a daily basis . Discovery and monitoring also includes an ongoing review of CMS-372 reports and CMS-64 reports.

An independent audit is required annually of the provider agency when:
State expenditures are $100,000 or more;
Federal expenditures are $500,000 or more; or
The contract the Department of Human Services (DHS) has with the provider agency requires an independent audit, regardless
of funding level.

If the federal expenditures are $500,000 or more, the audit must be performed in accordance with OMB Circular A-133, which implemented the Single Audit Act as amended. A Government Auditing Standards (GAS) audit must be performed if DHS funding provided is $100,000 or more of federal, state, or federal and state combined. In addition, the Division of Medical Services (DMS) Field Audit (Program Integrity) Section conducts an annual random review of HCBS Waiver programs. If the review finds errors in billing, and fraud is not suspected, Medicaid recoups the money from the HCBS Waiver provider. If fraud is suspected, the DMS Field Audit (Program Integrity) Section refers the HCBS Waiver provider to the Arkansas Attorney General's Office for appropriate action.

The DHS Office of Chief Counsel, Audit Section is responsible for reviewing all independent audits. The provider's audit report is reviewed by the Audit Section to determine whether requirements of applicable authorities and those contained in agency policy were met; material weaknesses in internal control exist; material noncompliance with the provision of grants, contracts, and agreements occurred; and the report included findings, recommendations, and responses thereto by management.

Material weaknesses and non-compliance, other findings, recommendations, and responses will be recorded and communicated to the DDS Home and Community Based Services Director, who will take appropriate action to resolve audit findings within 90 days of the referral of the finding from the Audit Section.

If applicable, through audit requirements regarding provider organizations and thresholds of funding, the DHS Office of Quality Assurance (OQA) maintains a database of audit due dates. Each provider selects an independent auditor. The auditor completes a report and submits the report to the provider and to the DHS OQA. The DHS OQA submits a monthly report indicating findings to the DHS Executive Staff.

DDS Individual File Reviews include a review of claims paid to provider agencies for services specified in the service plan. A systematic random sampling of the active case population is drawn whereby every "nth" name in the population is selected for inclusion in the sample for Individual File Review. The sample size is based on a 95% confidence level with a margin of error of +/-5%. The sample is drawn, and divided by twelve for monthly review.

# Appendix I: Financial Accountability

## Quality Improvement: Financial Accountability

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Financial Accountability**
***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**FA1: Number and percent of HCBS Waiver claims that were paid using the correct rate as specified in the HCBS Waiver application. Numerator: Number of claims paid at the correct rate; Denominator: Number of claims.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Recipient Claims History Profile (Individual File 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 = 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:
**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**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other**<br>Specify:<br>DMS reviews 20% of the charts reviewed by DDS during Individual File Reviews, as a validation review. |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**FA2: Number and percent of edit checks which are corrected to assure appropriate payment. Numerator: Number of corrected MMIS edit checks; Denominator: Number of edit checks.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Daily LTC Update Error 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:
**Daily Waiver Update Error 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**<br>Specify: |

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Weekly Worksheets**

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |

☐ **Other**
Specify:

**Performance Measure:**
**FA3: Number and percent of reviewed claims with services specified in the participant's service plan. Numerator: Number of claims with services specified in the service plan; Denominator: Number of claims.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Recipient Claims History Profile (Individual File 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**<br>Confidence Interval = 95% with a +/- 5% margin of error. |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Medicaid Quarterly QA Report (Validation Chart Reviews)**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100%** |

| | | Review |
|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☑ **Other** Specify: DMS reviews 20% of the charts reviewed by DDS during Individual File Reviews, as a validation review. |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Developmental Disabilities Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in periodic team meetings to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DDS and DMS have an Interagency Agreement that includes measures related to financial accountability for the HCBS Waiver.

The performance measure for number and percent of HCBS Waiver claims paid using the correct rate specified in the HCBS Waiver application will always result in 100% compliance because the rates for services are already set in MMIS; therefore, claims will not be paid at any other rate.

DDS's remediation for failed MMIS checks not corrected to assure appropriate payment includes correcting the issue upon discovery, making system changes and training staff.

DDS's remediation for claims for services not specified in the participant's service plan includes adding services to the participant's service plan if necessary, recouping payment to the provider, imposing provider sanctions, training providers and conducting a participant monitoring visit.

The tool used for record review captures and tracks remediation in these areas.

**ii. Remediation Data Aggregation**
**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider

payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Case management - The monthly rate for case management is a fixed prospective rate of $117.70 based on provider costs.

Supported employment - the rate is based on historical prevailing rate for non-waiver programs at a maximum rate of $3.59 for a 15 minute unit of service.

