Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Includes Changes Implemented through November 2014

Submitted by:

Submission Date:	

CMS Receipt Date *(CMS Use)*	

State:	
Effective Date	

1. Request Information

A. The **State** of **Arkansas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional – this title will be used to locate this waiver in the finder*): **Community and Employment Support Waiver**

C. **Type of Request: Amendment**

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○	**3 years**
⦿	**5 years**

☐	**New to replace waiver** Replacing Waiver Number:		
☐	**Migration Waiver** – this is an existing approved waiver Provide the information about the original waiver being migrated		
	Base Waiver Number: **Draft ID:**	**AR.0188** **AR.**	
☑	**Amendment Number** (if applicable):		
	Effective Date: (mm/dd/yy)	07/01/17	

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

○	**Model Waiver**
⦿	**Regular Waiver**

E. **Proposed Effective Date:** 07/01/17

Approved Effective Date (*CMS Use):*

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 under age 21 as provided in 42 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 facility level of care:	

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Community and Employment Support Waiver (the "Waiver") is to support individuals of all ages who have a developmental disability, meet ICF level of care and require waiver support services to live in the community and prevent institutionalization.

The goals of the Waiver are to:
1) Support the person in all major life activities,
2) Promote community inclusion through integrated employment options and community experiences, and
3) Implement Independent Assessments; and
4) Add 500 additional waiver slots.

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

The objectives are as follows:
1) To enhance and maintain community living for all persons participating in the Waiver program, and
2) To transition eligible persons who choose the Waiver option from residential facilities to the community, and
3) To implement Independent Assessments with the goal of enrolling new and existing Waiver participants into a Provider Owned Arkansas Shared Savings Entity (PASSE), which is a provider led managed care entity.

Under the organizational structure of the Department of Human Services (DHS), the Division of Medical Services (DMS) is the state Medicaid agency. DMS 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. 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 providers before the provider can deliver services.

ACS Waiver services are accessed through DDS Intake and Referral units, which include DDS Adult

Intake and Referral, DDS Children's Services Intake and Referral, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Intake and Referral staff. The Intake and Referral staff distribute the initial application, assist with completion of the application, explain program options and offer choice of waiver services or ICF/IID services. The application packet can be obtained on DDS's website at http://humanservices.arkansas.gov/ddds/Pages/waiverServices.aspx.

The completed application packet is transmitted to the Waiver Application Unit (WAU) who tracks the application and documents eligibility determinations. The DDS Psychology Team determines whether the applicant is ICF/IID eligible. The Medicaid Income Eligibility Unit is responsible for determining if the individual is Medicaid eligible. After an applicant has been determined eligible and enrolled in the Waiver, a DDS Specialist offers him or her a choice of waiver providers.

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

Providers must request in writing and receive written permission from DDS before reducing numbers of participants served by ceasing provision of services in a designated county or counties, freezing the number of persons they serve at the current number and reducing the number through attrition or ceasing provision of services to those persons they have most recently begun serving. Providers are responsible for continuing to provide services until transition of persons to another provider is complete.

Each individual who is determined to meet the ICF/IID level of care and enrolled in the Waiver must receive an Independent Assessment performed by a Third Party Vendor. The Independent Assessment, along with the individual's application packet and functional assessments, will determine whether the Participant is in Tier 2 or Tier 3. The Independent Assessment will assess the participant in the following areas:
i. Individual Areas
a. Medical history, current medical conditions, or conditions observed by the assessor or self-reported by the individual;
b. Behavioral;
c. Home living activities;
d. Community activities;
e. Employment;
f. Health and safety assessment; and
g. Social functioning

ii. Caregiver (natural supports) areas
a. Physical/behavioral (health);
b. Involvement;
c. Social resources;
d. Family Stress; and
e. Safety

iii. Current Risk Assessment Review
a. Safety Plan, if available;
b. Behavior Plan;
c. Physical Plan; and

d. Medical Plan

Tier 3 participants require care 24 hours per day, 7 days per week. Participants assessed at the pervasive level of need from the previous Waiver will be transitioned into Tier 3. Tier 2 participants require care less than 24 hours per day, seven days per week. Participants assessed at the limited and extensive levels of need from the previous Waiver will transitioned into Tier 2, until such time as their PCSP comes up for renewal and they must undergo an Independent Assessment. The Independent Assessment will also include a risk and needs assessment that must be used to create the PCSP. (Tier 1 individuals do not need institutional level of care, and therefore are not eligible to receive Waiver Services).

By implementing Independent Assessments, this Waiver sets Arkansas on the path to conflict free case management. Beginning in October 2017, once a participant has been assessed and assigned a tier, that participant will be enrolled into a Provider-owned Arkansas Shared Savings Entity (PASSE), or a provider-led managed care organization, that will provide case management and care coordination services administratively.

All services must be delivered based on an individual person-centered service plan (PCSP), which is based on the Independent Assessment and other psychological and functional assessments. The PCSP must have measurable goals and specific objectives, measure progress through data collection, been overseen and updated by the participant's case manager through consultation with the team, which includes the person receiving services.

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

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.*

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 throughout the application and in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

DDS secured public input into the amendment of the HCBS Community and Employment Supports Waiver (formerly, the Alternative Community Service Waiver) through the use of an informal workgroup and a formal public notice. The workgroup was was made up of Waiver provider. This workgroup met twice while the Amendments were being drafted and then reviewed the proposed amendments and made comments. Some changes were made before the draft was put out for public comment. The remaining changes will be considered by DDS, along with the other comments received during the formal public comment period.

Due to space limitations, actual comments and responses have been added to this document and can be located in the section titled Optional.

Websites for the Arkansas Waiver Association, the Developmental Disabilities Provider Association and DDS contain information about the Waiver. DDS staff participate at provider conferences and take comments by phone and email from providers and people receiving or applying for services.

DDS will conduct a formal public comment period, with a public hearing to be held on March 29, 2017, at 1:30 p.m. All written comments must be submitted prior to April 1, 2017. Once all comments have been received, DDS will consider both the comments it received during the informal review and comments received during the formal public comment period and make any necessary changes to the Waiver application before submitting it to CMS.

Upon approval by CMS, DMS and DDS will implement the regulations, policies, rules and procedures that are promulgated in accordance with the Arkansas Administrative Procedure Act. This process allows for another opportunity for public comment and changes prior to the final rule submission. After review and approval from Arkansas Legislative Committees, the implementing regulations, policies, rules and procedures are incorporated into the DMS Medical Services Manual. This manual is available to all providers and the general public on the DMS website.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Nye
First Name:	Bradford
Title:	Director, Office of Policy Development
Agency:	Office of Legislative and Intergovernmental Affairs, Arkansas Department of Human Services
Address :	P.O. Box 1437, Slot S295
Address 2:	
City:	Little Rock
State:	Arkansas
Zip:	72203-1437
Phone:	501-320-6306 **Ext:** ☐ **TTY**
Fax:	501-404-4619
E-mail:	Brad.Nye@dhs.arkansas.gov

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

Last Name:	Davenport
First Name:	Regina
Title:	Assistant Director for ACS Waiver Services
Agency:	Division of Developmental Disabilities Services, Arkansas Department of Human Services
Address:	P.O. Box 1437, Slot N502
Address 2:	
City:	Little Rock
State:	Arkansas
Zip :	72203-1437
Phone:	(501) 683-0575 **Ext:** ☐ **TTY**
Fax:	(501) 682-8380
E-mail:	Regina.davenport@dhs.arkansas.gov

Attachment #1: Transition Plan

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

☐ **Replacing an approved waiver with this waiver.**
☐ **Combining waivers.**
☐ **Splitting one waiver into two waivers.**
☐ **Eliminating a service.**
☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
☐ **Reducing the unduplicated count of participants (Factor C).**
☑ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
☑ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Once this amendment is approved, there will be 500 new slots on the Community and Employment Supports Waiver.

In order to effectively serve 500 new clients, DDS (the Operating Agency) is implementing a new assessment tool, known as Independent Assessments. The Independent Assessment is a risk and needs assessment done in conjunction with psychological and functional testing to determine an eligible applicant's tier. DDS will now be using a three tier system. The tiers are as follows:

Tier 1: Community Clinic Level of Care. These clients are not eligible for ICF/IID. If the clients are determined to need waiver or ICF/IID services, they will be moved into a higher Tier.

Tier 2: Institutional Level of Care. These clients are eligible to receive ICF/IID services but do not need care 24 hours a day, seven days a week.

Tier 3: Institutional Level of Care, 24/7. These clients are eligible to receive ICF/IID services and do need care 24 hours a day, seven days a week.

Waiver participants will only receive services through Tiers 2 and 3. Current participants will be transferred as follows:

1) Participants now classified as pervasive will be classified as Tier 3, until their yearly PCSP is due and they undergo an Independent Assessment.
2) Participants now classified as limited or extensive will be classified as Tier 2, until their yearly PCSP is due and they undergo an Independent Assessment.

The Independent Assessment will assess the participant in the following areas:

i. Individual Areas

a. Medical history, current medical conditions, or conditions observed by the assessor or self-reported by the individual;

b. Behavioral;

c. Home living activities;

d. Community activities;

e. Employment;
f. Health and safety assessment; and
g. Social functioning

ii. Caregiver (natural supports) areas
a. Physical/behavioral (health);
b. Involvement;
c. Social resources;
d. Family Stress; and
e. Safety

iii. Current Risk Assessment Review
a. Safety Plan, if available;
b. Behavior Plan;
c. Physical Plan; and
d. Medical Plan

Immediately after receiving approval of these Waiver amendments, Arkansas will begin the process of amending the waiver to create the PASSE managed care model, where every participant will be enrolled in a PASSE and receive case management and care coordination services administratively through that PASSE. Participants who are enrolled in a PASSE and choose to receive Participant Directed Services will also receive financial management and information and support services through the PASSE.

Beginning on the effective date of this Waiver Amendment (proposed July 1, 2017) DDS will refer 300 current Waiver participants and 250 new participants to the Third Party Vendor for Independent Assessments. These 550 participants will be the first rolled into a PASSE (proposed October 1, 2017). 300 current Waiver participants and 250 new participants will also be assessed in August 2017 to be enrolled in a PASSE on November 1, 2017. The remaining new participants (200) and another 300 current participants will be assessed in September 2017 and will be enrolled in a PASSE on December 1, 2017. After that, 300 current participants will be assessed with the Independent Assessment tool per month until all participants have been assessed and enrolled in a PASSE. The target date to have everyone enrolled in a PASSE and phase out case management as a service is December 31, 2018.

Participants who wish to enroll in participant driven services sooner will be able to undergo and Independent Assessment and enroll in a PASSE ahead of schedule.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Put comments received here.

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 (DDS)		
	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).*		

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.

The Division of Medical Services (DMS), within the Department of Human Services (DHS), is the State Medicaid agency and has administrative authority for the Waiver including the following:
1) Develop and Monitor the Interagency Agreement to ensure that provisions specified are executed;
2) Oversee the Waiver program through a DMS case record review process that allows for response to all individual and aggregate findings;
3) Review and approve, via Medicaid Manual promulgation process, public policies and procedures developed by DDS regarding the Waiver and monitoring their implementation;
4) Reimburse providers enrolled in the Medicaid Program who provide services to eligible Waiver participants;
5) Promulgate the DDS Waiver Provider Manual, which provides the rules and regulations for participation in the Arkansas Medicaid Program, in accordance with the Arkansas Administrative Procedures Act;
6) Final authority on all functions related to provider participation in the Arkansas Medicaid Program;
7) Train providers on proper procedures to follow in submitting claims (through fiscal agent, Electronic Data Systems);
8) Notify providers of participative changes in the Arkansas Medicaid Program;
9) Respond to provider questions concerning submission of claims (through EDS);
10) Ensure that providers remain in compliance with rules and regulations required for participation in the Medicaid program;
11) Review of provider information and determination as to whether to enroll the provider into the Arkansas Medicaid Program;
12) Assign to each new enrolled provider a unique Medicaid provider number;
13) Notify DDS of any providers removed from the active Medicaid provider file;
14) Insure that a specified number of service plans are reviewed by DMS or their designated representative;
15) Provide to DDS relevant information pertaining to the Medicaid program and any federal requirements governing applicable waiver programs;
16) Monitor compliance with the interagency agreement;
17) Complete and Submit the CMS 372 Annual Report.

The Division of Developmental Disabilities Services (DDS), also within DHS, is responsible for operation of the Waiver including the following:
1) Develop and Implement internal, administrative policies and procedures to operate the Waiver DMS does not approve these internal procedures, but does review them to ensure there are no compliance issues with either State or Federal Regulations.
2) Develop and implement public policy and procedures;
3) Provide training to providers regarding certification requirements set forth by DDS;
4) Certify qualified providers who request to render Waiver services and provide information on certified providers to DMS;
5) Conduct certification surveys of providers in accordance with current DDS policies and procedures to their certification status;
6) Notify DMS of any provider who DDS disqualifies and removes from the Waiver Program;
7) Establish and monitor the person center service plan (PCSP) requirements that govern the provision of services;
8) Monitor professionals who conduct the PCSP development, implementation and monitoring process;
9) Coordinate the collection of data and issuance of reports through MMIS with DMS as needed to complete the CMS 372 Annual Report;
9) Provide to DMS the results of monitoring activities;
10) Develop and implement a Quality Assurance protocol that meets criteria as specified in the

Interagency Agreement.

DDS is also responsible for:
1) Determining waiver participant eligibility according to DMS rules and procedures;
2) Implementing service delivery through a prior authorization process;
3) Providing technical assistance to providers and consumers on Waiver requirements, policies, procedures and processes;
4) Conducting program and individual service concern reviews and investigations with subsequent follow-up, and imposing sanctions, when indicated.

DMS and DDS staff will meet at least on a semi-annual basis to discuss problems, evaluate the program, and initiate appropriate changes in policy or reimbursement rates so as to maintain an efficient administration of the Waiver.

DMS Waiver Quality Assurance staff uses Quality Management Strategy, case record reviews, monitoring report reviews, and meetings with DDS Waiver administrative staff to monitor the operation of the Waiver and assure compliance with waiver requirements. DMS Program Integrity also conducts random onsite reviews of provider records throughout the year. DMS Waiver Quality Assurance staff reviews DDS reports, records findings and prioritizes any issues that are found as a result of the review process.

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:

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.*
	DMS and DDS contracts with a Third Party Vendor to conduct Independent Assessments that are used to determine the participants' service tier and create his or her PCSP.
○	**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

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** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *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*:

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:

DDS is the agency in charge of operational management of the Waiver and is responsible for oversight of tier determinations and PCSPs. DMS, as the State Medicaid Agency, retains authority over the waiver in accordance with 42 CFR §431.10(e). DHS's Contracting Official will oversee the contract between DHS and the Third Party Vendor. The Contract will have performance measures that the Vendor will be required to meet.

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:

The Third Party Contractor must submit monthly contractor reports to DMS and DDS that include:
1. Demographics about the Participants who were assessed;
2. An activities summary, including the volume, timeliness and outcomes of all Assessments and Reassessments; and
3. A running total of the activities completed.

The Third Party Contractor must submit an annual program performance report that includes:

1. An activities summary for the year, including the total number of assessments and

reassessments;
2. A summary of the Third Party Contractor's timeliness in scheduling and performing assessments and reassessments;
3. A summary of findings from Beneficiary feedback research conducted by the Third Party Contractor;
4. A summary of any challenges and risks perceived by the Third Party Contractor in the year ahead and how the Third Party Contractor proposes to manage or mitigate those; and
5. Recommendations for improving the efficiency and quality of the services performed.

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	Contracted Entity
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	☑	☑	☐

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

Performance Measure:	**AA5: Number and percentage of participants with delivery of at least two HCBS Waiver services on their PCSP. Numerator: Number of participants with delivery of at least two HCBS Waiver services on their PCSP; 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*		
		☐ Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ 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:	**AA6: Number and percentage of providers certified by DDS. Numerator: Number of provider agencies that obtained annual recertification in accordance with promulgated standards. Denominator: Number of provider agencies reviewed.**

Data Source *(Select one):* **Other**

b. Methods for Remediation/Fixing Individual Problems

i *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

The Division of Developmental Disabilities Services (DDS, the operating agency) and the Division of Medical Services (DMS, the State Medicaid agency) participate in quarterly team meetings to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DDS and DMS have measures related to administrative authority of the HCBS Waiver.

