OMB Approved 0938-1024

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to traditional service delivery model are noted below.

Participants may be disenrolled for the following reasons:

1. Health and Welfare: Any time DAAS feels the health and welfare of the participant is compromised by continued participation in the IndependentChoices Program, the participant may be returned to the traditional personal care program. Prior to this point the counselor has worked with the participant offering suggestions, identifying or changing representatives or employees to better meet the needs of the consumer, making in-home visits as needed by APS or HCBS RNs, and working to resolve these concerns. If no resolution is available, meeting the participant's health and well-being needs is of most importance; including referral back to the traditional model.

2. Change in Condition: Should the participant's cognitive ability to direct his/her own care diminish to a point where the participant can no longer self-direct and there is no responsible representative available to direct the care the counselor will seek out sources of support. If no resources are available, the IndependentChoices case will be closed. The participant will be informed of the pending closure by letter. The letter will include a list of traditional personal care agencies serving the participant's area. If the participant is also a 1915(c) waiver recipient, an e-mail will be auto generated to the HCBS RN or targeted case manager. The e-mail to the HCBS RN or targeted case manager is auto generated and populated with the appropriate names once a closure date is entered in the database. The e-mail will inform the HCBS RN or targeted case manager of the pending closure of the IndependentChoices case necessitating a change in the HCBS service plan. Within five days of sending the letter the counselor will follow up with the participant to determine which agency the participant may wish to choose. The counselor will coordinate the referral with the agency provider. However, if the participant declines agency services, the counselor will respect the choice made by the participant. The participant may choose to have their needs met by informal caregivers.

3. Misuse of Allowance: A notice will be issued should the participant or the representative who manages their cash allowance: 1) fail to pay related state and federal payroll taxes; 2) use the allowance to purchase items unrelated to personal care needs; 3) fail to pay the salary of a personal assistant; or 4) misrepresent payment of a personal assistant's salary. The counselor will discuss the violations with the participant and allow the participant to take corrective action including restitution if applicable. The participant will be permitted to remain in the program, but will be assigned to the fiscal intermediary, who will provide maximum bookkeeping support and services. The participant or representative will be notified that further failure to follow the expenditure plan will result in disenrollment and a report filed with **Office of Medicaid Inspector General** when applicable.

OMB Approved 0938-1024

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

vii. Involuntary Disenrollment (Continued)

Should an unapproved expenditure or oversight occur a second time, the participant/ representative will be notified that their IndependentChoices case is being closed and the participant is being returned to traditional personal care. **Office of Medicaid Inspector General** is informed of situations as required. The State will assure interruption of services will not occur while the participant is transitioning from IndependentChoices to traditional services.

4. Underutilization of Allowance: The fiscal intermediary is responsible for monitoring the use of Medicaid funds received on behalf of the participant. If the participant is underutilizing the allowance and not using the allowance according to their cash expenditure plan, the fiscal intermediary will inform the counseling entities through quarterly reports and monthly reports upon request. The counselor will discuss problems that are occurring with the participant and their support network. Together the parties will resolve the underutilization. The counselor will continue to monitor the participant's use of their allowance through both reviewing of reports and personal contact with the participant. If a pattern of underutilization continues to occur, future discussions will focus on what is in the best interest of the participant in meeting their ADLs even if the best solution is a return to agency services. Unused funds are returned to the Arkansas Medicaid program within 45 days upon disenrollment. Funds accrued in the absence of a savings plan will be returned to the Arkansas Medicaid program within a twelve month filing deadline. Exceptions to involuntary disenrollment may be considered if the participant has been hospitalized for an extended period of time or has had a brief visit out of state with approval by the participant's physician. Person-centered planning allows the flexibility of decision making based on individual needs that best meet the needs of the participant.

5. Failure to Assume Employer Authority: Failure to Assume Employer Authority occurs when a participant fails to fulfill the role of employer and does not respond to counseling support. Participants who fail in their employer responsibilities but do not have a representative will be given the opportunity to select a representative who can assume employer responsibilities on behalf of the participant. Disenrollment will not occur without guidance and counseling by the counselor or by the fiscal intermediary. When this occurs, the counselor will coordinate agency personal care services to the degree requested by the participant. The participant may wish to self-advocate from a list provided by the counselor, ask the counselor to coordinate, or may simply wish to receive personal assistance services informally. The participant's wishes will be respected.