Rate Determination Public Comments: Public comments are sought at the time rates are promulgated. This process requires public notice in a major newspaper with opportunity for public hearing and individual comment. Comments are collected and in the absence of controversy requiring a substantive change the rules for rate change are presented for legislative review. Following legislative review the policy becomes effective.

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers bill directly through the state Medicaid Management Information System (MMIS).

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures** *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

- [ ] **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

- [ ] **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS verifies participant HCBS Waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a HCBS Waiver claim by use of categorical eligibility code. DDS Medicaid Income Eligibility Unit (MIEU) is responsible to assure correct coding prior to the start of the HCBS Waiver services. This assures that the person is approved for HCBS Waiver prior to any payment.

All services are required to be identified in the participant's service plan. The provider must submit encounter data to MMIS for services delivered during the service period. Additionally, the provider is required to maintain daily progress notes of services provided, time sheets, payroll, sub-contracts (if using Organized Health Care Delivery System), vendor purchase orders and payments to support and justify the billing. The direct service provider is responsible to assure that services are delivered in accordance with the service plan. This activity includes review of daily case notes by the workers who deliver the services. The case management provider is responsible to perform oversight of the service delivery in accordance with the service plan.

DDS staff verifies services were provided according to the service plan by conducting on-site review of a 10% random sample of cases, and 100% off site case reviews. The DDS staff does a 100% review of billing on MMIS annually.

Providers are required to report a gap in services of thirty days or more and failure to do so may result in a citation for a deficient practice. Collectively, these activities are effective for timely remediation to resolve any problems in delivery of services. Remediation is effected via adjustments in the future payments, as allowable under the 365 day Medicaid billing authorization when or if new billing may be required, and via sanctions as may be indicated by the QA findings.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

**a. Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- **No. The State does not make supplemental or enhanced payments for waiver services.**
- **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or

enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

**Answers provided in Appendix I-3-d indicate that you do not need to complete this section.**

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for

expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

DDS has established an Organized Health Care Delivery System (OHCDS) option as per 42 CFR447.10 (b) for certified HCBS Waiver providers. Providers agree in writing to guarantee that the services of a subcontractor will comply with Medicaid regulations. The OHCDS provider assumes all liability for contract non-compliance. The OHCDS provider must provide at least one HCBS Waiver service directly utilizing its own employees. The OHCDS provider must also have a written contract that specifies the services and assures that work will be completed in a timely manner and be satisfactory to the person served. OHCDS is optional.

DDS Quality Assurance reviews compliance with DDS Standards annually during an on-site visit. DDS reviews 10% of OHCDS files, up to 10 files.

When OHCDS is used, the enrolled provider is required to have a duly executed sub-contract in place and must review and assure financial accountability. The provider must ensure that services were delivered and proper documentation was submitted for services delivered under OHCDS.

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [x] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Developmental Disabilities Services receives state funding that is used for Medicad HCBS Waiver match. The money is transferred to DMS through an interagency agreement.

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source

or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

*Check each that applies:*

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

*Check each that applies:*

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

**As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Supplemental Security Income (SSI)/personal accounts are used to cover room and board costs and are maintained separately from HCBS Waiver reimbursements. Providers are prohibited from including room and board as any part of HCBS Waiver direct/indirect expense formulations.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

**Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

**No. The State does not impose a co-payment or similar charge upon participants for waiver services.**

**Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care: ICF/IID**

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 1065.03 | 61175.75 | 62240.78 | 82050.58 | 1896.54 | 83947.12 | 21706.34 |
| 2 | 1547.38 | 62705.15 | 64252.53 | 83970.57 | 1940.92 | 85911.49 | 21658.96 |
| 3 | 1550.71 | 64272.78 | 65823.49 | 85935.48 | 1986.34 | 87921.82 | 22098.33 |
| 4 | 1554.05 | 65879.60 | 67433.65 | 87946.37 | 2032.82 | 89979.19 | 22545.54 |
| 5 | 1217.97 | 67526.59 | 68744.56 | 90004.31 | 2080.39 | 92084.70 | 23340.14 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Number Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |
|---|---|---|
| | | Level of Care: |
| | | ICF/IID |
| Year 1 | 8668 | 8668 |
| Year 2 | 8668 | 8668 |
| Year 3 | 8668 | 8668 |
| Year 4 | 8668 | 8668 |
| Year 5 | 8668 | 8668 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of stay for Year 1 and 2 was calculated based on phase in schedule of estimate of maximum possible number of participants that may enroll in the Waiver. Maximum number of individuals to be phased in was estimated by combining waiver wait list of 2791 individuals and other estimated woodwork effect of 25% of total current Waiver participants and Wait list individuals. Additional individuals are expected to be phased in over 24 months period. On average, of 189 persons are expected to enter Waiver services per month. In year 1, maximum of 2268 individuals is estimated to be phased in. In year 2, maximum of 2257 individuals is estimated to be phased in. The length of stay estimate for Years 3-5 is based on the actual prior year experience from the FY 11 372 report for the HCBS Waiver. The average is based on total sum of HCBS Waiver covered days divided by the total unduplicated