In cases where the numbers of unduplicated participants served in the HCBS Waiver are not within approved limits, remediation includes HCBS Waiver amendments and implementing a waiting list. DMS reviews and approves all policy and procedures, including HCBS Waiver amendments, developed by DDS prior to implementation. In cases where policy or procedures were not reviewed and approved by DMS, remediation includes DMS reviewing the policy upon discovery, and approving or removing the policy.

In cases where there are problems with level of care determinations completed by a qualified evaluator, where instruments and processes were not followed as described in the Waiver, or were not completed within specified timeframes, additional staff training, staff counseling or disciplinary action may be part of remediation. Similarly, remediation for PCSPs not completed in specified time frames includes completing the PCSP upon discovery, additional training for staff, and staff counseling or disciplinary action. DDS conducts all remediation efforts in these areas.

Remediation to address participants not receiving monthly monitoring of at least two waiver services ~~at least two waiver services a month~~ in accordance with the PCSP and the agreement with DMS includes closing a case, conducting monitoring visits, revising a PCSP to add a service, checking on provider billing, and providing training. DDS conducts remediation efforts in these areas, and the tool used for case record review documents and tracks remediation.

Remediation associated with provider certifications that are not current may include recertifying providers upon discovery if appropriate, requesting termination of the provider's Arkansas Medicaid enrollment, referral to the Office of Medicaid Inspector General for possible recoupment for services provided after certification expired, and allowing the participant to choose another provider. DDS conducts remediation in these areas.

ii ***Remediation Data Aggregation***

Remediation-related Data Aggregation and Analysis (including trend	***Responsible Party** (check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that*

identification)		*applies)*
	☑*State Medicaid Agency*	☐ *Weekly*
	☑ *Operating Agency*	☑*Monthly*

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	**Unduplicated Number of Participants**
Year 1	~~4303~~4803
Year 2	~~4343~~4843
Year 3	~~4363~~4863
Year 4	~~4383~~4883
Year 5	~~4403~~4903

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

○	**The State does not limit the number of participants that it serves at any point in time during a waiver year.**
⊙	**The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	**Maximum Number of Participants Served At Any Point During the Year**
Year 1	~~4183~~4683
Year 2	~~4223~~4723
Year 3	~~4243~~4743
Year 4	~~4263~~4763

Year 5	~~4283~~4783

○	**The State establishes the following reasonable limits** *Specify*:

Appendix 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, <u>and</u> (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 waiver 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*:* 2	
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:
		<u>A participant must receive case management and have authorized and delivered one other Waiver Service, as documented in the PCSP.</u> <u>Most participants receive waiver services on a monthly basis. Case managers are responsible for monthly monitoring of participant's health and safety.</u> <u>It is the intention of DDS to move from the current model of conflict free case management to case management through a contracted Managed Care Organization known as a Provider-owned Shared Savings Entity (PASSE). All participants will be enrolled with a PASSE and case management will be provided administratively, rather than as a service. The proposed date for beginning this transition is October 1, 2017.</u> <u>Therefore, DDS is requiring case management, plus one other waiver service to ensure all participants are receiving appropriate services to transition to a PASSE and remain eligible for the Waiver.</u>

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	**Directly by the Medicaid agency**
⦿	**By the operating agency specified in Appendix A**
○	**By an entity under contract with the Medicaid agency.** *Specify the entity*:
○	**Other** *Specify*:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The initial evaluation of level of care is determined by a licensed psychologist or psychiatrist or individual working under the supervision of a licensed psychologist or psychiatrist.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The initial determination of eligibility for both the HCBS Waiver and Intermediate Care Facilities for Individuals with Intellectual Disabilities (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 Waiver. This eligibility process mirrors eligibility for ICF/IID institutional care. The same criteria as specified in "B1b" is applied for both HCBS Waiver and ICF/IID initial evaluations and reevaluations.

A person meets the level of care criteria when he or she:

(1) Requires the level of care provided in an ICF/IID, as defined by 42 CFR § 440.150; and
(2) Would be institutionalized in an ICF/IID in the near future (that is, in a month or less), but for the provision of Waiver services.

According to 42 CFR 435.1009, Ark. Code Ann. § 20-48-101 *et seq*. and DDS Policy 1035, Eligibility, the DDS Psychology Team uses the same criteria to determine eligibility for HCBS Waiver as for ICF/IID. The criteria are:

(1) Verification of a categorically qualifying diagnosis;
(2) Age of onset is established to be prior to age 22;
(3) Substantial functional limitations in activities of daily living (adaptive functioning deficits) are

present and are as a result of the categorically qualifying diagnosis. Adaptive functioning deficits are defined as an individual's inability to function in three of the following six categories as consistently measured by standardized instruments administered by qualified professionals: Self-Care, Understanding and Use of Language, Learning, Mobility, Self-Direction, and Capacity for Independent Living; and

(4) The disability and deficits are expected to continue indefinitely.

The DDS Psychology team is composed of psychological examiners and psychologists (employed or contracted). It must consider any standardized evaluation of intellect and adaptive behavior when conducted by the appropriate credentialed professional as specified by the instrument. Current standard of practice dictates the acceptability of testing instruments. Examples of instruments that may be considered acceptable in the determination of eligibility for the HCBS Waiver are Wechsler Scales of Intelligence, the Stanford-Binet Scales of Intelligence, the Vineland Adaptive Behavior Scales and the Adaptive Behavior Assessment Scales.

The DDS Psychology Team reviews the evaluations that are submitted and determines whether: the instruments used are appropriate based on age, mental capacity, medical condition and physical limitations; the evaluation was performed by a qualified evaluator; scores were interpreted by the evaluator; and the report was signed and dated. DDS maintains records of instruments used and assures the appropriateness of each instrument. The DDS Psychology Team also considers social history narratives, an evaluation of the person's areas of needs, and other written reports.

A Qualified Developmental Disability Professional (QDDP) assures that an annual evaluation of the person's institutional level of care is submitted to DDS. DDS requires that a Qualified Medical Professional, as defined by the State Medicaid Agency (i.e., a physician) prescribes home and community based services to meet the assessed needs of the individual. The DDS 703 form is used to submit this information. The DDS 703 form is comparable to the DHS 703 form used by the Office of Long Term Care to determine eligibility for ICF/IID but includes modifications specific to the HCBS Waiver.

Annually, and before the end of the current PCSP year, DDS notifies the participant’s case manager of the need for PCSP renewal and the date for the next full evaluation by the DDS Psychology Team. For a full evaluation by the DDS Psychology Team, the provider must submit an IQ testing report, if required, and adaptive functioning test results, based on age and the DDS -703 Physician's form.

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

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

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

Eligibility for persons with co-occurring diagnoses of intellectual disability or developmental disability and mental illness is established when the DDS Psychology Team has determined that the primary disability for the person is the intellectual or developmental disability, not the mental illness. DDS reserves the right to require an evaluation of eligibility at any time.

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

⦿	**The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
○	**A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.** Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

DDS evaluates all applicants using the process described in B6d for the initial application for ICF/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 DHS 704.

DDS requires that, annually, providers send documentation of a standard functional assessment conducted by a Qualified Developmental Disability Professional (QDDP) for each person served by the Waiver. DDS staff review the results of the functional assessment and determine continued functional eligibility. This process is consistent with the requirements and processes for ICF/IID.

Every three (3) years, persons receiving Waiver services must be reassessed with the Independent Assessment administered by a Third Party Contractor. This assessment must be submitted to DDS for purposes of determining participant's Tier level. If there is a change in participant's condition, a new Independent Assessment may be completed to determine if the participant's Tier Level has changed.

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 Quality Assurance for an administrative review of the findings. Individuals may also appeal directly to the DHS Office of Appeals and Hearing, in accordance with DDS Appeals Policy 1076.

g. **Reevaluation Schedule**. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○	**Every three months**
○	**Every six months**
⦿	**Every twelve months**
○	**Other schedule** *Specify* the other schedule:

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

○	**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
⦿	**The qualifications are different.** *Specify the qualifications:*
	A QDDP at the Provider organization prepares and signs documentation annually to request continuation of Waiver services for persons receiving Waiver services. This is known as the annual level of care reevaluation. DDS staff who review this annual documentation will meet QDDP qualifications or have their reviews signed by a staff person who meets QDDP qualifications. DDS staff who perform periodic redeterminations of eligibility (not level of care reevaluations) will meet the qualifications of a Psychological Examiner.

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

DDS staff generate a monthly report identifying any person whose periodic functional assessment and annual institutional level of care packet are due. Periodic functional assessment are described in B.6. d. Packets include the reports and assessments noted in this section. DDS sends the report to the person's case manager, who is responsible for ensuring 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:

b.

Service Type	**Service**

Statutory Service	**Case Management**
Statutory Service	**Respite**
Statutory Service	**Supported Employment**
Statutory Service	**Supportive Living**
Extended State Plan Service	**Specialized Medical Supplies**
Other Service	**Adaptive Equipment**
Other Service	**Community Transition**
Other Service	**Consultation**
Other Service	**Crisis Intervention**
Other Service	**Environmental Modifications**
Other Service	**Supplemental Support**

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

Alternative Service Title (if any):

Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

⦿Service is included in approved waiver. The service specifications have been modified.	
Service Definition (Scope):	

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

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

1) All proposed waiver services;

2) Other state plan services;

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

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

Case Management services include the following activities:

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

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

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

4) Facilitating crisis intervention;

5) Guidance and support to obtain generic needs;

6) Case planning;

7) Needs assessment and referral for resources;

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

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

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

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

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

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

representative;

14) Provides assistance with appeals when appeal is chosen.

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

Each individual who is determined to meet the ICF/IID level of care and enrolled in the Waiver must receive an Independent Assessment performed by a Third Party Vendor. The Independent Assessment, along with the individual's application packet and functional assessments, will determine whether the Participant is in Tier 2 or Tier 3. The Independent Assessment will assess the individual in the following areas:

i. Individual Areas
- a. Medical history, current medical conditions, or conditions observed by the assessor or self-reported by the individual;
- b. Behavioral;
- c. Home living activities;
- d. Community activities;
- e. Employment;
- f. Health and safety assessment; and
- g. Social functioning

ii. Caregiver (natural supports) areas
- a. Physical/behavioral (health);
- b. Involvement;
- c. Social resources;
- d. Family Stress; and
- e. Safety

iii. Current Risk Assessment Review
- a. Safety Plan, if available;
- b. Behavior Plan;
- c. Physical Plan; and
- d. Medical Plan

Current participants will be transferred as follows:

1) Participants now classified as pervasive will be classified as Tier 3, until their yearly PCSP is due and they undergo an Independent Assessment.
2) Participants now classified as limited or extensive will be classified as Tier 2, until their yearly PCSP is due and they undergo an Independent Assessment.

Starting in October 2017, DHS and DDS will implement a Provider Led Managed Care model of case management/care coordination where each Waiver Participant is assessed for a Tier Determination, as well as needs and risks. The participant will then be enrolled in a Provider Owned Shared Savings Entity (PASSE). The PASSE will receive a global payment for each participant based upon the participant's tier. The global

payment will be used to provide services for the participant in accordance with his or her PCSP. DDS will submit a Waiver Amendment with a proposed effective date of October 1, 2017, that will incorporate these changes.

This new PASSE model will implement conflict free case management for all waiver participants. The target date for moving every waiver participant into the Provider Led Managed Care model is December 31, 2018.

Until such time as every participant can be moved over into the Provider Led Managed Care model of case management/care coordination, DDS will continue to implement the following firewalls and mitigation strategies:

1) DDS will make eligibility determinations for the Waiver, including both level of care and financial need determinations;
2) DDS will review the Provider conducted annual clinical needs-based assessment prior to approving each participant's PCSP;
3) The individual who performs the annual needs based assessment may not be a provider of services on the PCSP and may not provide direct care. DDS will monitor to make sure that assessors are not providing treatment or direct care to waiver participants;
4) DDS will perform utilization reviews;
5) DDS will review and approve/deny participants' PCSPs at the annual time of renewal or with any submitted amendment/modification;
6) Participants will be encouraged to advocate or have an advocate present during planning meetings;
7) Providers will administratively separate case management functions and staff and direct care functions and staff;
8) DDS established a consumer council to monitor issues of choice;
9) DDS established an accessible means for consumers to file grievances or complaints and to appeal to DDS regarding concerns about choice, quality, and outcomes;
10) DDS Waiver Specialists and the DDS Assistant Director of Waiver Services will oversee all plans to ensure consumer choice and control; and
11) DDS has tools in place that measure consumer experiences and capture the quality of care.

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

Case Management will be provided for up to a maximum of a 90 day transition period for all persons who seek to voluntarily withdraw from Waiver services. The transition period will allow for follow up to ensure that the person is referred to other available services and to assure that the person's needs can be met through optional services. It also serves to assure that the person understands the effects and outcomes of withdrawal and to ascertain if the person was coerced or otherwise was unduly influenced to withdraw. During this 90 day timeframe, the person remains enrolled in the Waiver and the case remains open. During the transition period, Waiver services will continue to be available up and until such time as the individual finalizes their intent to withdraw.

Case management waiver services will be furnished when payment to the hospital, NF or ICF/IID is being made through private pay or private insurance and Medicaid is not reimbursing for this care. While the waiver participant is in a hospital, nursing facility or institution (ICF) receiving treatment, they are not residing in the treatment facility. Rather, just like any non-institutionalized person or person without a developmental disability, their community residence (home in which they reside) is maintained. When Medicaid is not the payer for the treatment, the waiver individual can remain enrolled in the Waiver without harm to the payments for the treatment. When this provision applies, approval is in 3 month increments with no approval beyond 1

year.

Given the nature of the population of the ACS waiver, it is sometimes necessary to place cases in abeyance to allow the case to remain open while the participant is temporarily placed in a licensed or certified treatment program for the purposes of behavior, physical or health treatment or stabilization. On a monthly basis, the case management provider must conduct a monitoring contact and report the status to the applicable DDS Specialist. If the case management provider does not conduct the monitoring contact for the month, the DDS Specialist is responsible for the monitoring contact.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

Service contacts minimum requirements are:

1) At least one contact monthly; and
2) At least one face-to-face contact per quarter
3) For Clients in abeyance – a minimum of one visit or contact a month by the Case Manager or the DDS Specialist (When the DDS Specialist performs the monitoring functions, no waiver fee is charged or reimbursed - the cost is absorbed in the DDS Waiver Administrative budget). Abeyance is used when a person is temporarily (must be out of service at least one month with abeyance approved in 3 month increments, not to exceed one year) placed in a licensed or certified treatment program for purposes of behavior, physical or health treatment or stabilization.

This waiver service is only provided to individuals age 21 and over. All medically necessary case management services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
			Certified Case Management Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		DDS certification as a case management provider. Persons who are designated as case managers by the provider must: 1(a). Hold a Bachelor's degree in a human services field, or (b). Have at least two years college credit and two years' experience working with individuals with developmental disabilities, or	

		(c). Have two years of verified experience working with individuals with developmental disabilities and have been mentored by a case manager for two additional years or (d). Have four years of experience as a case manager in a related field. 2. Not be related by blood or marriage to the individual or to any paid caregiver, are not financially responsible for the individual or would benefit from the provision of direct services. 3. Not be disqualified from employment due to a criminal record according to Ark Code Ann. 20- 38-101 et seq., 4. Not be listed on either the adult or child maltreatment registry, and 5. Have satisfactorily completed a drug screen in accordance with the certified case management organization's policies and procedures.	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DDS Quality Assurance	**Annually**

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternative Service Title (if any):

Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	Sub-Category 2:
09 Caregiver Support	09012 respite, in-home

Category 3:	Sub-Category 3:
Category 4:	**Sub-Category 4:**

⦿Service is included in approved waiver. There is no change in service specifications.

Service Definition (Scope)**:**

Respite services are provided on a short term basis to participants unable to care for themselves due to the absence of or need for relief to the non-paid primary caregiver. Federal Financial Participation (FFP) may not be claimed for the cost of room & board, except when provided as part of the respite care furnished in a facility approved by the state; FFP may not be claimed for room and board when Respite is provided in the participant's home or private place of residence.

Receipt of respite does not necessarily preclude a participant from receiving other services on the same day. For example, a participant may receive day services, such as supported employment, on the same day as respite services.

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite may not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.

Respite services may be provided through a combination of basic child care & support services required to meet the needs of a child. ~~When respite is provided in a licensed day care facility, licensed day care home, or other lawful child care setting, waiver will only pay for the support staff required by the person's developmental disability. Parents & guardians will remain responsible for the cost of basic child care fees.~~ Waiver will not pay for child care services.