A. The State will provide the following safeguards to ensure continuity of services and assure participant health, safety and welfare during the period of transition between self-directed and traditional service delivery models.

Revised: January 1, 2016

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

Methodology of Compliance Oversight Regarding False Claims Act

The State will ensure an entity's compliance with section 1902(a)(68) of the Act using the following methodology of compliance oversight:

(a) An entity as defined by section 1902(a)(68) of the Act must submit a Certification of Compliance with Employee Education About False Claims Recovery to the **Office of the Medicaid Inspector General (OMIG).**

OMIG will identify the entity or entities covered under 1902(a)(68) of the Act, which covers any entity receiving five million dollars or more for the federal fiscal year (FFY). The state plans to mail out the initial Certification request for calendar years 2007 and 2008 no later than May 31, 2008. The request will explain that compliance is mandatory. Identified entities will have one month (from the date the entity receives the Certification request) to comply with the request for calendar years 2007 and 2008.

The certification will not be specific to a single fiscal year. The certification is an attestation stating that the entity is in compliance with section 1902(a)(68). Following the initial determination for certification, the **OMIG** will review and compile any new information concerning any new entities meeting the threshold requirement for inclusion under this provision by December thirty-first (31) of each year. **OMIG** will then notify each entity of their responsibilities regarding false claims education. Entities will have one month thereafter to comply with the request. **OMIG** will validate the attestation on a sample basis each year. The false claims education requirement will be incorporated into **OMIG's** review program.

(b) This Certification will state that the entity:

(1) Has written policies that include detailed information about the False Claims Act and other provisions named in section 1902(a)(68)(A); and

(2) The policies include:

i. The entity's policies and procedures for detecting and preventing waste, fraud, and abuse; and
ii. A specific discussion of the laws described in the written policies; and
iii. A specific discussion of the rights of employees to be protected as whistleblowers; and

(3) The policies are readily available, in paper or electronic form, to all employees, contractors, or agents.

(4) The false Claims policy must be added to the provider's employee handbook if the provider has such a handbook. Employee handbooks will be reviewed for compliance as part of an audit by **OMIG.**

(5) Review for compliance will begin by **OMIG** staff July 1, 2008.

(c) As part of a **OMIG** Review, the **OMIG** will include additional procedures to ensure compliance with section 1902(a)(68). The procedures will include a review of the entity's written policies according to the terms of the Certification described in paragraph (b).

TOC required

110.700 Medicaid Fraud Detection and Investigation Program 1-1-16

Federal Regulations require the implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess reimbursements by the Medicaid program. The purpose of the Office of the Medicaid Inspector General (OMIG) is to investigate fraud allegations and ensure Arkansas' Medicaid compliance. **[Title XIX of the Social Security Act, Arkansas Code Annotated, 42 C.F.R. §455 and the Arkansas State Plan].**

The goal of the unit is to verify the nature and extent of services reimbursed by the Medicaid program, while ensuring reimbursements made are consistent with the quality of care being provided and protecting the integrity of both state and federal funds.

Responsibilities of the unit include the following:

A. Verifying medical services meet an accepted standard of care and are rendered as billed

B. Verifying services are provided by qualified providers to eligible beneficiaries

C. Verifying reimbursement for services is correct and that all funds identified for collection prior to Medicaid reimbursement are pursued

The OMIG Section is responsible for conducting on-site medical reviews for the purpose of verifying the above tasks as well as record keeping and other specified information. Providers selected for an on-site review will not be notified in advance. Review analysts may request additional information regarding the provider's medical practice. **View or print Office of Medicaid Inspector General contact information.**

Additionally, the OMIG Section is responsible for the identification and recoupment of questioned costs claimed for reimbursement from Medicaid funds when warranted. Situations resulting in recoupment include, but are not limited to, the following:

A. When duplicate payments are made

B. When the Quality Improvement Organization (QIO) denies all or part of a hospital admission

C. When medical consultants to the Medicaid Program determine lack of medical necessity

D. When Medicaid, Medicare or the Attorney General's Medicaid Fraud Unit discovers evidence of overpayment

E. When a provider has been assessed a monetary penalty for failure to follow a corrective action plan which was developed to correct a pattern of non-compliance as provided in Sections 151.000 and 190.005

When a review is completed, Office of Medicaid Inspector General will forward a findings report to the provider. If questioned costs are identified through the review, a "Notice of Decision/Action" will be forwarded to the provider. This notice must comply with Section 190.006 of this manual and must include the name(s) of the patient(s), date(s) of service, date(s) of payment and the reason(s) for the recoupment decision.