count of persons.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Case management and supported employment service costs are the basis for the estimates as identified in the FY 11 372 Report; inclusive of number of people receiving each service and unit of service received. Case management cost is assumed to remain fixed. For supported employment, Year 1 of the estimates includes a 10% growth adjustment factor and each year thereafter includes growth rate of 2.5% for State COLA adjustments.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was computed based on CMS-372 SFY11 report including supportive living, supplemental support, environmental modifications, specialized medical supplies, adaptive equipment, crisis intervention, PERS, community transition services, consultation services, and respite service costs that will be provided under Community First Choice 1915(k) program starting July 1, 2014. Year 1 of the estimates includes a 10% growth adjustment factor and each year thereafter includes growth rate of 2.5% for State COLA adjustments.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Year 1 Factor G is based on factor G in the FY 11 372 report including a 10% growth adjustment factor and each year thereafter includes average growth rate of 2.34% calculated for SFY 2009, 2010 and 2011.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Year 1 Factor G' is based on factor G' in the FY 11 372 report including a 10% growth adjustment factor and each year thereafter includes average growth rate of 2.34% calculated for SFY 2009, 2010 and 2011.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

| Waiver Services |
|---|
| Case Management |
| Supported Employment |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

d. **Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **8526658.80** |
| Case Management | month | 6037 | 12.00 | 117.70 | **8526658.80** | |
| **Supported Employment Total:** | | | | | | **705014.97** |
| Supported Employment | 15 minutes | 121 | 1623.00 | 3.59 | **705014.97** | |
| | | | | **GRAND TOTAL:** | | **9231673.77** |
| | | | | **Total Estimated Unduplicated Participants:** | | **8668** |
| | | | | **Factor D (Divide total by number of participants):** | | **1065.03** |
| | | | | **Average Length of Stay on the Waiver:** | | 302 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **12242683.20** |
| Case Management | month | 8668 | 12.00 | 117.70 | **12242683.20** | |
| **Supported Employment Total:** | | | | | | **1170020.70** |
| Supported Employment | 15 minutes | 178 | 1623.00 | 4.05 | **1170020.70** | |
| | | | | **GRAND TOTAL:** | | **13412703.90** |
| | | | | **Total Estimated Unduplicated Participants:** | | **8668** |
| | | | | **Factor D (Divide total by number of participants):** | | **1547.38** |
| | | | | **Average Length of Stay on the Waiver:** | | 306 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

| Waiver Service/ | | | | | Component | |
|---|---|---|---|---|---|---|

| Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **12242683.20** |
| Case Management | month | 8668 | 12.00 | 117.70 | **12242683.20** | |
| **Supported Employment Total:** | | | | | | **1198910.10** |
| Supported Employment | 15 minutes | 178 | 1623.00 | 4.15 | **1198910.10** | |
| | | | | **GRAND TOTAL:** | | **13441593.30** |
| | | | | **Total Estimated Unduplicated Participants:** | | **8668** |
| | | | | **Factor D (Divide total by number of participants):** | | **1550.71** |
| | | | | **Average Length of Stay on the Waiver:** | | 361 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **12242683.20** |
| Case Management | month | 8668 | 12.00 | 117.70 | **12242683.20** | |
| **Supported Employment Total:** | | | | | | **1227799.50** |
| Supported Employment | 15 minutes | 178 | 1623.00 | 4.25 | **1227799.50** | |
| | | | | **GRAND TOTAL:** | | **13470482.70** |
| | | | | **Total Estimated Unduplicated Participants:** | | **8668** |
| | | | | **Factor D (Divide total by number of participants):** | | **1554.05** |
| | | | | **Average Length of Stay on the Waiver:** | | 361 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | **9297829.20** |
| Case Management | month | 6583 | 12.00 | 117.70 | **9297829.20** | |
| **Supported Employment Total:** | | | | | | **1259577.84** |
| Supported Employment | 15 minutes | 178 | 1623.00 | 4.36 | **1259577.84** | |

| | |
|---|---|
| **GRAND TOTAL:** | **10557407.04** |
| **Total Estimated Unduplicated Participants:** | **8668** |
| **Factor D (Divide total by number of participants):** | **1217.97** |
| **Average Length of Stay on the Waiver:** | 361 |