Respite may be provided in the following locations:

1) Participant's home or private place of residence;

2) The private residence of a respite care provider;

3) Foster home;

4) Licensed respite facility; or

5) Other community residential facility approved by the state, not a private residence. Respite care may occur in a licensed or accredited residential mental health facility.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There is a maximum daily rate for supportive living service, participant directed supportive living, and respite, collectively or individually. Individual daily rates in all levels require prior approval by DDS

staff.

1) Tier 3 - maximum daily rate is $391.95 with a maximum of $143,061.75 annually.

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

There is a 30 day consecutive maximum on respite services in non-HCB settings.

All units must be billed in accordance with the participant's PCSP. Extensions will be provided when extended benefits are determined to be medically necessary.

DDS and DMS have developed a timeline for implementing a new cost methodology by October 1, 2017. The proposed cost methodology will be part of the next waiver amendment and will be based upon a rate study conducted by a third party actuary.

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(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
			Certified Respite Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		The provider entity must be certified by DDS as an HCBS provider and have elected to provide respite services. The provider must provide evidence that they require the following qualifications and requirements of staff who provide respite services: 1. Have one of the following: (a) high school diploma, or GED, and (b) At least one year of relevant supervised work experience with a public health, human services or other community service agency, or (c) Have two years of verifiable successful history working with persons with developmental disabilities. 2. Demonstrate the ability to: (a) Understand written person-centered service plans, follow instructions, and document services delivered, (b) Communicate effectively,	

		(c) Perform CPR and administer first aid, (d) Access emergency service systems, and (e) Access transportation services as appropriate. 3. Not be disqualified from employment due to a criminal record according to Ark. Code Ann. §20-38-101 et seq., 4. Not be listed on either the adult or child maltreatment registry, 5. Have satisfactorily completed a drug screen in accordance with the Organization's policies.	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DDS Quality Assurance	**Annually**

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

Alternative Service Title (if any):

Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	Sub-Category 2:
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	Sub-Category 3:
03 Supported Employment	03022 ongoing supported employment, group
Category 4:	Sub-Category 4:
03 Supported Employment	03030 career planning
⦿Service is included in approved waiver. The service specifications have been modified.	
Service Definition (Scope)**:**	

Supported Employment is a tailored array of services that offers ongoing support to participants with the most significant disabilities to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for individuals for whom competitive employment has not traditionally occurred, or has been interrupted or intermittent as a result of a significant disability, and who need ongoing supports to maintain their employment.

Supported Employment array consist of the following supports:

1) Discovery Career Planning-information is gathered about a participant's interests, strengths, skills, the types of supports that are most effective, and the types of environments and activities where the participant is at his or her best. Discovery/Career Planning services should result in the development of the Individual Career Profile which includes specific recommendations regarding the participant's employment support needs, preferences, abilities and characteristic of optimal work environment. The following activities may be a component of Discovery/Career Planning: review of the participant's work history, interest and skills; job exploration; job shadowing; informational interviewing including mock interviews; job and task analysis activities; situational assessments to assess the participant's interest and aptitude in a particular type of job; employment preparation (i.e. resume development); benefits counseling; business plan development for self-employment; and volunteerism.

The service provider must produce and maintain the following documents to demonstrate compliance and delivery of services- Individual Career Profile-Discovery Staging Record.

2) Employment Path-Participant's receiving Employment Path services must have goals related to employment in integrated community settings in their Person Centered Support Plan (PCSP). Employment Path is a time-limited service that requires prior authorization for the first 12 months. One reauthorization of up to 12 months is possible, but only if the participant is also receiving Job Development services which indicates the participant is actively seeking employment. Service activities must be designed to support such employment goals. Employment Path services can replace non-work services. Activities under Employment Path should develop and teach soft skills utilized in integrated employment which include but are not limited to following directions, attending to tasks, problem solving skills and strategies, mobility training, effective and appropriate communication.-verbal and nonverbal, and time management.

The service provider must maintain the following documents to demonstrate compliance and delivery of services-PCSP, progress notes, Arkansas Rehabilitation Services Referral.

Employment supports consists of two primary components-Job development and Job Coaching.

Employment Supports Job Development services are individualized services that are specific in nature to obtaining certain employment opportunity. The initial outcome of Job Development Services is a Job Development Plan to be incorporated with the Individual Career Profile no later than 30 days after job development services commence. Job development plan should specify at a minimum the short and long term employment goals, target wages, tasks hours and special conditions that apply to the worksite for that participant; jobs that will be developed and/or description of customized tasks that will be negotiated with potential employers; initial list of employer contacts and plan for how many employers will be contacted each week; conditions for use of on-site job coaching.

The service provider must maintain the following documents to demonstrate compliance and delivery of services-Job Development Plan and participant's remuneration statement.

Employment Supports Job Coaching services are on-site activities that may be provided to a participant once employment is obtained. Activities provided under this services may include, but are not limited to, the

following: Complete job duty and task analysis; assist the participant in learning to do the job by the least intrusive method; develop compensatory strategies if needed to cue participant to complete job; analyze work environment during initial training/learning of the job, and make determinations regarding modifications or assistive technology.

This service may also be utilized when the participant choses self-employment. Activities such as assisting the participant to identify potential business opportunities, assisting in the development of business plan, as well as other activities in developing and launching a business. Medicaid Waiver funds may not be used to defray expenses associated with starting or operating a self-employment business such as capital expenses, advertising, hiring and training of employees.

The service provider of Employment Supports Job Coaching must develop a fading plan for this service to be achieved within 12 months. Additional authorizations of Employment Supports Job Coaching with no additional fading gains will require additional documentation of level of need for service.

Employment supports extended services. The expected outcome of Employment Supports Extended Services is sustained paid employment at or above minimum wages with associated benefits and opportunities for advancement in a job that meets the participant's personal and career planning goals. This service allows for the continued monitoring of the employment outcome through maintenance of regular contact with the participant and employer. Activities allowed under this service must include, but are not limited to, a minimum of one contact per quarter with the employer.

The service provider must maintain the following documents to demonstrate compliance and delivery of this service-ARS letter of closure, remuneration statement (paycheck stub) and participant's work schedule if available.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Supported employment cannot exceed $3.59 per 15 minute unit with a maximum of 32 units a day. Supported Employment provided as long term support requires monitoring at a minimum of two meetings with the individual and one employer contact each month. The person is required to work 15 hours minimum per week in accordance with ARS regulations. Exceptions must be justified by the individual's case manager and prior approved by ARS. ARS approves the exception with monthly monitoring. Exception justifications (such as medical involvement) citing why the person cannot work at least 15 hours per week must be prepared in writing by the individual's case manager and submitted to the ARS counselor assigned to the case.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
			Certified Supported Employment Vendor	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		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.~~	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DDS Quality Assurance	**Annually**
	Arkansas Rehabilitation Services	**Annually**

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternative Service Title (if any): Supportive Living

Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
02 Round-the-clock Services	02031 in-home residential habilitation
Category 2:	Sub-Category 2:
02 Round-the-clock Services	02011 group living, residential habilitation
Category 3:	Sub-Category 3:
04 Day Services	04010 prevocational services
Category 4:	Sub-Category 4:
04 Day Services	04020 day habilitation

⦿Service is included in approved waiver. The service specifications have been modified.
Service Definition (Scope):

Supportive Living is an array of individually tailored services & activities to enable participants to reside successfully in their own home, with family, or in an alternative living residence or setting. Alternative living residences include apartments, leased or owned homes, or provider group homes. Supportive living services must be provided in integrated community settings. Services are flexible to allow for unforeseen changes needed in schedules and times of service delivery. Services are approved as maximum days that can be adjusted within the annual plan year to meet changing needs.

The payments for these services exclude the costs of the person's room & board expenses including general maintenance, upkeep or improvement to the participant's or their families' homes.

Care & supervision for which payment will be made are those activities that directly relate to active treatment goals & objectives.

Residential habilitation supports are to assist the participant to acquire, retain or improve skills in a wide variety of areas that directly affect the person's ability to reside as independently as possible in the community. These services provide the supervision & support necessary for a person to live in the community. The supports that may be provided to an eligible person include the following:

-Decision making, including the identification of & response to dangerously threatening situations, making decisions & choices affecting the person's life & initiating changes in living arrangement or life activities;

-Money management, including training, assistance or both in handling personal finances, making purchases & meeting personal financial obligations;

-Daily living skills, including habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medications (to the extent permitted under state law) & other areas of daily living including proper use of adaptive & assistive devices, appliances, home safety, first aid and emergency procedures;

-Socialization, including training, assistance or both in participation in general community activities, & establishing relationships with peers. Activity training includes assisting the person to continue to participate on an ongoing basis;

-Community integration experiences, including activities intended to instruct the person in daily living & community living skills in integrated settings. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. Community experiences include activities & supports to accomplish individual goals or learning areas including recreation and specific training or leisure activities. Each activity is then adapted according to the participant's individual needs. Transportation to or from community integration experiences is an integral part of this service and is included in the daily rate computation. DDS will ensure duplicate billing between Waiver services & other Medicaid state plan services will not occur. The habilitation objectives to be served by such training must be documented in the person's service plan;

-Mobility, including training, assistance or both aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing & using public transportation, independent travel or movement within the community;

-Communication, including training in vocabulary building, use of augmentative communication devices & receptive and expressive language;

-Behavior shaping and management, including training, assistance or both in appropriate expressions of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors;

-Reinforcement of therapeutic services, including conducting exercises or reinforcing physical, occupational, speech & other therapeutic programs.

Companion & activities therapies are services and activities to provide reinforcement of habilitative training. This reinforcement is accomplished by using animals as modalities to motivate participants to meet functional goals established for the participant's habilitative training. Through the utilization of an animal's presence, enhancement and incentives are provided to participants to practice and accomplish such functional goals as follows:

1) Language skills;

2) Increase range of motion;

3) Socialization by developing the interpersonal relationships skills of interaction, cooperation and trust & the development of self-respect, self-esteem, responsibility, confidence and assertiveness;

This service does not include the cost of veterinary or other care, food, or ancillary equipment that may be needed by the animal that is providing reinforcement.

The Direct Care Supervisor employed by the Supportive Living provider is responsible for ensuring the delivery of all supportive living direct care services including the following activities:

1) The coordination of all direct service workers who provide care through the direct service provider;

2) Serving as liaison between the person, parents, legal representatives, case manager, & DDS officials;

3) Coordinating schedules for both waiver & generic service categories;

4) Providing direct planning input and preparing all direct service provider segments of any initial plan of care and annual continued stay review;

5) Assuring the integrity of all direct care service Medicaid waiver billing in that the service delivered must have DDS prior authorization & meet required waiver service definition and must be delivered before billing can occur;

6) Arranging for staffing of all alternative living settings;

7) Ensuring transportation as identified in participant's PCSP specific to supportive living services;

8) Timely collaboration with the case manager to obtain comprehensive behavior & assessment reports, continued PCSP, revisions as needs change and information and documents required for ICF/IID level of care & waiver Medicaid eligibility determination;

9) Reviewing the person's records & environments in which services are provided by accessing appropriate professional sources to determine whether the person is receiving appropriate support in the management of medication.

Health maintenance activities may be provided a supportive living worker All health maintenance activities ~~(to include oral medication administration/assistance, shallow suctioning, maintenance and use of intral-feeding and breathing apparatus /devices)~~, except injections and IV's, can be done in the home by a designated care aide, such as a waiver worker, with appropriate documentation of training. With the exception of injectable

medication administration, tasks that consumers would otherwise do for themselves, or have a family member do, can be performed by a paid designated care aide at their direction, as long as the criteria specified in the Arkansas Nurse Practices Consumer Directed Care Act has been met. Health maintenance activities are available in the Arkansas Medicaid State Plan as self-directed services. State Plan services must be exhausted before accessing waiver funding for health maintenance activities.

Persons may access both supportive living and respite on the same date as long as the two services are distinct, do not overlap and the daily rate maximum is correctly prorated as to the portion of the day that each respective service was actually provided. DDS monitors this provision through retrospective annual look behind with providers responsible to maintain adequate time records and activity case notes or activity logs that support the service deliveries. Maximum daily rate is established in accordance with budget neutrality wherein both supportive living and respite ~~independently and collectively~~ cannot exceed the daily maximum.

Controls to assure payments are only made for services rendered: ~~Controls in place include~~ requirement by assigned staff to complete daily activity logs for activities that occurred during the work timeframe with such activities linked to the PCSP objectives; supervision of staff by the direct care supervisor with sign off on timesheets weekly; audits & reviews conducted by DDS Quality Assurance (annually) & random; DDS Waiver Services annual reviews (retrospective), random attendance at planning meetings & visits to the home; DMS random audits; & oversight by the chosen and assigned case manager. Retainer payments are allowable to providers for the lesser of 14 consecutive days or number of days a participant is hospitalized or otherwise away from his or her home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There is a maximum daily rate for supportive living service, and respite, collectively or individually. Individual daily rates in all levels require prior approval by DDS staff.

1) Tier 3 - maximum daily rate is $391.95 with a maximum of $143,061.75 annually.

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

All units must be billed in accordance with the participant's PCSP. Extensions will be provided when extended benefits are determined to be medically necessary.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
			Certified Supportive Living Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Agency		The provider must be certified by DDS as an HCBS provider and have elected to provide Supportive Living services. The provider must maintain evidence that they require the following qualification and requirements of staff who provide supportive living and transportation: 1. Must have at least one of the following: a) Have a high school diploma, or GED, and b) At least one year of relevant supervised work experience with a public health, human services or other community service agency, or c) Have two years of verifiable successful history working with persons with developmental disabilities; 2.Staff must demonstrate the ability to: A) Understand written person-centered service plans, follow instructions, and document services delivered, b) Communicate effectively, c) Perform CPR and administer First Aid, d) Access emergency service systems, and e) Access transportation services as appropriate; 3. Hold a current and valid driver's license or a Commercial Driver's License (CDL), as appropriate, if they provide transportation; 4.Not be disqualified from employment due to a criminal record according to Ark. Code Ann. §20-38-101 et seq.; 5. Not be listed on either the adult or child maltreatment registry; 6. Have satisfactorily completed a drug screen in accordance with the Organization's policies; and 7. Show proof of specific training in behavioral support plans and de-escalation techniques.	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DDS Quality Assurance	**Annually**

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service:

Specialized Medical Supplies

Alternative Service Title (if any):

Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	Sub-Category 2:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
⦿Service is included in approved waiver. There is no change in service specifications.	
Service Definition (Scope)**:**	

_Specialized medical equipment and supplies include:

1) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

2) Such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations and has been deemed medically necessary by the prescribing physician;

3) Necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. The most cost effective item will be considered first.

Additional supply items are covered as a Waiver service when they are considered essential and medically necessary for home and community care. A physician must document and order all items. And all items must be included in the PCSP. When such items are included as a Medicaid state plan service, this will be an extension of such services. A denial of extension of benefits by utilization review will be required prior to approval for waiver funding by DDS. Items covered include:

1) Nutritional supplements;

2) Non-prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage.

3) Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under state plan are exhausted.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The maximum for Specialized Medical Supplies, Supplemental Support Services, and Community Transition Services, collectively or individually, is $3,690.00 per year. When a non-prescription or prescription medication is necessary to maintain or avoid health deterioration and has been deemed medically necessary, the $3,690.00 limit can be increased with the difference in the Specialized Medical Supplies maximum allowance and the required amount being deducted from the supported living maximum allowance. All such requests must be prior approved by the DDS Assistant Director of Waiver Services.

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(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
			Certified Specialized Medical Supplies Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		The Provider must be certified by DDS as an HCBS provider and have elected to provide the service Specialized Medical Supplies	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DDS Quality Assurance	**Annually**

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

Service:

Adaptive Equipment

Alternative Service Title (if any):

Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 Personal Emergency Response System (PERS)
Category 2:	Sub-Category 2:
14 Equipment, Technology, and Modifications	14020 Home and/or vehicle accessibility adaptations
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
⦿Service is included in approved waiver. The service specifications have been modified.	
Service Definition (Scope)**:**	

Adaptive Equipment means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants.

This service includes adaptive, therapeutic and augmentative equipment that enables a person to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. ~~However, therapeutic tools that therapists employ in the course of therapy are not included. Educational aids are not included.~~ Adaptive equipment needs for supported employment for a person is also included. This service may include specialized equipment such as devices, controls or appliances that will enable the person to perceive, control or communicate with the environment in which they live and to improve the person's functional capacity to perform daily life tasks that would not be possible otherwise.