Upon receipt of this notice, the provider has thirty-five (35) calendar days in which to pursue one of the following actions:

A. Forward a check for the indicated recoupment amount

B. Request administrative reconsideration

C. Appeal

See Sections 160.000 through 169.000 for rules and procedures related to administrative reconsideration and appeals.

125.300 Reporting Suspected Misuse of I.D. Card 1-1-16

When a provider suspects misuse of a Medicaid identification card, the provider should contact the Office of Medicaid Inspector General. An investigation will then be made. **View or print the Office of Medicaid Inspector General contact information.**

161.200 Administrative Reconsideration 1-1-16

A. Within 30 calendar days after notice of an adverse decision/action, the provider may request administrative reconsideration. Requests must be in writing and include:

1. A copy of the letter or notice of adverse decision/action
2. Additional documentation that supports medical necessity

Administrative reconsideration does not postpone any adverse action that may be imposed pending appeal.

B. Requests for reconsideration must be submitted as follows:

1. In situations where the adverse decision/action has been taken by a reviewing agent, the request must be directed to that reviewing agent. Contact information for the department's reviewing agents can be found in Section V of this manual. General rules regarding due process are contained in Section I of each provider manual; but some administrative reconsideration and appeal processes are program-specific and are set forth in Section II of the applicable program manual.
2. When an adverse decision/action has been taken by the Division of Medical Services, the request for reconsideration must be directed to Office of Medicaid Inspector General (OMIG). **View or print the Office of Medicaid Inspector General contact information.** Within 20 calendar days of receiving a timely and complete request for administrative reconsideration, the Director of the Division of Medical Services will designate a reviewer, who did not participate in the initial determination leading to the adverse decision/action, who is knowledgeable in the subject matter of the administrative reconsideration, to review the reconsideration request and associated documents. The reviewer shall recommend to the Director that the adverse decision/action be sustained, reversed or modified. The Director may adopt or reject the recommendation in whole or in part.

A reconsideration request received within 35 calendar days of the written notice will be deemed timely. The request must be mailed or delivered by hand. Faxed or E-mailed requests will not be accepted.

No administrative reconsideration is allowed if the adverse decision/action is due to loss of licensure, accreditation or certification.

SECTION V – FORMS

500.000

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	1-800-457-4454

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form - AAS-9559	Client Employer
Dental – ADA-J430	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004
Adverse Effects Form	DMS-2704

Form Name	Form Link
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	DMS-679A
Amplification/Assistive Technology Recommendation Form	DMS-686
Application for WebRA Hardship Waiver	DMS-7736
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement	DMS-844
Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form	DMS-845
Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form	DMS-846
ARKids First Behavioral Health Services Provider Qualification Form	DMS-612
Authorization for Automatic Deposit	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
Change of Ownership Information	DMS-0688
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A
CHMS Request for Prior Authorization	DMS-102
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
Contact Lens Prior Authorization Request Form	DMS-0101
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
DDTCS Transportation Log	DMS-638
DDTCS Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disclosure of Significant Business Transactions	DMS-689
Disproportionate Share Questionnaire	DMS-628
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693

Form Name	Form Link
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Provider Agreement	DMS-831
Explanation of Check Refund	HP-CR-002
Gait Analysis Full Body	DMS-647
Home Health Certification and Plan of Care	CMS-485
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Individual Renewal Form for School-Based Audiologists	DMS-7782
Lower-Limb Prosthetic Evaluation	DMS-650
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	HP-MS-005
Medicaid Claim Inquiry Form	HP-CI-003
Medicaid Form Request	HP-MFR-001
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Ownership and Conviction Disclosure	DMS-675
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish
Practitioner Identification Number Request Form	DMS-7708
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Procedure Code/NDC Detail Attachment Form	DMS-664
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A
Provider Enrollment Application and Contract Package	Application Packet
Quarterly Monitoring Form	AAS-9506
Referral for Audiology Services – School-Based Setting	DMS-7783

Form Name	Form Link
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634
Referral for Medical Assistance	DMS-630
Request for Appeal	DMS-840
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request for Molecular Pathology Laboratory Services	DMS-841
Request For Orthodontic Treatment	DMS-32-0
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Research Request Form	HP-0288
Service Log – Personal Care Delivery and Aides Notes	DMS-873
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form – Information for Men	PUB-020
Sterilization Consent Form – Information for Women	PUB-019
Upper-Limb Prosthetic Evaluation	DMS-648
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	Vendorperformreport
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502
AAS-9506
AAS-9559
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DDS/FS#0001.a
DMS-0101
DMS-0688
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-2704
DMS-32-A
DMS-32-0
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-679A
DMS-683
DMS-686
DMS-689
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-831
DMS-840
DMS-841
DMS-844
DMS-845
DMS-846
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

Arkansas Medicaid Contacts and Links

Click the link to view the information.

American Hospital Association
Americans with Disabilities Act Coordinator
Arkansas Department of Education, Health and Nursing Services Specialist
Arkansas Department of Education, Special Education
Arkansas Department of Finance Administration, Sales and Tax Use Unit
Arkansas Department of Human Services, Division of Aging and Adult Services
Arkansas Department of Human Services, Appeals and Hearings Section
Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit
Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit

Arkansas Department of Human Services, Children's Services

Arkansas Department of Human Services, Division of County Operations, Customer Assistance Section

Arkansas Department of Human Services, Division of Medical Services

Arkansas DHS, Division of Medical Services Director

Arkansas DHS, Division of Medical Services, Benefit Extension Requests, UR Section

Arkansas DHS, Division of Medical Services, Dental Care Unit

Arkansas DHS, Division of Medical Services, HP Enterprise Services Provider Enrollment Unit

Arkansas DHS, Division of Medical Services, Financial Activities Unit

Arkansas DHS, Division of Medical Services, Hearing Aid Consultant

Arkansas DHS, Division of Medical Services, Medical Assistance Unit

Arkansas DHS, Division of Medical Services, Medical Director for Clinical Affairs

Arkansas DHS, Division of Medical Services, Pharmacy Unit

Arkansas DHS, Division of Medical Services, Program Communications Unit

Arkansas DHS, Division of Medical Services, Provider Reimbursement Unit

Arkansas DHS, Division of Medical Services, Third-Party Liability Unit

Arkansas DHS, Division of Medical Services, UR/Home Health Extensions

Arkansas DHS, Division of Medical Services, Utilization Review Section

Arkansas DHS, Division of Medical Services, Visual Care Coordinator

Arkansas Department of Health

Arkansas Department of Health, Health Facility Services

Arkansas Department of Human Services, Accounts Receivable

Arkansas Foundation for Medical Care

Arkansas Foundation for Medical Care, Retrospective Review for Therapy and Prior Authorization for Personal Care for Under Age 21

Arkansas Hospital Assocciation

Arkansas Office of Medicaid Inspector General (OMIG)

ARKids First-B

ARKids First-B ID Card Example

Central Child Health Services Office (EPSDT)

ConnectCare Helpline

County Codes

Dental Contractor

HP Enterprise Services Claims Department

HP Enterprise Services EDI Support Center (formerly AEVCS Help Desk)

HP Enterprise Services Inquiry Unit

HP Enterprise Services Manual Order

HP Enterprise Services Provider Assistance Center (PAC)

HP Enterprise Services Supplied Forms

Example of Beneficiary Notification of Denied ARKids First-B Claim

Example of Beneficiary Notification of Denied Medicaid Claim

First Connections Infant & Toddler Program, Developmental Disabilities Services

First Connections Infant & Toddler Program, Developmental Disabilities Services, Appeals

Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment

Health Care Declarations

Immunizations Registry Help Desk

Magellan Pharmacy Call Center

Medicaid ID Card Example

Medicaid Managed Care Services (MMCS)