Adaptive equipment includes enabling technology, such as safe home modifications, that empower participants to gain independence through customizable technologies that allow them to safely perform activities of daily living without assistance while still providing monitoring and response for those participants, as needed. Enabling technology allows participants to be proactive about their daily schedule and integrates participant choice. Before any enabling technology may be approved, it must be shown to meet a goal of the PCSP, ensures the participant's health and safety, and provides for adequate monitoring and response. Each participant who receives enabling technology must have an assessment conducted and a plan created for how that technology will be used to meet a PCSP goal, ensure the participant's health and safety, and provide adequate monitoring and response.

Personal Emergency Response Systems (PERS) can be approved when it can be illustrated to be necessary to protect the health and safety of the participant. PERS is a stationary or portable electronic device used in the participant's place of residence, which enables the participant to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device. PERS services are limited to participants who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. Included in this support are assessment, purchase, installation and monthly rental fee. PERS shall consist of installation and testing, as well as monthly monitoring performed by a response center.

Equipment may only be purchased if not available to the person from any other source. When items are included as a Medicaid state plan service, a denial by utilization review will be required prior to approval for waiver funding by DDS. Professional consultation must be accessed to ensure that the equipment will meet the needs of the person when the purchase will at a minimum but not necessarily exceed $500.00. Consultation must be conducted by a medical professional applicable as determined by the participant's condition for which the equipment is needed. Computer equipment can be approved when it will allow the participant control of their environment, to assist the participant to gain independence, or it can be demonstrated as necessary to protect the health and safety of the participant. The waiver does not cover supplies. Printers may be approved for non-verbal participants. Computer desks or other furniture items will not be covered. Communication boards are an allowable device. Computers may be approved for communication when there is substantial documentation that a computer will meet the needs of the person more appropriately than a communication board. Software will be approved only when required to operate the accessories included for environmental control; or to provide text-to-speech capability.

Vehicle Modifications are adaptations to an automobile or van to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant. Payment for permanent modification of a vehicle is based on the cost of parts and labor, which must be quoted and paid separately from the purchase price of the vehicle to which the modifications are or will be made. Transfer of any part of the purchase price of a vehicle, including preparation and delivery, to the price of a modification is fraudulent activity. All suspected fraudulent activity will be reported to the Office of Medicaid Inspector General (OMIG) for investigation. Reimbursement for a permanent modification cannot be used or considered as down payment for a vehicle. Lifts that require vehicle modification and the modifications are, for purposes of approval and reimbursement, one project and cannot be separated by plan of care years in order to obtain up to the maximum. ~~of $7687.50 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 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. Cost of repair shall be determined by repair estimates from three qualified repairers. 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, Kansas City, Saint Louis, and Memphis. If the participant 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, only the estimated residual value of the vehicle modification will be considered for approval. Estimated residual value shall be determined by comparing the purchase price of the modified vehicle when acquired by the participant or legally responsible party with the vehicle value at the time of sale determined as stated above. 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%). Vehicle modifications apply only to modifications and may not be applied to routine auto maintenance or repairs for the vehicle.~~

Vehicle Modification Exclusions: The following are specifically excluded:

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

2) Purchase, down payment, monthly car payment, or lease cost of the vehicle;

3) Regularly scheduled upkeep and maintenance of the vehicle ~~except upkeep and maintenance of the modifications~~.

Conditions - The care and maintenance of environmental equipment, adaptive equipment and personal emergency response systems are entrusted to the individual or legally responsible person for whom the aids are purchased. Negligence (defined as failure to properly care for or perform routine maintenance) shall mean that the service will be denied for a minimum of two plan years. Any abuse or unauthorized selling of aids by the individual or legally responsible person shall mean that the aids will not ever be replaced using Waiver funding. Deterrent for non-compliance is in the form of public comment through promulgation of this stipulation; notice of cause and effect at the time of individual equipment approval; monitoring is accomplished when the item is later requested again with denial if the original item is found to been sold; identification of other funding sources when the item is needed to help assure health and safety. Examples: Special needs (100% state general revenue) funding is available for persons not receiving waiver services. If waiver services are not available then special needs is an option. Another example or option is that waiver services would continue but not in the home of the person who was responsible for the loss.

All adaptive equipment must be solely for the waiver individual and used only by that individual. All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids with the lowest bid with comparable quality being awarded; however, DDS may require 3 bids for any requested purchase. Swimming pools (in-ground or above ground) and hot tubs are not allowable as either an environmental modification or adaptive equipment. ~~Therapy and educational aids are not allowable. Medicaid purchased equipment cannot be donated if the equipment being donated is needed for use of another waiver individual residing in the residence.~~

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The annual expenditure cap for environmental modifications and adaptive equipment is $7,687.50.

The $7,687.50 limit can be increased with the difference in the Adaptive Equipment maximum allowance and the total required amount being deducted from the supportive living maximum allowance. The allowed maximum can be increased upon a showing of medical necessity, with the difference in the total rate amount and the amount allowed being deducted from the supplemental living maximum allowance.

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(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
			Certified Adaptive Equipment Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		The Provider must be certified by DDS as an HCBS provider and have elected to provide the service Adaptive Equipment.	

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DDS Quality Assurance	**Annually**

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

Service:

Community Transition Service

Alternative Service Title (if any):

Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
16 Community Transition Service	16010 community transition service
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
⦿Service is included in approved waiver. There is no change in service specifications.	
Service Definition (Scope)**:**	
Community Transition Services are non-recurring set-up expenses for participants who are transitioning from an institutional or provider-operated living arrangement, such as an ICF or group home, to a living arrangement in a private residence where the participant or his or her guardian is directly responsible for his or her own living expenses. Waiver funds can be accessed once it has been determined that the Waiver is the payer of last resort. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute	

room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the PCSP development process, clearly identified in the PCSP, and the person is unable to meet such expenses or when the services cannot be obtained from other sources.

Community Transitions Services cannot duplicate environmental modifications. This will be prevented through DDS control of prior authorizations.

Costs for Community Transition Services, furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the Waiver, are considered to be incurred and billable when the person ~~leaves the institutional setting and enters the Waiver~~ is determined to be eligible for Waiver services. If for any unseen reason, the individual does not enroll in the Waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid ~~as an administrative cost~~.

Exclusions: Community Transition Services may not include payment for room and board; monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a Waiver provider where the provision of these items and services are inherent to the service they are already providing. Diversionary or recreational items such as televisions, cable TV access or VCR's are not allowable.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum annual allowance for Supplemental Support Services, Community Transition Services and Specialized Medical Supplies is $3,690.00.

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(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Certified Community Transition Service Provider

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		The provider entity must be certified by DDS as an HCBS provider and have elected to provide community transition services. The provider must maintain evidence that they require the following qualifications and requirements of staff who coordinate expenditure	

		of community transition funds: 1. Must have at least one of the following: a. Hold a Bachelor's degree in a human services field, or b. Have at least two years college credit and two years’ experience working with persons with developmental disabilities, or c. Have two years of verified experience working with persons with a developmental disability and have been mentored by a case manager for two additional years, or d. Have four years of experience as a case manager in a related field; 2. Must: a. Not be disqualified from employment due to a criminal record according to Ark. Code Ann. §20-38-101 et seq., b. Not be listed on either the adult or child maltreatment registry, and c. Have satisfactorily completed a drug screen in accordance with the Organization’s policies.	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DDS Quality Assurance	**Annually**

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

Service:

Consultation

Alternative Service Title (if any):

Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
17 Other Service	17990 other

Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

⦿Service is included in approved waiver. There is no change in service specifications.

Service Definition (Scope)**:**

Consultation services are clinical and therapeutic services which assist the participant, parents, legally responsible persons, responsible individuals and service providers in carrying out the person's PCSP. Consultation activities are provided by professionals licensed as one of the following:

1) Psychologist

2) Psychological Examiner

3) Mastered Social Worker

4) Professional Counselor

5) Speech Pathologist

6) Occupational Therapist

7) Registered Nurse

8) Certified Parent Educator or Provider Trainer

9) Certified Communication and Environmental Control Specialist

10) Qualified Developmental Disability Professional (QDDP)

11) Positive Behavior Support (PBS) Specialist

12) Physical Therapist

13) Rehabilitation Counselor

14) Dietitian

15) Recreational Therapist

16) Behavior Analyst

These services are direct in nature. The parent educator or provider trainer is authorized to provide the activities identified below in items 2, 3, 4, 5, 7 and 13. The provider agency will be responsible for maintaining the necessary information to document staff qualifications. Staff that meets the certification criteria necessary for other consultation functions may also provide these activities. Selected staff or contract individuals may not provide training in other categories unless they possess the specific qualifications required to perform the other consultation activities. Use of this service for provider training CANNOT be used to supplant provider trainer responsibilities that are included in provider indirect costs. Consultation Service activities include:

1) Provision of updated psychological and adaptive behavior assessments;

2) Screening, assessing and developing therapeutic treatment plans;

3) Assisting in the design and integration of individual objectives as part of the overall individual service planning process as applicable to the consultation specialty;

4) Training of direct services staff or family members in carrying out special community living services strategies identified in the participant's PCSP as applicable to the consultation specialty;

5) Providing information and assistance to the persons responsible for developing the participant's overall PCSP as applicable to the consultation specialty;

6) Participating on the interdisciplinary team, when appropriate to the consultant's specialty;

7) Consulting with and providing information and technical assistance with other service providers or with direct service staff or family members in carrying out the participant's PCSP specific to the consultant's specialty;

8) Assisting direct services staff or family members to make necessary program adjustments in accordance with the participant's PCSP applicable to the consultant's specialty;

9) Determining the appropriateness and selection of adaptive equipment to include communication devices, computers and software consistent with the consultant's specialty;

10) Training or assisting participants, direct services staff or family members in the set up and use of communication devices, computers and software consistent with the consultant's specialty;

11) Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment and plan modification consistent with the consultant's specialty;

12) Training of direct services staff or family members by a professional consultant in:

a) Activities to maintain specific behavioral management programs applicable to the participant,

b) Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the participant,

c) The provision of medical procedures not previously prescribed but now necessary to sustain the participant in the community.

13) Training or assisting by advocacy consultants to participants and family members on how to self-advocate.

14) Rehabilitation Counseling for the purposes of supported employment supports that do not supplant the federal Rehabilitation Act of 1973 and PL 94-142 and the supports provided through the Arkansas Rehabilitation Services.

15) Training and assisting participants, direct services staff or family members in proper nutrition and special dietary needs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum annual amount is $1,320.00 ~~the first waiver year~~ and is reimbursable at no more than $136.40 per hour.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☐	Agency. List the types of agencies:
	Certified Consultation Provider			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual		DDS Certification as an HCBS provider and have selected to provide Consultation services. The certified HCBS provider must ensure that the individual providing Consultation has current credentials which correspond to the specific area of consultation they provide. Consultation service providers must demonstrate evidence that they require that professionals who provide the direct service hold a current license or certification by the Arkansas state board or organization of licensing or certification as follows: 1. Psychologists: Current license from the Arkansas	

		Psychology Board as a Psychologist 2. Psychological Examiners: Current license from the Arkansas Psychology Board as a Psychological Examiner. 3. Mastered Social Workers: Current license as an LMSW or ACSW by the Arkansas Social Work Licensing Board. 4. Professional counselors: Current license as a counselor by the Arkansas Board of Examiners in Counseling. 5. Speech pathologists: Current license in Speech Therapy by the Arkansas Board of Examiners in Speech Language Pathology and Audiology. 6. Occupational therapists: Current license in Occupational Therapy by the Arkansas State Medical Board. 7. Registered Nurses: Current license as a Registered Nurse by the Arkansas State Board of Nursing. 8. Certified parent educators: Qualified Developmental Disabilities Professional (QDDP) as defined in 42 C.F. R. Subsection 483.430(a). 9. Certified communication and environmental control adaptive equipment or aids providers: Documentation as a current provider of Durable Medical Equipment with the Arkansas Medicaid Program. 10. QDDP must present documentation of credentials in accordance with 42 CFR Subsection 483.430(a). 11. Positive Behavior Support Specialist must be certified through our Center of Excellence University of Arkansas Partners for Inclusive Communities. 12. Physical Therapists as licensed by Arkansas State Board of Physical Therapy. 13. Rehabilitation counselors with Masters Rehabilitation Counseling must be certified through Arkansas Rehabilitation Service. 14. Dieticians with degree in Nutrition must be certified by Arkansas Dietetics Licensing Board. 15. Recreational Therapists with degree in Recreational Therapy-State certification not required but to provide services must provide credentials (appropriate degree). 16. Behavior Analyst certified by the Behavior Analyst Certification Board as defined in Arkansas Code Ann. §23-99-418.	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DDS Quality Assurance	**Annually**

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

Service:

Crisis Intervention

Alternative Service Title (if any):

Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	Sub-Category 2:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
⦿Service is included in approved waiver. There is no change in service specifications.	
Service Definition (Scope)**:**	
Crisis Intervention is delivered in the eligible person's place of residence or other local community site by a mobile intervention team or professional. Intervention shall be available 24 hours a day, 365 days a year. Intervention services shall be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geographic area conducive to rapid intervention as defined by the provider responsible to deploy the team or professional. Services may be provided in a setting as determined by the nature of the crisis; i.e., residence where behavior is happening, neutral ground, local clinic or school setting, etc., for persons participating in the Waiver program and who are in need of non-physical intervention to maintain or re-establish a behavior management or positive programming plan.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The maximum rate is $127.10 per hour. <u>The annual maximum is $2640.00.</u> This waiver service is only provided to individuals age 21 and over. All medically necessary Crisis Intervention services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.	

Service Delivery Method *(check each that*	☐	Participant-directed as specified in Appendix E	☑	Provider managed

applies):				

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
			Certified Crisis Intervention Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		Crisis Intervention service providers must demonstrate evidence that they require that professionals who provide the direct service hold a current license or certification by the Arkansas Board of licensing or certification as follows: 1. Psychologists: Current license as a Psychologist by the Arkansas Board of Psychology. 2. Psychological Examiners: Current license as a Psychological Examiner by the Arkansas Board of Psychology. 3. Mastered social workers: Current license as an LMSW, LCSW, or ACSW by the Arkansas Social Work Licensing Board. 4. Professional counselors: Current license as a counselor by The Arkansas Board of Examiners in Counseling. 5. Qualified Developmental Disabilities Professional as defined in 42 C.F.R. Subsection 483.430(a). 6. Certified Positive Behavior Supports Specialist Crisis Intervention Providers must maintain documentation that they require that professionals who provide the direct service have satisfactorily passed a criminal background check and adult and child maltreatment registry checks. Criminal background checks and adult maltreatment checks must be repeated every five years and child maltreatment registry check every two years.	

		Crisis Intervention Providers must require that direct staff have satisfactorily passed a pre-employment drug screen.	

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DDS Quality Assurance	**Annually**

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

Service:

Environmental Modifications

Alternative Service Title (if any):

Service Specification	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
⊙Service is included in approved waiver. There is no change in service specifications.	
Service Definition (Scope)**:**	
Environmental Modifications are modifications made to or at the home, required by the participant's PCSP, which are necessary to ensure the health, welfare and safety of the participant, <u>or that enable the participant to function with greater independence,</u> and without which, the participant would require institutionalization. Such environmental modifications may include the installation of ramps, widening of doorways, modification of bathroom facilities, installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment, installation of sidewalks or pads to accommodate ambulatory impairments, and home property fencing when medically necessary to assure non-elopement, wandering or	

straying of persons who have dementia, Alzheimer's disease, other causes of memory loss or confusion as to location or decreased mental capacity or aberrant behaviors.

Expenses for the installation of the modification and any repairs made necessary by the installation process are allowable. Portable or detachable modifications that can be re-located with the individual and that have a written consent from the property owner or legal designee will be considered. All services shall be provided in accordance with applicable state and local building codes. Requests for modifications must include an original photo of the site where modifications will be done; to scale sketch plans of the proposed modification project; identification of other specifications relative to materials, time for project completion and expected outcomes; labor and materials breakdown and assurance of compliance with any local building codes. Final inspection for the quality of the modification and compliance with specifications and local codes is the responsibility of the Waiver case manager. Payment to the contractor is to be withheld until the work meets specifications, including a signed customer satisfaction statement.