Medicaid Reimbursement Unit Communications Hotline

Medicaid Tooth Numbering System

National Supplier Clearinghouse

Partners Provider Certification

Primary Care Physician (PCP) Enrollment Voice Response System

Provider Qualifications, Division of Behavioral Health Services

Select Optical

Standard Register

Table of Desirable Weights

UAMS College of Pharmacy Evidence-Based Prescription Drug Program Help Desk

U.S. Government Printing Office

ValueOptions

Vendor Performance Report

Arkansas ~~DHS, Division of Medical Services, Program Integrity Unit (PI)~~Office of Medicaid Inspector General (OMIG)

~~Toll Free:~~	~~(800) 482-4850, extension 2-8349~~
Direct:	(501) 682-8349
Fax:	(501) 682-8350
Mailing Address:	~~DHS Division of Medical Services~~ ~~Program Integrity Unit~~323 Center Street, Suite 1200 ~~P.O. Box 1437, Slot S414~~ Little Rock, AR 7220~~3-1437~~1

TOC not required

216.100 Vehicle Modifications 1-1-16

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

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

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

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

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

Permanent vehicle modifications may be replaced if the vehicle is stolen, damaged beyond repair as long as the damage is not through negligence of the vehicle owner, or used for more than its reasonable useful lifetime.

A. A vehicle has reached its reasonable useful lifetime when repairs are required to make the vehicle useable, and the cost of the repairs exceeds the fair market value of the vehicle in repaired condition.

B. Cost of repair shall be determined by repair estimates from three qualified repairers.

C. Vehicle value shall be determined by reference to sales listing for similar vehicles within a 200 mile radius of the beneficiary's home, and to listings in Dallas, Texas; Kansas City, Missouri; Saint Louis, Missouri and Memphis, Tennessee.

D. If the beneficiary or legally responsible party sells or trades a permanently modified vehicle before the vehicle reaches its reasonable useful lifetime, the modification will not be replaced on any replacement vehicle. Instead, the beneficiary may be eligible for partial payment based on the estimated remaining residual value of the vehicle at the time of sale.

   1. Estimated residual value shall be determined by comparing the purchase price of the modified vehicle when acquired by the beneficiary or legally responsible party when the vehicle value at the time of sale determined as stated above.

   2. Example: A permanently modified vehicle purchased for $30,000 is sold with a value of $20,000 (66% residual value). If parts and labor for the modification of the replacement vehicle are $10,000, the amount paid is $3,333 (33%).

E. Vehicle modifications apply only to modifications and not to routine auto maintenance or repairs for the vehicle.

F. The following are specifically excluded:

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

   2. Purchase, down payment or lease of a vehicle as documented by the vehicle sales contract and requested invoices;

3. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modification.

TOC not required

200.500 Quality Measures 1-1-16

This section describes, for each episode type, the data and measures which Medicaid will track and evaluate to ensure provision of high-quality care for each episode type.

A. *Quality measures "to pass":* Measures for which a PAP must meet or exceed a minimum threshold in order to qualify for a full positive supplemental payment for that episode type.

B. *Quality measures "to track":* Measures for which a PAP's performance is not linked to supplemental payments. Performance on these measures may result in an Office of Medicaid Inspector General review.

For quality measures "to pass" and quality measures "to track" that require data not available from claims, PAPs must submit data through the provider portal in order to qualify for a full positive supplemental payment.

TOC not required

231.600 Involuntary Disenrollment 1-1-16

Participants may be disenrolled for the following reasons:

A. **Health, Safety and Well-being**: At any time that DAAS determines that the health, safety and well-being of the participant is compromised by continued participation in the IndependentChoices Program, the participant may be returned to the traditional personal care program.

B. **Change in Condition**: Should the participant's cognitive ability to direct his or her own care diminish to a point where he or she can no longer direct his or her own care and there is no Decision-Making Partner available to direct the care, the IndependentChoices case will be closed. The counselor will assist the participant with a referral to traditional services.

C. **Misuse of Allowance**: Should a participant or the Decision-Making Partner who is performing all of their payroll functions (and not using the fiscal agent) use the allowance to purchase items unrelated to personal care needs, fail to pay the salary of an assistant, misrepresent payment of an assistant's salary, or fail to pay related state and federal payroll taxes, the participant or Decision-Making Partner will receive a warning notice that such exceptions to the conditions of participation are not allowed. The participant will be permitted to remain on the program, but will be assigned to the fiscal intermediary, who will provide maximum bookkeeping services. The participant or Decision-Making Partner will be notified that further failure to follow the expenditure plan could result in disenrollment. Should an unapproved expenditure or oversight occur a second time, the participant or Decision-Making Partner will be notified that the IndependentChoices case is being closed and they are being returned to traditional personal assistance services. The Office of Medicaid Inspector General is informed of situations as required. The counselor will assist the participant with transition to traditional services. The preceding rules are also applicable to participants using the fiscal agent.

D. **Underutilization of Allowance**: The fiscal agent is responsible for monitoring the use of the Medicaid funds received on behalf of the participant. If the participant is underutilizing the allowance and not using it according to the cash expenditure plan, the fiscal agent will inform the counseling entities through quarterly reports and monthly reports on request. The counselor will discuss problems that are occurring with the participant and their support network. The counselor will continue to monitor the participant's use of their allowance through both review of reports and personal contact with the participant. If underutilization continues to occur, future discussions will focus on what is in the best interest of the participant in meeting their ADL's even if the best solution is a return to agency services. Unused funds are returned to the Arkansas Medicaid program within 45 days after disenrollment. Funds accrued in the absence of a savings plan will be returned to Medicaid within a twelve-month filing deadline. Involuntary disenrollment may be considered if the participant has been hospitalized for more than 30 days and a discharge date is unknown to the participant or Decision-Making Partner. Participants with approval by their physician for an out-of-state visit may be involuntarily disenrolled if their stay extends past the approval period authorized by their physician. The participant is required to provide a copy of the physician's authorizations to their counselor for monitoring purposes.

E. **Failure to Assume Employer Authority**: Failure to Assume Employer Authority occurs when a participant fails to fulfill the role of employer and does not respond to counseling support. Disenrollment will not occur without guidance and counseling by the counselor or by the fiscal intermediary. When this occurs, the counselor will coordinate agency personal care services to the degree requested by the participant. The participant may wish to self-advocate from a list provided by the counselor, ask the counselor to coordinate

or may simply wish to receive personal assistance services informally. The participant's wishes will be respected.

Whenever a participant is involuntarily disenrolled, the IndependentChoices program will mail a notice to close the case. The notice will provide at least 10 days but no more than 30 days before IndependentChoices will be discontinued, depending on the situation. During the transition period, the counselor will work with the participant or Decision-Making Partner to provide services to help the individual transition to the most appropriate services available.

TOC required

203.000 Office of Medicaid Inspector General 1-1-16

A PACE Organization must have a formal process in place to gather information and must be able to respond in writing to a request from CMS and/or the State Administering Agency (SAA) for information regarding:

A. Persons with criminal convictions.

B. A PACE Organization must not employ individuals or contract with organizations or individuals:

1. Who have been excluded from participation in the Medicare or Medicaid programs;
2. Who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under title XX of the Social Security Act; or
3. In any capacity where an individual's contact with participants would pose a potential risk because the individual has been convicted of physical, sexual, drug or alcohol abuse.

C. Direct or indirect interest in contracts. No member of the PACE Organization's governing body or any immediate family member may have a direct or indirect interest in any contract that supplies any administrative or care-related service or materials to the PACE Organization.

TOC required

105.300 Arkansas Delta Primary Care Case Management Pilot Program 7-1-14

The purpose of the Arkansas Delta Primary Care Case Management Pilot program is to establish a contract with a vendor who meets criteria through a request for qualifications (RFQ) process. The vendor will provide case management by recruiting an adequate number of primary care clinics in the Arkansas Delta Region for a two-year program beginning 7/1/14. Thirty-nine (39) of Arkansas' seventy-five (75) counties have been selected to participate in the pilot; and within those counties, a minimum of five thousand (5,000) beneficiaries meeting certain criteria must be enrolled in the program. However, if enrollment falls below five thousand (5,000) beneficiaries, DMS will apply actuarially sound modifications to the shared savings calculations. The vendor will be responsible for enrolling enough clinics to satisfy the beneficiary requirements. This goal of this program is to lower the total cost of care, enhance a patient's health care experience, and improve health outcomes.