Exclusions: Outside fencing is limited to one fence per lifetime. Total perimeter fencing is excluded. Excluded are those modifications or improvements to the home which are of general utility, and are not of direct medical and remedial benefit to the individual, such as carpeting, roof repair, central air conditioners, etc. Also excluded are modifications or improvements that are of aesthetic value (such as wallpaper, marble countertops, or ceramic tile) Modifications that add to the total square footage of the home are excluded from this benefit. Expenses for remodeling or landscaping which are cosmetic, designed to hide the existence of the modification, or result from erosion are not allowable. Environmental modifications that are permanent fixtures will not be approved for rental property without the prior written authorization and a release of current or future liability by the residential property owner. Environmental modifications may not be used to adapt living arrangements that are owned or leased by providers of waiver services. ~~Requests that fall within the category of general home repairs or modifications will not be allowable.~~ Swimming pools (both in and out of ground) and hot tubs are not allowable. The moving of modifications, such as fencing or ceiling tracks and adaptive equipment that may be permanently affixed to the structure or outside of a premises is not allowed.

Conditions - All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids with the lowest bid with comparable quality being awarded; however, DDS may require 3 bids for any requested modification. All modifications must be completed within the plan of care year in which the modifications are approved.

Environmental modifications may only be funded by Waiver if not available to the participant from any other source. When environmental modifications are included as a Medicaid state plan service, a denial by utilization review will be required prior to approval for Waiver funding by DDS.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The annual expenditure cap for environmental modifications and adaptive equipment is $7,687.50.

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(s)	☐	Individual. List types:	☑	Agency. List the types of agencies:
			Certified Environmental Modifications Provider	

(check one or both):		

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		Certification by DDS as an HCBS Provider and have elected to provide Environmental Modifications services. Certified providers must demonstrate evidence that they require that professionals who provide the direct services be appropriately licensed and bonded in the State of Arkansas, as required, and possess any other appropriate credentials, skills, and experience to perform jobs requiring specialized skills, including but not limited to electrical and plumbing services and heating and ventilation services.	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DDS Quality Assurance	**Annually**

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).

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

Service:

Supplemental Support

Alternative Service Title (if any):

Service Specification
HCBS Taxonomy

Category 1:	Sub-Category 1:
17 Other Service	17990 other
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

⦿Service is included in approved waiver. There is no change in service specifications.

Service Definition (Scope)**:**

Supplemental Support services meet the needs of the person to improve or enable the continuance of community living. ~~This service is only available in response to crisis, emergency or life threatening situations.~~ Supplemental Support Services will be based upon demonstrated needs as identified in a person's PCSP as unforeseen problems arise that, unless remedied, could cause a disruption in the participant's services, placement, or place the participant at risk of institutionalization. Waiver funds will be used as the payer of last resort.

This service can be accessed ONLY as a last resort. Lack of other available resources must be proven.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum annual allowance for Supplemental Support Services, Community Transition Services and Specialized Medical Supplies, collectively or individually, is $3,690.00.

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(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
			Certified Supplemental Support Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		The provider entity must be certified by DDS as an HCBS provider and have elected to provide supplemental support services. The provider must maintain evidence that they require the following qualifications and requirements of staff who coordinate expenditure of supplemental support funds: 1. Must have at least one of the following: a. A Bachelor's degree in a human services field,	

		or b. At least two years college credit and two years' experience working with persons with developmental disabilities, or c. Two years of verified experience working with persons with a developmental disability and have been mentored by a case manager for two additional years, or d. Four years of experience as a case manager in a related field; 2. These individuals must: a. Not be disqualified from employment due to a criminal record according to Ark. Code Ann. §20-38-101 et seq.; b. Not be listed on either the adult or child maltreatment registry; and c. Have satisfactorily completed a drug screen in accordance with the Organization's policies.	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	DDS Quality Assurance	**Annually**

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:
	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. In certain narrowly prescribed circumstances, a provider may waive DDS disqualification of an applicant or employee in accordance with Section 504 of the DDS Criminal Record Check Standards.
○	**No**. Criminal history and/or background investigations are not required.

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)*:

⦿	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	Arkansas maintains two statewide Central Registries of substantiated cases of abuse and neglect. The DHS Division of Children and Family Services (DCFS) maintains the child abuse registry and Adult Protective Services (APS) maintains the adult abuse registry. All DDS certified Waiver providers must initiate a check of both registries. Providers must also check any adult over the age of 18 residing in an alternative living home or group home, including employee's spouses. This check will provide documentation that the prospective employee's name and any adult family members' who reside with Waiver participants, names do not appear on the statewide central registry. Each provider is required to adopt policies that comply with Licensure Standards addressing what actions will be taken if an adult family member's name appears on the central registry when the individual being served is in an alternative living home or group home. If a record is found in either registry, the individual who received this information shall notify the Director of the program in writing so that corrective measures may be determined. When a provider is notified that an individual's name is on either Registry, the provider must take corrective measures to comply with DDS Licensure Standards. DDS Quality Assurance staff reviews evidence of central registry checks for each provider during the annual review. In addition, all DDS staff are required to undergo abuse registry checks. If any disqualifying record is found, the individual's employment with DDS is terminated. Process for ensuring that mandatory screenings have been conducted: on-site Quality Assurance monitoring by Licensure/Certification staff includes review of personnel files for compliance.

○	**No**. The State does not conduct abuse registry screening.

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. *Do not complete Items C-2-c.i – c.iii.*
⊙	**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). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility		
Support living arrangement apartments owned and operated by waiver providers		
Group Homes		

	☐ *Other* *Specify:*

Add another Performance measure (button to prompt another performance measure)

b Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

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

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.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

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

Performance Measure:	**QP C1: Number and percentage of provider agencies that meet DDS requirement for abuse and neglect reporting training for staff. Numerator: Number of provider agencies investigated who complied with Standard 303.A.1.l & 304.A.8; Denominator: Total number of provider agencies reviewed or investigated.**		
Data Source *(Select one) (Several options are listed in the on-line application):* **Other**			
If 'Other' is selected, specify: **Report of Abuse and Neglect Staff Training Deficiencies**			
Report of Abuse and			
	Responsible Party for	***Frequency of data***	***Sampling Approach***

	data collection/generation *(check each that applies)*	***collection/generation:*** *(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*	
		☑ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	**QP C2: Number and percentage of provider agencies that meet DDS requirements for training staff on the specific needs of the persons they serve. Numerator: Number of provider agencies who complied with Standard 305.A.2.a-d, 305.A.3.a, & 305.A.4.a-c; Denominator: Total number of provider agencies reviewed or investigated.**		
Data Source *(Select one) (Several options are listed in the on-line application):* **Other**			
If 'Other' is selected, specify: **Report of Individualized Staff Training Deficiencies**			
Report of Abuse and			
	Responsible Party for data collection/generation *(check each that*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	applies)		

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.

N/A

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

○	**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; and, (f) how participants are notified of the amount of the limit.

☑	**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*.
	The rates included in this waiver were initially set in 1990. Arkansas proposed in the last waiver, effective ____, that it will submit an amendment to implement a new rate methodology for all services within 12 months. Arkansas also promised to provide a timeline for the new rate

methodology within 3 months of the effective date of that amendment. In order to honor that commitment, Arkansas DMS and DDS are working with a third party vendor to conduct a comprehensive rate study of all HCBS Waiver services. AR will consult with CMS during the development of the rate methodology and will comply with all public notice requirements.

Proposed timeline of rate methodology amendments:

- March 10, 2017: Have all data submitted to the actuary for the rate study.
- April 9, 2017: Receive the propose rate methodology from the actuary.
- April 10-May 8, 2017: Draft Waiver Amendment, including DHS Internal Review and approval; obtain stakeholder engagement and input.
- May 8-15, 2017: Governor's office review and approval of waiver amendments, including rate methodology.
- May 15-June 15, 2017: Public Comment Period and Public Hearing.
- June 15-30, 2017: Review public comments, respond to comments, and compile comments for submission with Waiver amendment.
- July 1, 2017: Submit the rate methodology as part of the waiver amendments to CMS.

Rate Determination Responsibility: DDS is responsible to develop and present all proposed rates to the DMS. The Division of Medical Services is responsible for the approval of rates and methodologies.

Rate Determination Public Comments: Public comments are sought on an informal basis as the State develops the draft waiver document. Public comments are sought on a formal basis as the State promulgates the waiver document according to the AR Administrative Procedures Act. The Act requires advertisement in a newspaper of statewide circulation and a public comment period. The State collects all comments and makes changes as necessary. The Act requires that the document is presented for legislative review and approval. After public comment and legislative approval, the document is duly promulgated.

Current Limits:

1) The annual expenditure cap for environmental modifications and adaptive equipment is $7,687.50. Basis for the limit: Environmental Modifications and Adaptive Equipment - the rate is prospective based on provider costs up to a maximum of $7,687.50. However, if exceeding the cap for adaptive equipment is medically necessary, the difference in the total amount needed for adaptive equipment and $7,687.50, will be offset against the supportive living maximum. The maximum was based on average consumer needs at the time of limitation setting in 1990.

2) The maximum annual allowance for Supplemental Support Services, Community Transition Services and Specialized Medical Supplies, collectively or individually, is $3,690.00. When services are accessed in the same year, the combined maximum allowance is $3690.00. Basis for cost limit: Specialized Medical Supplies, Supplemental Supports and Community Transition Services - the rate is prospective based on provider costs up to a maximum of $3,690.00. The maximum was based on average consumer needs at the time of limitation setting in 1990.

3) There is a maximum daily rate for supportive living services, and respite. Supportive living includes provider indirect costs for each component in the array. Individual daily rates in all levels require prior approval by DDS staff.

(1) Tier 3 - maximum daily rate is $391.95 with a maximum of $143,061.75 annually.

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

All services must be billed in accordance with the participant's PCSP. Extensions of Benefits can be given. No exceptions are made if the documentation does not support that the person is eligible for a higher limit. Once the maximum limit for Tier 3 is reached, funding sources other than Medicaid are sought to provide for the additional care needed. Once all other sources are exhausted health and safety cannot be assured; case closure proceedings are initiated and implemented.

Each prior authorization approval that identifies the limit approved is provided to the case manager who in turn provides a copy to the participant. If a higher level is requested and denied, then written notice to include appeal rights is provided to the case manager and the participant. All waiver limits, along with other waiver information, is published on the DDS and DHS websites and incorporated in training modules and guides.

Methodology for Supported Living and Respite Pervasive Rate: In the fall of 2004, DDS professionals reviewed all waiver plans of care that: 1) met the Pervasive Service Level definition, 2) were capped at $160.00 a day, and 3) had extended, generic care that required the provision of additional state revenue above the authorized waiver service level ($160.00) in order to enable continued community living. Research of available resources identified a number of possibilities that met some but not all of the service needs identified at that time. DDS identified a companion program to the waiver Supportive Living service titled Community Integration, which was being used to increase the level of service to one that met the needs of the waiver participants. Community Integration, using SGR funding, permitted service delivery (in addition to the waiver Supportive Living service) up to a daily maximum of $196.32. The combined maximums then became the base for establishing the maximum daily rate of $356.32/day for the ACS Home and Community Based Waiver pervasive service level.

~~Extensive and Limited Level of Care is prospective based on provider costs up to a maximum of $184.80 for extensive and $160.00 for limited a day. The maximum is based on comparison costs with ICF/MR facilities at the time of limitation setting - 1990. By prospective it is meant that the rate should meet financial expectations at least for period covered for initial approval or renewal at the item of the rate setting.~~

~~Specific to the Limited Level of Care, it is based upon average provider costs to serve individuals in group homes, apartments and congregate settings. These averages were established based upon 1998 data. Waiver rates have not changed since the time of limitation rate setting.~~

DDS will now be using a three tier system. The tiers are as follows:

Tier 1: Community Clinic Level of Care. These clients are not eligible for ICF/IID; and, therefore are not eligible for waiver services.

Tier 2: Institutional Level of Care. These clients are eligible to receive ICF/IID services but do not need care 24 hours a day, seven days a week.

Tier 3: Institutional Level of Care, 24/7. These clients are eligible to receive ICF/IID services and do need care 24 hours a day, seven days a week.

	Current participants will be transferred as follows: 3) Participants now classified as pervasive will be classified as Tier 3, until their yearly PCSP is due and they undergo an Independent Assessment. 4) Participants now classified as limited or extensive will be classified as Tier 2, until their yearly PCSP is due and they undergo an Independent Assessment. Tier 2 has a maximum daily rate of 184.80, the previous extensive level maximum. Tier 3 now has a maximum daily rate of 391.95, the previous Pervasive level maximum.
☐	**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*.
	All waiver participants will now receive an independent assessment upon entry into the waiver or expiration of their existing case plan. This independent assessment will be one of many tools used to place participants into a level (or tier) of support. Tier 2 is for participants who need less than 24 hours a day, seven days a week of care. Tier 3 is for participants who need 24 hours a day, seven days a week of care. The Independent Assessment, along with the individual's application packet and functional assessments, will determine whether the Participant is in Tier 2 or Tier 3. The Independent Assessment will assess the participant in the following areas: i. Individual Areas a. Medical history, current medical conditions, or conditions observed by the assessor or self-reported by the individual; b. Behavioral; c. Home living activities; d. Community activities; e. Employment; f. Health and safety assessment; and g. Social functioning ii. Caregiver (natural supports) areas a. Physical/behavioral (health); b. Involvement; c. Social resources; d. Family Stress; and e. Safety iii. Current Risk Assessment Review

	a. Safety Plan, if available; b. Behavior Plan; c. Physical Plan; and d. Medical Plan DDS has transferred the old three level methodology over to the new two tier system. Tier 2 has a maximum daily rate of 184.80, based on the extensive level of care. Tier 3 now has a maximum daily rate of 391.95, the previous Pervasive level maximum. Current participants will be transferred as follows: 1) Participants now classified as pervasive will be classified as Tier 3, until their yearly PCSP is due and they undergo an Independent Assessment. 2) Participants now classified as limited or extensive will be classified as Tier 2, until their yearly PCSP is due and they undergo an Independent Assessment. DDS is currently undergoing a comprehensive rate study and will re-evaluate all service rates and limits. DDS plans to implement a new rate methodology based on this study beginning in October 2017.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*

Appendix C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Participant Centered Service Plan (PCSP)

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 *(check 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:*

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*:
	The new Provider-owned Arkansas Shared Savings Entity (PASSE) model will implement conflict free case management for all waiver participants. The target date for enrolling every waiver participant into a PASSE is December 31, 2018. Until that time, DDS will continue to implement the following firewalls and mitigation strategies: 1) DDS will make eligibility determinations for the Waiver, including both level of care and financial need determinations; 2) DDS will review the Provider conducted annual clinical needs-based assessment prior

to approving each participant's PCSP;

3) The individual who performs the annual needs based assessment may not be a provider of services on the PCSP and may not provide direct care. DDS will monitor to make sure that assessors are not providing treatment or direct care to waiver participants;
4) DDS will perform utilization reviews;
5) DDS will review and approve/deny participants' PCSPs at the annual time of renewal or with any submitted amendment/modification;
6) Participants will be encouraged to advocate or have an advocate present during planning meetings;
7) Providers will administratively separate case management functions and staff and direct care functions and staff;
8) DDS established a consumer council to monitor issues of choice;
9) DDS established an accessible means for consumers to file grievances or complaints and to appeal to DDS regarding concerns about choice, quality, and outcomes;
10) DDS Waiver Specialists and the DDS Assistant Director of Waiver Services will oversee all plans to ensure consumer choice and control; and
11) DDS has tools in place that measure consumer experiences and capture the quality of care.

c. **Supporting the Participant in Service Plan Development**. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

DDS starts the flow of information about the person's direction of and engagement in PCSP development during the intake and referral process for waiver services. Intake and Referral staff provide this information in written format and through conversations with the person and any legal representative. DDS staff provide the same information after the person has been determined eligible and is approved for HCBS Waiver services when the person chooses a provider. The entity chosen by the person for PCSP development (case manager) reinforces these rights and assures active participation by the person and any legal representative. DDS Waiver Handbooks, found on the DDS website and the website of the Arkansas Waiver Association, share this information in a user-friendly format and include contact information regarding the PCSP, provider choice, and rights and responsibilities.

The person served may invite any person they choose to participate at any step of the PCSP development process. DDS staff and the chosen provider inform all persons of any confidentiality and conflict of interest issues.

The case manager must participate as the person who will develop, oversee implementation, and update the PCSP. DDS staff and the case manager inform the person served about the benefits of inviting other individuals, such as direct service providers, professionals associated with other services (e.g., representatives of public school, other DHS Divisions, generic community supports), and DDS staff. It remains the decision of the person served to invite others to participate in the process.

When necessitated by the support needs of the person, advocates or other support person identified by the consumer may accompany the individual to help assure that the person understands the discussion and can make their desires understood. All persons responsible for implementation of the PCSP, as well as the individual, must sign the PCSP. The case manager ensures that the plan is distributed to the person served and other people involved in the implementation of HCBS services included in the plan.

If the case manager fails to include the person served and any legal representative in the PCSP development process, the PCSP is not valid. DDS staff provide information to the person served regarding direction of and engagement in the PCSP development process. People with complaints about a person's direction of, engagement in, or satisfaction with the outcome of the PCSP development process may call DDS Quality Assurance, which will investigate the complaint in compliance with DDS Policy 1010, Service Concern Investigation. DDS Quality Assurance conducts an on-site review of each provider annually and cites deficient practices related to each person's direction of and engagement in the PCSP development process.

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. Before the Person Centered Case Plan (PCSP):

1. Independent Assessments

Every applicant must undergo an Independent Assessment that will determine whether the individual is a Tier 2 (requires care less than 24 hours per day, seven days a week) or Tier 3 (requires care 24 hours a day, seven days a week). This Independent Assessment will also assess each applicants overall strengths, needs, and risks; and will be used to develop the PCSP.

2. Interim Service Plan (ISP)

When a person accesses HCBS Waiver services for the first time, the person is issued a prior approved Interim Service Plan (ISP) for up to 60 days. The ISP may include case management and supportive living for direct case supervision. DDS staff track the expiration dates of ISPs and ensure that a PCSP is complete before the ISP expires.

B. Developing the PCSP:

1. Development, Participation and Timing

The case manager is responsible for scheduling and coordinating the Person Centered Case Plan (PCSP) development meeting, including inviting all parties and making sure that the location and the attendees are acceptable to the Waiver participant. If the Waiver participant objects to the presence of any individual, that person may not attend the meeting. Aside from any objections from the Waiver participant or their legal guardian, the team may consist of professionals who might assist with generic resources, professionals who conducted assessments or evaluations, and friends and persons who support the participant. DDS staff will attend if the participant invites them. The case manager is responsible for managing and resolving any disagreements which occur during the PCSP development meeting.

2. Assessment Types, Needs, Preferences, Goals and Health Status

Prior to development of the PCSP, DDS requires that the case manager secures a functional

assessment and any evaluations that are specific to the needs of the individual. In addition to psychological testing to include a measure of IQ and the adaptive behavior assessments conducted to establish eligibility, the case manager may secure social histories, medical, physical and mental histories, a current physician evaluation, an assessment of educational needs, physical, speech and occupational therapy evaluations, as well as a risk assessment. Licensed professionals conduct applicable assessments. Other assessments which do not require a licensed person, are conducted by persons who are most familiar with the individual.

The PCSP development team must utilize the results of the Independent Assessment in creating the PCSP. When developing the PCSP the development team must consider cost-efficient options that foster independence, such as shared staffing and other adaptations. When such options are not utilized in the PCSP for a Tier 3 participant, it must be documented that the participant's health and safety require one on one staffing, twenty-four hours a day.

3. Information regarding availability of services
The DDS staff informs the participant of available Waiver services at the time of initial application. After the case manager has completed the functional assessment and met with the individual to discuss which services are needed based on the assessment, DDS meets with the individual again to offer choice of provider for each service need identified that will be addressed through the provision of HCBS services in the PCSP. The case manager has the responsibility to present information regarding service availability during the PCSP development process.

4. Addressing goals, needs and preferences and assignment of responsibilities
DDS prescribes the elements of the PCSP that requires that PCSP developers address how the team discussed, planned for and incorporated the individual's goal, needs (including health care needs), and preferences, as well as any cultural considerations. DDS requires that the developers designate who is responsible for implementation of and monitoring the PCSP. DDS requires that the PCSP be reviewed and prior authorized prior to implementation of services. During the onsite review of each provider, Certification and Licensure staff review PCSPs to make sure all elements are included.

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

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

7. Participant Engagement
From the time an individual first makes contact with DDS to apply for Waiver services, they are informed of their rights to make choices about each aspect of the services that they receive. It is the responsibility of every person at the state and the provider level to make sure that the participant is aware of and exercises their rights and to ensure that the process is driven to the maximum extent possible by him or her. During the person-centered planning meeting, every person present is

Appendix 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 HCBS Waiver staff, DDS Certification and Licensure staff and DMS Quality Assurance staff are responsible for monitoring the implementation of PCSPs and participants' health and welfare.

The case management provider is charged with the first-line responsibility for monitoring the implementation of the PCSP and the participant's health and welfare. They must maintain regular contact with the participant, making at least one ~~face-to-face~~ contact with the participant 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 participant 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 their health and safety. If the participant identifies problems, the case manager must take action to remediate the issue. The case manager is required to maintain documentation of their conversation with the participant as evidence that they are fulfilling their obligation to monitor the PCSP.

DDS Standards also require that the case manager, along with the team, must review the PCSP at least quarterly. The team must review the participant's objectives and determine if they have been accomplished, should be continued, or should be modified or discontinued. The team must use participant's input, data collection and case notes to make decisions as they review the PCSP.

DDS HCBS staff conducts a file review and a random on-site review of PCSPs. DDS staff compares planned services to those actually provided as documented on utilization reports from the Medicaid Management Information System (MMIS). These activities are conducted once every twelve months for each PCSP as it is renewed but may be conducted more frequently or when problems requiring remediation are identified.

DDS Quality Assurance staff conduct annual onsite reviews of 100% of certified providers. They select a sample of at least 10% of participants served by the provider and conduct interviews, observations and file reviews to monitor implementation of the PCSPs and the participants' health and welfare. If any of the processes reveal a problem with implementation of the PCSP or participants' health and welfare, 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 (DMS) staff (the Medicaid agency) also conducts a follow-behind review of 20% of PCSP previously reviewed by DDS staff as part of their oversight responsibilities.

DDS participates in the National Core Indicator (NCI) project. During the interview, staff ask participants if they exercised their right to choose providers, if their services are meeting their needs and wants, and if they have an effective backup plan when emergencies occur. DDS reviews the annual NCI report to identify any areas of need and takes appropriate action as necessary.

b. Monitoring Safeguards. *Select one:*

○	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
⦿	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.** The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	Case managers have frontline responsibility for monitoring implementation of PCSPs and participants' health and welfare. The new Provider Owned Shared Savings Entities (PASSE) model will implement conflict free case management for all waiver participants. The target date for enrolling every waiver participant into a PASSE is December 31, 2018. Until that time, DDS will continue to implement the following firewalls and mitigation strategies: 1) DDS will make eligibility determinations for the Waiver, including both level of care and financial need determinations; 2) DDS will review the Provider conducted annual clinical needs-based assessment prior to approving each participant's PCSP; 3) The individual who performs the annual needs based assessment may not be a provider of services on the PCSP and may not provide direct care. DDS will monitor to make sure that assessors are not providing treatment or direct care to waiver participants; 4) DDS will perform utilization reviews; 5) DDS will review and approve/deny participants' PCSPs at the annual time of renewal or with any submitted amendment/modification; 6) Participants will be encouraged to advocate or have an advocate present during planning meetings; 7) Providers will administratively separate case management functions and staff and direct care functions and staff; 8) DDS established a consumer council to monitor issues of choice; 9) DDS established an accessible means for consumers to file grievances or complaints and to appeal to DDS regarding concerns about choice, quality, and outcomes; 10) DDS Waiver Specialists and the DDS Assistant Director of Waiver Services will oversee all plans to ensure consumer choice and control; and 11) DDS has tools in place that measure consumer experiences and capture the quality of care.

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**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-assurances:

a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

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

Performance Measure:	**SP A1: Number and percentage of providers who developed service plans that were adequate and appropriate to the needs of individuals as indicated by their assessment(s). Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1408.A.3 Denominator: Total number of provider agencies reviewed or investigated.**			
Data Source *(Select one) (Several options are listed in the on-line application):* **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*		
		☑ Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and	***Frequency of data aggregation and***

analysis *(check each that applies*	***analysis:*** *(check each that applies*
☐ State Medicaid Agency	*☐ Weekly*
☑ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☑ Quarterly*
☐ Other Specify:	*☐ Annually*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:	**SP A2: Number and percentage of providers who developed service plans that addressed the individual's personal goals. Numerator: Number of provider agencies <u>reviewed or investigated</u> who complied with Standard 1404.A.6, 1404.G, & 1408.A.4; Denominator: Total number of provider agencies reviewed or investigated.**		
Data Source *(Select one) (Several options are listed in the on-line application):* **Other**			
If 'Other' is selected, specify:			
Report of Service Plan Personal Goal Deficiencies			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	*☐ Weekly*	*☑ 100% Review*
	☑ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		☑ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Data Aggregation and Analysis

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

applies	*applies*
☐ *State Medicaid Agency*	☐ *Weekly*
☑ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☑ *Quarterly*
☐ *Other* *Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other* *Specify:*

Performance Measure:	**SP A3: Number and percentage of providers who developed service plans that addressed the individual's risk factors. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1404.C; Denominator: Total number of provider agencies reviewed or investigated.**		
Data Source *(Select one) (Several options are listed in the on-line application):* **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*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *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.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

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

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

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

Performance Measure:	**SP C1: Number and percentage of providers who updated service plans at least annually. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1401.A.6 & 1412.A; Denominator: Total number of provider agencies reviewed or investigated.**		
Data Source *(Select one) (Several options are listed in the on-line application):* **Other**			
If 'Other' is selected, specify:			
Report of Service Plan Annual Update Deficiencies			
	Responsible Party for	***Frequency of data***	***Sampling Approach***

	data collection/generation *(check each that applies)*	***collection/generation:*** *(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*	
		☑ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	**SP C2: Number and percentage of providers who reviewed and revised service plans as warranted by changes in individual needs. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1401.A.6 & 1411.A.3&4; Denominator: Total number of provider agencies reviewed or investigated.**		
Data Source *(Select one) (Several options are listed in the on-line application):* **Other**			
If 'Other' is selected, specify:			
Report of Service Plan Individual Needs Deficiencies			
	Responsible Party for data collection/generation *(check each that*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	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	
		☑ Continuously and Ongoing	☐ Stratified: Describe Group:
		☐ 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.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

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

Performance	**SP D1: Number and percentage of providers who delivered services in the type, scope, amount, frequency & duration specified in the PCSP. Numerator: Number of**

Measure:	**provider agencies reviewed or investigated who complied with Standard 2201.F and 2202.E and 2203.E and 2205.F and 2206.F and 2207.E and 2208.E; Denominator: Total number of provider agencies reviewed or investigated.**		
Data Source *(Select one) (Several options are listed in the on-line application):* **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*	
		☑ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

e. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

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

Performance Measure:	**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) (Several options are listed in the on-line application):* **Other**				
If 'Other' is selected, specify:				
Individual File Review				
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*	
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*	
	☑ Operating Agency	*☐ Monthly*	*☑ Less than 100% Review*	
	☐ Sub-State Entity	*☐ Quarterly*		*☑ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*		95% with a +/- margin of error
		☑ Continuously and Ongoing		*☐ Stratified: Describe Group:*
		☐ Other Specify:		
				☐ Other Specify:

Add another Data Source for this performance measure

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:*

Add another Performance measure (button to prompt another performance measure)

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

The state operates a system of review that assures completeness, appropriateness, and accuracy of the PCSP development and service delivery, and assures freedom of choice by the participant. The system focuses on participant-centered service planning and delivery, participant rights and responsibilities, and participant outcomes.

During onsite provider certification reviews, DDS Certification and Licensure staff review PCSP for 10% of the population served for verification of service delivery in the type, scope, amount, frequency and duration specified. They also review to determine if the PCSPs address the assessed needs, personal goals, and risk factors, and were developed according to established procedures. They also review to determine if PCSPs are updated annually or when participants' needs change.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

If deficiencies are cited based on any of performance measures stated above as a result of an annual onsite certification review of a certified provider, DDS gives the provider an opportunity to develop a plan of correction. The plan of correction must address how individual problems have been resolved as well as what processes the provider will put in place to assure the deficiencies do not occur again in the future. After receipt of an acceptable plan of correction, depending on the severity of the cited deficiencies, DDS staff either issues a Certificate, or returns for a follow-up onsite review. If the follow-up review reveals that the provider has not successfully corrected the deficiencies, DDS may impose an array of enforcement remedies, and may ultimately revoke the certification of the provider.

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

When DDS determines, during a certification review or an investigation, that the provider has not met

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

Annually, DDS mails Choice Forms to all participants which offer the participant choice

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

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

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	**Responsible Party** *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **State Medicaid Agency**	☐ **Weekly**
	☑ **Operating Agency**	☐ **Monthly**
	☐ **Sub-State Entity**	☑ **Quarterly**
	☐ **Other** Specify:	☐ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

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.**

Don't need 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, including the right to change providers;

3) Service denials;

4) When their chosen providers refuse to serve them, and

5) Case closure.

The right to change providers more frequently than annually is specified in the Waiver handbook that is published on the DDS website, the promulgated Medicaid provider manual, and on the Rights and Choice form that is given to the participants annually. The form states: "I have the right to change providers at any time I may choose without fear of retaliation." This topic is covered on NCI surveys conducted by the DDS Quality Assurance Section.

Thereafter, the case manager provides continued education at each annual review and provides support at any time a service request is denied. The individual or the legal representative may file an appeal or may authorize the case manager to file an appeal on behalf of the individual.

When any adverse action occurs, including reduction, suspension or termination of HCBS Waiver services, written notice is provided to the individual, the legally responsible person, and both the case management provider and the providers of other HCBS waiver services in accordance with the Medicaid Provider Manual, Section 191.000 and the Arkansas Administrative Procedures Act, A.C.A. 25-15-201 et seq. A copy of Section 191.000 is enclosed with the notice to the individual, the legal representative, and the providers. This notice is sent both through regular and certified mail. The participant may ask for the determining entity to reconsider the denial, this request must be made in writing within 10 days of receipt of the notice.

If the reconsideration upholds the denial, reduction, suspension, or termination, participants, or their representative, may request a hearing, in writing within 30 days of receipt of the notice.

Notices of adverse action and the opportunity to request a fair hearing are maintained in the case file. When the adverse action is case closure, services shall continue during the appeal process if a fair hearing is timely requested ~~and the service provider agrees to assume the risk of nonpayment for services delivered during this time~~.

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 and Certified 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 (DCFS) and the Arkansas State Police, Crimes Against Children Division (CACD) are responsible for investigating allegations of child abuse or neglect. The DHS Division of Aging and Adult Services is responsible investigating allegations of adult abuse or neglect.

DHS Incident Reporting Policy 1090 and DDS Certification Standards for HCBS Waiver Services, Section 300 describe the incidents that the certified providers must report. 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 providers must immediately report the incident to DDS QA staff who in turn notifies the DHS Communication Director. Providers must 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 ~~by a staff person~~,
3) elopement,
4) use of restrictive interventions,
5) death, and
6) arrest.

When investigative staff receive reports of any of the critical incidents, 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.

Incidents which must be reported (but are not necessarily considered critical, unless also on the above list):
1. Death
2. The use of any restrictive intervention, including seclusion, or physical, chemical or mechanical restraint,
3. Suspected maltreatment or abuse as defined in Ark. Code Ann. §§ 12-18-103 & 12-12-1703;
4. Any injury that:
   a. Requires the attention of an Emergency Medical Technician, a paramedic, or physician,
   b. May cause death,
   c. May result in a substantial permanent impairment, or
   d. Requires hospitalization.
5. Suicide, threatened or attempted,
6. Arrest or conviction of any crime,
7. Any situation in which the location of a person has been unknown for two hours,
8. Any event in which a staff threatens a person served by the program,
9. Sentinel events, such as unexpected occurrences involving actual or risk of death or serious physical or psychological injury,
10. Medication errors made by staff that cause or have the potential to cause serious injury or illness,
11. Any rights violation that jeopardizes the health and safety or quality of life of a person served by the program,
12. Communicable disease,
13. Violence or aggression,
14. Vehicular accidents,
15. Biohazardous accidents,
16. Use or possession of illicit substances or licit substances in an unlawful or inappropriate manner,
17. Property destruction, and
18. Any condition or event that prevents the delivery of services for more than 2 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 and the Arkansas Guide to Services for Adults, 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.