The Delta Primary Care Case Management Pilot program excludes:

A. Beneficiaries who are currently in the Arkansas Beneficiary Centered Medical Home (PCMH) Program

B. Beneficiaries who are currently in the federal Comprehensive Primary Care Initiative (CPCI)

C. Beneficiaries who are currently in a home health program that is similar to PCMH and CPCI (For the purposes of this pilot, these programs are those designed by DMS to provide care coordination services for beneficiaries meeting the health home criteria set out in the Affordable Care Act Section 2703.)

D. Beneficiaries who are in the Alternatives for Persons with Disabilities

E. Beneficiaries who are in the Division of Developmental Disabilities Services Alternative Community Services

F. Beneficiaries who are in the Elder Choices

G. Beneficiaries who are in the Living Choices Assisted Living waivers

H. Beneficiaries who are in the Program of All-Inclusive Care for the Elderly

One hundred percent of the dollar value of care coordination payments is included in the per beneficiary cost of care calculation.

The following costs are excluded from the calculation of per beneficiary cost of care:

A. All costs in excess of $100,000 for any individual beneficiary

B. Behavioral health costs for patients with the most complex behavioral health needs

C. Select costs associated with developmental disabilities (DD) services, identified on the basis of DD provider types

D. Select direct costs associated with Long-Term Support and Services (LTSS)

E. Select costs associated with nursing home fees, transportation fees, dental, and vision

F. Select neonatal costs

G. Other costs as determined by DMS

Detailed information on specific exclusions can be found at **www.paymentinitiative.org**.

The following adjustments are made to costs for calculation of per beneficiary cost of care:

A. Inpatient hospital claims will be adjusted to reflect a standard per diem.

B. Inpatient hospital claims will be adjusted to reflect a standard per diem.

C. Pharmacy costs will be adjusted to reflect all supplemental and OBRA rebates.

D. The per beneficiary cost of care for the PCCM Program is adjusted by the amount of supplemental payment incentives, both positive and negative, made under Episodes of Care for the beneficiaries attributed to the PCCM Program.

E. Technical adjustments may be made by DHS and will be posted at **www.paymentinitiative.org.**

TOC required

214.100 Utilization Review and Office of Medicaid Inspector General 1-1-16

A. The Utilization Review and Office of Medicaid Inspector General of the Arkansas Medicaid Program have the responsibility for assuring quality medical care for Medicaid beneficiaries and for protecting the integrity of state and federal funds supporting the Medical Assistance Program. Those responsibilities are mandated by federal regulations.

B. The Utilization Review and Office of Medicaid Inspector General shall:

1. Conduct on-site medical audits for the purpose of verifying the nature and extent of services paid for by the Medicaid Program,
2. Research all inquiries from beneficiaries in response to the Explanation of Medicaid Benefits and
3. Retrospectively evaluate medical practice patterns and providers' patterns by comparing each provider's pattern to norms and limits set by all the providers of the same specialty.

TOC not required

202.000 Visual Care Records Providers are Required to Keep 1-1-16

Visual care providers are required to keep the following records and, upon request, must immediately furnish the records to authorized representatives of the Division of Medical Services, the state Medicaid Fraud Control Unit, representatives of the Department of Human Services and the Centers for Medicare and Medicaid Services:

A. History and visual care examination on initial visit.

B. Chief complaint on each visit.

C. Tests and results.

D. Diagnosis.

E. Treatment, including prescriptions.

F. Signature or initials of visual care provider after each visit.

G. Copies of hospital and/or emergency room records that are available to disclose services.

1. All records must be kept for five (5) years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish these records upon request may result in sanctions being imposed.
2. All documentation must be immediately made available to representatives of the Division of Medical Services at the time of an audit by the Office of Medicaid Inspector General. All documentation must be available at the provider's place of business. When a recoupment is necessary, no more than thirty (30) days will be allowed after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30 days allowed after recoupment.
3. Visual Care providers furnishing any Medicaid-covered good or service for which a prescription is required by law, by Medicaid rule, or both, must have a copy of the prescription for such good or service. The Visual Care provider must obtain a copy of the prescription within five (5) business days of the date the prescription is written.
4. The Visual Care provider must maintain a copy of each relevant prescription in the Medicaid beneficiary's records and follow all prescriptions and care plans.