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 within 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. § 12-18-601 et seq. 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 45 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 Quality Assurance (QA) investigation unit. The QA investigator reviews and evaluates the incident reports to determine if correct procedures and timeframes 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; 5) death; and 6)arrest. Certified providers are required to report an array of incidents, including the six listed above.~~

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 QA 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 investigation unit which investigates complaints and concerns, which may or may not constitute a critical incident. DDS Policy 1010 Service Concern prescribes the methods and timeframes for conducting an investigation of a concern or complaint. In brief, the investigator has three working days from the time the complaint is received to make initial contact with the person making the complaint. The investigator must begin the fact finding process within one day of initiation of the investigation and must complete the investigation within 30 days~~, unless granted an extension for cause~~. The investigator 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.

DDS Quality Assurance Certification and Licensure section is responsible for overseeing the reporting of and response to critical incidents regarding 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 to reports of incidents that certified providers submit to the DDS Investigative Unit. Thirdly, the 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 improvement 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 mandates reporting adult or child maltreatment to the Child or Adult Maltreatment Hotline. Standards also require that certified providers develop and implement policy that mandates program staff report certain incidents that occur within the program. The policy must:

1. Include all incidents described as <u>critical</u> by DDS,
2. Include any other incidents determined reportable by the program,
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 program's Internal Incident Reporting policy, and
4. 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 that 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 G-1-d. above. They review the report to determine if the provider responded appropriately to the incident; reported it timely and to the appropriate hotline, if necessary; and if it 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 Waiver participant, and the date of occurrence. Certification and Licensure staff review incident 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 <u>to determine if any actions are needed</u>.

DDS Certification and Licensure Administration maintains oversight of investigative activities. Investigative staff maintains a database that includes timeframes regarding initiation and resolution of incidents, 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-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints ***(select one):(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)***

○	**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 when the challenging behavior exhibited by the Waiver participant threatens the health or safety of the participant or others. Physical restraint ~~or "personal restraint"~~ means the application of physical force without the use of any device, for the purposes of restraining the free movement of an individual's body. Manually holding all or part of a person's body in a way that restricts the person's free movement; including any approved controlling maneuvers. 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 does not permit medications to be used to modify behavior or for the purpose of chemical restraint. 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.

DDS does not permit the use of mechanical restraints. 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.

Definitions:

"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.

~~"Restrictive Intervention" are procedures that restrict or limit 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. This includes seclusion and restraints.~~

~~"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.~~

DDS requires that, before a provider may use physical restraints, they must have developed alternative strategies to avoid the use of restraints 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,
10. Involve the fewest interventions or strategies possible, and
11. Specify the length of time restraints must be used, who will authorize the use of restraints, and methods for monitoring restraints.

A behavior management plan must be written 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 the use of restraint, restrictive intervention or 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 restraints. 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 such measure is necessary for the health and safety of the individual or others.

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 restraints. DDS Standards require that the provider report to DDS the use of restraints. 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.

DDS investigative staff collect data from provider incident reports. The data includes the frequency of use, length of time of each use, the duration of use over time and the impact of use for restraints. 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 and restrictive interventions.

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.

b. Use of Restrictive Interventions

○	**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.

Restrictive interventions are defined as procedures that restrict an individual's freedom of movement, restrict access to their property, prevent them from doing something they want to do, require an individual to do something they do not want to do, or remove something they own or have earned. Restrictive interventions include the use of time-out or separation (exclusionary and non-exclusionary).

Restrictive interventions that include aversive techniques, restrict an individual's right, or involve a mechanical or chemical restraint are prohibited.

Time-out or separation is permitted. Time-out or separation is a restrictive intervention in which a person is temporarily, for a specified period of time, removed from positive reinforcement or denied the opportunity to obtain positive reinforcement for the purpose of providing the person an opportunity to regain self-control. During that time, the person is under constant visual and auditory 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. The person is not physically prevented from leaving. Time-out may only be used when it has been incorporated into a positive behavior plan which has specified the use of positive behavior support strategies to be used before utilizing time-out.

DDS requires that, before a provider may use any restrictive intervention, they must have developed alternative strategies to avoid the use of those interventions 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 (QDDP). 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, duration of use over time and impact of restraints, restrictive interventions 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 any restrictive intervention. The DDS investigative staff review each report to determine if the use of the technique was unauthorized or misapplied. Additionally, in an effort to detect the unauthorized use 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 such measure is necessary for the health and safety of the individual or another.

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 Quality Assurance (QA) is responsible for overseeing and 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 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, duration of use over time and 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 report of the data to the DDS QA 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 I: Financial Accountability

PPENDIX 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.

The entity responsible for the periodic independent audit of the waiver program is Arkansas Legislative Audit. Audits are conducted in compliance with state law. All providers who receive a total of $100,000 up to $500,000 in state funding are required to submit a GAS audit annually. Providers who receive $500,000 or more are required to submit an A133 audit annually. The audit must be an independent audit of the provider's financial statements. All audits are reviewed by the Department of Human Services, Office of Chief Counsel (OCC) audit staff for compliance with audit requirements. If there are any concerns or problems noted, the OCC Audit staff will notify the funding division. The funding division (in this case DDS) defers the notifications to the DDS Quality Assurance Services Unit for dispensation.

Waiver programs and providers must use the Medicaid Management Information System (MMIS) for billing and payment. The Division of Medical Services (DMS) and its fiscal agent are responsible for maintaining the MMIS and the Decision Support System (data warehouse for reporting). The Division of Developmental Disabilities Services (DDS) is responsible for identifying necessary edits and audits to be used in the MMIS for proper billing and payment, and for notifying DMS of the changes needed in MMIS. DMS is responsible to determine priority for programming changes requested of Electronic Data Systems to include denial or non-priority of the change request. DMS may review claims activity through utilization review and conduct random financial audits for billing practices and utilization.

DDS is responsible for reviewing billing claims activity for each provider with DDS Specialists conducting a 100% post payment financial audit annually. This audit consists of a paper review of paid services based on MMIS records as compared to DDS prior approved Waiver services for the PCSP being reviewed. This audit occurs prior to approval of all renewed PCSPs with providers required to justify any underutilization and correct any billing errors found. When payment is questioned, a referral is made to the DMS Program Integrity for onsite resolution.

The Office of Medicaid Inspector General (OMIG) conducts annual random reviews of HCBS Waiver programs. If a review finds errors in billing, and fraud is not suspected, Medicaid recoups the money from the Waiver provider. If fraud is suspected, a referral of the Waiver provider is made to the Arkansas Attorney General's Office for appropriate action.

DDS Individual File Reviews include a review of claims paid to provider agencies for services specified

in the service plan. DMS arranges with DDS for a specified number of service plans to be reviewed annually as specified in the interagency agreement with DMS in their role as overseer. DMS conducts a retrospective review of identified program, financial and administrative elements critical to CMS quality assurance. DMS randomly reviews plans and ensures that they have been developed in accordance with applicable policies and procedures, that plans ensure the health and welfare of the participant and that financial components or prior authorizations, billing and utilization are correct and in accordance with applicable policies and procedures. DMS uses the sampling guide “A Practical Guide for Quality Management in Home & Community-Based Waiver Programs” developed by the Human Services Research Institute and the Medstat Group for CMS in 2006. 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%. An online calculator is used to determine the appropriate sample size for the Waiver population. To determine the “nth” integer, the sample is divided by the population. Names are drawn until the sample size is reached. The sample is divided by twelve for monthly review. DMS oversight results are reconciled quarterly with DDS. Where applicable, individual actions are taken with the provider or DDS staff to correct any known non-compliance or questionable practices; sometimes a change in policy or procedure may be necessary when systemic issues are discovered. Corrective action plans are required if indicated by file review. Payment Integrity looks at the circumstances to determine if fraud is suspected If so, Payment Integrity forwards the case to the Office of Medicaid Inspector General. If policy manual or rules change are indicated, a recommendation is made to the Medicaid Program, Planning and Development.

In addition to the annual retrospective review of billing utilization with any underutilization requiring explanation from the provider, DDS Waiver Specialists randomly attend a minimum of 10% of the PCSP meetings for their caseload and conduct visits to the home. DDS billing claims activity compares billing utilization to services approved on the PCSP. DDS Individual File Reviews monitors choice forms, billing, PCSP and level of care. DDS Individual File Reviews are a more complete review as opposed to just a billing review.

OMIG performs regular reviews of Waiver service providers. During the last two state fiscal years, 21% of our audits were devoted to Waiver providers. There are a number of ways in which OMIG selects providers and identifies claims for reviews. They may audit providers due to a complaint, issues identified through data analytics, or follow-ups from previous audits that resulted in findings. When identifying claims selected for review, OMIG considers a number of different factors. In the event that potential issues are identified through complaints and data analytics, the claims identified by those sources will be reviewed. OMIG also may choose to audit a random sampling of claims submitted by that provider from a specified time period. That process is completed by their data analytics department and follows the following process:

There are no generally accepted principles of statistical sampling; however, it is the goal of the data analytics department to ensure that the frames for the planned sample of claims are appropriate for the review and are composed of a representative sample of that provider’s population. OMIG does not extrapolate overpayments, they only use statistically valid random sampling as a means to conduct a probe audit of a providers’ claims when the sampling frame is too large for a full review.

OMIG utilizes a basic procedure that is reproducible and results in a probability sample. This methodology allows for an unlimited set of distinct samples that could be selected if applied to the target sampling frame. Given the random sampling methodology, it is important to note that each sampling unit has an equal probability of being selected from the sampling frame for review. The basic methodology is as follows:

1. Select a provider for review
2. Select a period to be reviewed

3. Define the claims universe, the sampling unit (number of recipients), and sampling frame (recipients to choose from)
4. Design a sampling plan and select the sample for review

OMIG utilizes a few different sampling techniques, including simple random, stratified, and cluster samples. The application of sampling technique is largely dependent upon data hypothesis and sampling frame. If a provider contains subpopulations that are necessary for review, then a stratified or cluster sample would be most appropriate. If not, the default sampling methodology is a simple random sample.

The recommended sample size based on a defined sampling frame has a 95% confidence interval with a 5% margin of error. However, sample sizes are no less than a 90% confidence interval with 10% margin of error, and this is only in the case of a very large provider with a prohibitively large patient population. This sample size would only be intended to be a probe of that patient population, with the option to drill down and expand the sample size if necessary based on findings.

The sample size is calculated using a sample size calculator by Raosoft. This calculator can be accessed at http://www.raosoft.com/samplesize.html. The calculator provides the desired sample size by prompting for margin of error, confidence interval, population size, and response distribution. Once the desired sample size has been identified, a random number generator is applied to the recipient list for a provider selected for review for a defined time period. The random recipients identified in the sampling frame then constitute the sample for review, and all other recipients' claims are removed from the claims universe; this only leaves the selected sample of recipients' claims for review.

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 Assurance**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "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. Sub-assurances:

a Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and

N/A

APPENDIX I-2: Rates, Billing and Claims

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 $117.70. This rate is consistent with the rate paid for the preceding five years of this waiver.

Supportive Living - The maximum daily rate for supportive living is $391.95 (Tier 3) and $184.80 for Tier 2. Service providers develop a budget for each individual which justifies costs based upon the assessed need and the resulting level of support identified in the person-centered service plan. The budget to support the daily cost of supportive living must include the anticipated hourly rate to be paid each direct service staff, and the associated fringe costs, up to a maximum of 32%. The initial fringe costs associated with the waiver were set in 1990 and were based on the cost of fringe for state employees. A fringe benefit is a form of pay for the performance of services. DDS uses the IRS definition of fringe benefits. Examples of fringe benefits are holidays, annual leave, sick leave, FICA, SUTA, life insurance, retirement, WC, and health and medical insurance. The budget may also include a monthly fee of $100.00 for the cost of direct service staff supervision that rate was established in 1990. Providers may include up to 20% of the cost of salary and fringe, as indirect, administrative costs. Administrative costs include clerical/bookkeeping support, rent, supervisory support, utilities, salary fringe for supervisory/support staff, supplies/materials, quality assurance and training, advertising for recruiting/employing waiver direct delivery of service staff and other expenses. The salaries of senior executives and cost of general services (such as accounting, contracting, and industrial relations) fall under administrative costs. The budget may also include the costs of non-medical transportation as part of implementation of the PCSP. The rate for transportation is .42 cents per mile and is not subject to the 20% indirect cost charge. Each provider is responsible for independently setting the hourly rate paid for direct service staff. It is basically whatever the labor market pool will tolerate. Providers must be in compliance with Department of Labor relative to minimum wage but other than that DDS only deals with a capitated daily rate.

Respite Care - The prospective rate is developed as described for supportive living, with the exception that transportation costs and the supervisory fee may not be included. The maximum daily rate is the same. This maximum rate is applied to two waiver services (supportive living and respite) because these waiver services are closely related and can serve as a substitute for one another. Without respite there would be a need for increased supportive living staff/hours to be approved in order to assure health and safety in the absence of the unpaid caregiver. There are many components of supportive living to include transportation, but the waiver recipients would only be approved for the components that they need based on a person centered service plan as approved by a physician and DDS.

Adaptive Equipment, PERS and Environmental Modifications - the rate is prospective based on actual cost with a cost maximum of $7,687.50 per individual per year. The maximum was based on average consumer needs at the time of limitation setting in 1990. The annual maximum includes Adaptive Equipment, PERS and Environmental Modifications. Personal Emergency Response System - the rate is prospective based on actual cost of installation, purchase and monthly service fees.

Specialized Medical Supplies, Supplemental Supports, and Community Transition - the rate is prospective based on actual costs with a maximum of $3,690.00 per year. The maximum was based on average consumer needs at the time of limitation setting in 1990. The annual maximum includes Specialized Medical Supplies, Supplemental Support and Community Transition.

Consultation - the annual maximum for an individual is $1320.00. This maximum is increased from the previous 5 years of the waiver.

Crisis Intervention - The maximum rate is $127.10 per hour. The annual maximum is $2640.00. There was no annual maximum for this service in the preceding 5 years of the waiver.

Supported Employment - Supported employment cannot exceed $3.59 per 15 minute unit with a maximum of 32 units a day, 5 days per week for the first year. The service may be provided up to 52 weeks in a year. The resulting maximum is $29,868.00 per year.

The rates included in this waiver were initially set in 1990. The State proposes that within 12 months from the effective date of this waiver renewal, AR will submit an amendment to implement a new rate methodology for all services. AR will consult with CMS during the development of the rate methodology and will comply with all public notice requirements.

Arkansas will submit a timeline for rate methodology amendment, well in advance, but no longer than three months after approval date of this renewal.

Rate Determination Responsibility: DDS is responsible to develop and present all proposed rates to the DMS. The Division of Medical Services is responsible for the approval of rates and methodologies.

Rate Determination Public Comments: Public comments are sought on an informal basis as the State develops the draft waiver document. Public comments are sought on a formal basis as the State promulgates the waiver document according to the AR Administrative Procedures Act. The Act requires advertisement in a newspaper of statewide circulation, and public hearings. The State collects all comments and makes changes as necessary. The Act requires that the document is presented for legislative review and recommendations. After legislative review and advice the document is duly promulgated.

The budget for each individual is determined through the Person Centered Service Plan development process. The multi-agency team includes the chosen case manager, the individual or their legal representative. All other persons attending are at the discretion of the individual or their legal representative and include other professionals as invited. The members of the team will determine services to be provided, frequency of service provision, number of units of service, cost for those services, and ensure the participant's desired outcomes, needs and preferences are addressed. The team members and a physician via a 703 certify the person's condition (level of care) and appropriateness of services initially and at the annual continued stay review date. A person centered services plan revision can be requested at any time that the person's needs change. The waiver services included in the plan of care must be prior approved by DDS.

The rates included in this waiver were initially set in 1990. Arkansas proposed in the last waiver, effective ____, that it will submit an amendment to implement a new rate methodology for all services within 12 months. Arkansas also promised to provide a timeline for the new rate methodology within 3 months of the effective date of that amendment. In order to honor that commitment, Arkansas DMS and DDS are working with a third party vendor to conduct a

comprehensive rate study of all HCBS Waiver services. AR will consult with CMS during the development of the rate methodology and will comply with all public notice requirements.

Timeline of rate methodology amendments:

- March 10, 2017: Have all data submitted to the actuary for the rate study.
- April 9, 2017: Receive the propose rate methodology from the actuary.
- April 10-May 8, 2017: Draft Waiver Amendment, including DHS Internal Review and approval; obtain stakeholder engagement and input.
- May 8-15, 2017: Governor's office review and approval of waiver amendments, including rate methodology.
- May 15-June 15, 2017: Public Comment Period and Public Hearing.
- June 15-30, 2017: Review public comments, respond to comments, and compile comments for submission with Waiver amendment.
- July 1, 2017: Submit the rate methodology as part of the waiver amendments to CMS.

Rate Determination Responsibility: DDS is responsible to develop and present all proposed rates to the DMS. The Division of Medical Services is responsible for the approval of rates and methodologies.

Rate Determination Public Comments: Public comments are sought on an informal basis as the State develops the draft waiver document. Public comments are sought on a formal basis as the State promulgates the waiver document according to the AR Administrative Procedures Act. The Act requires advertisement in a newspaper of statewide circulation and a public comment period. The State collects all comments and makes changes as necessary. The Act requires that the document is presented for legislative review and approval. After public comment and legislative approval, the document is duly promulgated.

The budget for each participant is determined through the Person Centered Service Plan (PCSP) development process. The multi-agency team includes the chosen case manager, the participant or his or her legal representative. All other persons attending are at the discretion of the participant or his or her legal representative and include other professionals, as invited. The members of the team will determine services to be provided, frequency of service provision, number of units of service, cost for those services, and ensure the participant's desired outcomes, needs and preferences are addressed. The team members and a physician via a 703 certify the person's condition (level of care) and appropriateness of services initially and at the annual continued stay review date. A PCSP revision can be requested at any time that the participant's needs change. The Waiver services included in the PCSP must be prior approved by DDS.

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

○	**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:

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.

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. This is incorporated into the DDS ACS Waiver Provider Manual at § 201.200. 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 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 ensure financial accountability. The provider must ensure that services were delivered and proper documentation was submitted for services delivered under OHCDS.

iii. Contracts with MCOs, PIH

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

⊙	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – 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					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service / Component	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Case Management	Monthly	4622	11.36	117.70	6,179,946.784
Respite	Day	177	18.16	126.2311	405,747.1494
Supported Employment	15 Minutes	118	1838.01	3.59	778,617.7962
Supportive Living	Day	4529	294	188.74	251,312,217.20
Specialized Medical Supplies	Monthly	1083	11	58.5	696,910.50
Adaptive Equipment: PERS	Monthly	39	12	29.25	13,689.0
Adaptive Equipment	Package	58	1.39	1692.41	136,442.0942
Community Transition	Package	18	1.05	3254.05	61,501.545
Consultation	Hour	857	6.25	102.96	551,479.50
Crisis Intervention	Hour	50	1.6	127.10	10,168.00
Environmental Modification	Package	180	1.05	4439.27	839,022.03
Supplemental Support	Monthly	89	3.33	378.94	112,306.4478
GRAND TOTAL:					261,098,048.10
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4835
FACTOR D (Divide grand total by number of participants)					54,001.6645
AVERAGE LENGTH OF STAY ON THE WAIVER					355

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	Monthly	4622	11.36	117.70	6,179,946.784
Respite	Day	177	18.16	126.2311	405,747.1494
Supported Employment	15 Minutes	118	1838.01	3.59	778,617.7962
Supportive Living	Day	4529	294	188.74	251,312,217.20
Specialized Medical Supplies	Monthly	1083	11	58.5	696,910.50
Adaptive Equipment: PERS	Monthly	39	12	29.25	13,689.0
Adaptive Equipment	Package	58	1.39	1692.41	136,442.0942
Community Transition	Package	18	1.05	3254.05	61,501.545
Consultation	Hour	857	6.25	102.96	551,479.50
Crisis Intervention	Hour	50	1.6	127.10	10,168.00
Environmental Modification	Package	180	1.05	4439.27	839,022.03
Supplemental Support	Monthly	89	3.33	378.94	112,306.4478
GRAND TOTAL:					261,098,048.10
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4835
FACTOR D (Divide grand total by number of participants)					54,001.6645
AVERAGE LENGTH OF STAY ON THE WAIVER					355

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	Monthly	4622	11.36	117.70	6,179,946.784
Respite	Day	177	18.16	126.2311	405,747.1494
Supported Employment	15 Minutes	118	1838.01	3.59	778,617.7962
Supportive Living	Day	4529	294	188.74	251,312,217.20
Specialized Medical Supplies	Monthly	1083	11	58.5	696,910.50
Adaptive Equipment: PERS	Monthly	39	12	29.25	13,689.0
Adaptive Equipment	Package	58	1.39	1692.41	136,442.0942
Community Transition	Package	18	1.05	3254.05	61,501.545
Consultation	Hour	857	6.25	102.96	551,479.50
Crisis Intervention	Hour	50	1.6	127.10	10,168.00
Environmental Modification	Package	180	1.05	4439.27	839,022.03
Supplemental Support	Monthly	89	3.33	378.94	112,306.4478
GRAND TOTAL:					261,098,048.10
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4835
FACTOR D (Divide grand total by number of participants)					54,001.6645
AVERAGE LENGTH OF STAY ON THE WAIVER					355

Waiver Year: Year 4					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	Monthly	4622	11.36	117.70	6,179,946.784
Respite	Day	177	18.16	126.2311	405,747.1494
Supported Employment	15 Minutes	118	1838.01	3.59	778,617.7962
Supportive Living	Day	4529	294	188.74	251,312,217.20
Specialized Medical Supplies	Monthly	1083	11	58.5	696,910.50
Adaptive Equipment: PERS	Monthly	39	12	29.25	13,689.0
Adaptive Equipment	Package	58	1.39	1692.41	136,442.0942
Community Transition	Package	18	1.05	3254.05	61,501.545
Consultation	Hour	857	6.25	102.96	551,479.50
Crisis Intervention	Hour	50	1.6	127.10	10,168.00
Environmental Modification	Package	180	1.05	4439.27	839,022.03
Supplemental Support	Monthly	89	3.33	378.94	112,306.4478
GRAND TOTAL:					261,098,048.10
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4835
FACTOR D (Divide grand total by number of participants)					54,001.6645
AVERAGE LENGTH OF STAY ON THE WAIVER					355

Waiver Year: Year 5					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management	Monthly	4622	11.36	117.70	6,179,946.784
Respite	Day	177	18.16	126.2311	405,747.1494
Supported Employment	15 Minutes	118	1838.01	3.59	778,617.7962
Supportive Living	Day	4529	294	188.74	251,312,217.20
Specialized Medical Supplies	Monthly	1083	11	58.5	696,910.50
Adaptive Equipment: PERS	Monthly	39	12	29.25	13,689.0
Adaptive Equipment	Package	58	1.39	1692.41	136,442.0942
Community Transition	Package	18	1.05	3254.05	61,501.545
Consultation	Hour	857	6.25	102.96	551,479.50
Crisis Intervention	Hour	50	1.6	127.10	10,168.00
Environmental Modification	Package	180	1.05	4439.27	839,022.03
Supplemental Support	Monthly	89	3.33	378.94	112,306.4478
GRAND TOTAL:					261,098,048.10
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4835
FACTOR D (Divide grand total by number of participants)					54,001.6645
AVERAGE LENGTH OF STAY ON THE WAIVER					355

TOC required

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

201.000 Arkansas Medicaid Program Participation Requirements for DDS ACS CES Waiver Program 10-8-107-1-17

All Division of Developmental Disabilities Services (DDS) Alternative Community Services (ACS)Community and Employment Supports (CES) waiver providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

All willing and qualified providers have the opportunity to enroll as a waiver provider. DDS provides continuous open enrollment for waiver service providers. Potential providers should contact DDS Quality Assurance staff for information on the ACS CES certification standards. Once a provider is certified by DDS, the provider must contact the DMS Provider Enrollment Unit to enroll as a Medicaid provider.

Certified and enrolled providers are allowed to specify the maximum number of persons they can serve, the county they can serve, the services they can provide and the service levels they can offer based on staff availability. Waiver beneficiaries have the freedom of choice of service providers. Once a provider is chosen by a beneficiary and who meets the designations made by the provider, the provider cannot refuse to provide services unless the provider cannot assure the health and safety of the beneficiary. It is incumbent upon the provider to prove the individual cannot be served by the provider. The burden of proof also requires written identification of the cause for the failure to provide health and safety supported by documentation that attests to that condition.

Before a provider can decrease the maximum number of persons they will serve, drop an existing county they serve, a service, or service level, the provider must identify any beneficiary currently being served that would be affected. The provider will be required to continue providing services to any persons that would be affected by the changes until such time as DDS can secure a new provider and services are in place under the new provider. If a provider elects to change the existing county served or the maximum number of participants served, the change cannot be made if it will adversely impact any person currently receiving services from the provider. The provider's maximum number of persons served may only be reduced through attritionceasing provision of services in a designated county or counties, freezing the number of persons they serve at the current number and reducing the number through attrition, or ceasing provision of services to those persons they have most recently begun serving. DDS will freeze new referrals when a provider requests to make changes in the above items but will not approve the changes for existing persons until such time as the transition has occurred to a new provider. Further, when less than an entire county is deleted from coverage, the provider must articulate in writing a business reason for making the change and demonstrate that the selection process is not capricious or arbitrary, does not result in discrimination and does not unfairly distinguish between levels of care. The process cannot be used to eliminate difficult families or persons. Other than business reasons for closing entire counties or programs, people can only be discontinued if the provider cannot assure health and safety.

Option: Based on individual choice, a provider may continue to serve a person without serving others in the county, when the individual served relocates their place of residence.

201.100 Providers of DDS ~~ACS~~ CES Waiver Services in Arkansas and Bordering States Trade Area Cities ~~3-1-10~~7-1-17

DDS ~~ACS~~ CES waiver services are limited to Arkansas and bordering state trade area cities. The DDS must certify providers located in a bordering state trade area city as ~~ACS~~ CES waiver providers before services may be provided for Arkansas Medicaid beneficiaries.

Bordering state trade area cities are Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee and Texarkana, Texas.

201.200 Organized Health Care Delivery System Provider ~~3-1-10~~7-1-17

The DDS ~~ACS~~ CES waiver allows a provider who is licensed and certified as a DDS ~~ACS~~ CES case management entity or a DDS ~~ACS~~ CES supportive living services provider to enroll in the Arkansas Medicaid Program as a DDS ~~ACS~~ CES organized health care delivery system (OHCDS) provider.

The option of OHCDS is available to any current or future provider through a written agreement between DDS and the provider entity. The agreement requires each OHCDS provider to guarantee that any sub-contractor will abide by all Medicaid regulations and provides that the OHCDS provider assumes all liability for contract noncompliance. The OHCDS provider must also have a written contract that sets forth specifications and assurances that work will be completed timely, satisfactorily to the beneficiary being served and with quality maintained. The OHCDS provider is responsible for ensuring that services were delivered and proper documentation, including a signed customer satisfaction statement, has been submitted prior to billing.

As long as the OHCDS provider delivers at least one waiver service directly utilizing its own employees, an OHCDS provider may provide any other DDS ~~ACS~~ CES waiver service via a sub-contract with an entity qualified to furnish the service. The subcontract must ensure financial accountability and that services were delivered, properly documented and billed. The primary use of OHCDS is consultation, adaptive equipment, environmental modifications, supplemental support and specialized medical supplies.

The OHCDS provider furnishes the services as the beneficiary's provider of choice as described in that beneficiary's person centered service plan

202.000 Documentation Requirements ~~3-1-10~~7-1-17

DDS ~~ACS~~ CES waiver providers must keep and properly maintain written records. Along with the required enrollment documentation, which is detailed in Section 141.000, the following records must be included in the beneficiary's case files maintained by the provider.

202.100 Documentation in Beneficiary's Case Files ~~3-1-10~~7-1-17

DDS ~~ACS~~ CES waiver providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

A. A copy of the beneficiary's person centered service plan, including any amendments thereto

B. The specific services rendered

C. The date, and actual time, the services were rendered

D. The name ~~and title~~ of the individual who provided the service

E. The relationship of the service to the treatment regimen of the beneficiary's person centered service plan

F. Updates describing the beneficiary's progress or lack thereof. Updates should be maintained on a daily basis or at each contact with or on behalf of the beneficiary. Progress notes must be signed and dated by the provider of the service.

~~G. Completed forms as required by DDS~~

~~H~~G. Certification statements, narratives and proofs that support the cost effectiveness and medical necessity of the service to be provided

Additional documentation and information may be required dependent upon the service to be provided.

202.200 HCBS Settings Requirements ~~9-1-16~~7-1-17

Home and Community-Based Services (HCBS) Settings

All providers must meet the following Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR 441.301(c) (4)-(5).

Settings that are HCBS must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

A. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.

    1. Choice must be included in the person-centered service plan.

    2. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.

B. Ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.

C. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

D. Facilitates individual choice regarding services and supports and who provides them.

E. The setting is integrated in and supports full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

F. In a provider-owned or controlled residential setting (e.g., Group Homes), in addition to the qualities specified above, the following additional conditions must be met:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each ~~HCBS~~ CES participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
2. Each individual has privacy in their sleeping or living unit:
   a. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
   b. Beneficiaries sharing units have a choice of roommates in that setting.
   c. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
3. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
4. Beneficiaries are able to have visitors of their choosing at any time.
5. The setting is physically accessible to the individual.
6. Any modification of the additional conditions specified in items 1 through 4 above must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
   a. Identify a specific and individualized assessed need.
   b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
   c. Document less intrusive methods of meeting the need that have been tried but did not work.
   d. Include a clear description of the condition that is directly proportionate to the specific assessed need.
   e. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
   f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
   g. Include the informed consent of the individual.
   h. Include an assurance that interventions and supports will cause no harm to the individual.

210.000 PROGRAM COVERAGE

211.000 Scope ~~9-1-16~~ 7-1-17

The Medicaid program offers certain home and community based services (HCBS) as an alternative to institutionalization. These services are available for eligible beneficiaries with a developmental disability who would otherwise require an intermediate care facility for the intellectually disabled/developmentally disabled (ICF/ID/DD)~~individuals with intellectual disabilities (ICF/IID)~~ level of care. This waiver does not provide education or therapy services.

The purpose of the ~~ACS~~ CES waiver is to support beneficiaries of all ages who have a developmental disability, meet the institutional level of care, and require waiver support services to live in the community and thus preventing institutionalization.

The goal is to create a flexible array of services that will allow people to reach their maximum potential in decision making, employment and community integration; thus giving their lives the meaning and value they choose.

The objectives are as follows:

A. To transition eligible persons who choose the waiver option from residential facilities into the community;

B. To provide priority services to persons who meet ~~the pervasive level~~criteria for the third tier of service (~~imminent danger and~~ requiring supports 24 hours a day, seven days a week); and

C. To enhance and maintain community living for all persons participating in the waiver program.

DDS is responsible for day-to-day operation of the waiver. All waiver services are accessed through DDS Adult Services, DDS Children's Services or the ICF/~~IID~~ ID/DD services intake and referral staff.

All ~~ACS~~ CES waiver services must be prior authorized by DDS and based on an independent assessment and functional evaluations. All services must be delivered based on the approved person-centered service plan.

Waiver services will not be furnished to persons while they are inpatients of a hospital, nursing facility (NF), or ICF/~~IID~~ ID/DD unless payment to the hospital, NF, or ICF/~~IID~~ ID/DD is being made through private pay or private insurance.

A person may be placed in abeyance in three-month increments (with status report every month) for up to 12 months when the following conditions are met:

A. The need for absence must be for the purposes of treatment in a licensed or certified program or facility for the purposes of behavior stabilization, physical or mental health treatment.

B. The loss of home or loss of the primary non-paid caregiver.

C. The request must be in writing with supporting evidence included.

D. The request must be prior approved by DDS.

E. A minimum of one visit or one contact each month is required.

NOTE: The DDS Specialist is responsible for conducting or assuring the conducting of the contacts or monitoring visits with applicable documentation filed in the case record.

F. All requests for abeyance are to be faxed to the DDS Waiver Program Director for Adult and Waiver Services. Monthly status reports are required to be submitted to the DDS Waiver Program Director as long as the person is in abeyance. Each request for continuance must be submitted in writing and supported by evidence of treatment status or progress. Requests for continuance must be made prior to the expiration of the abeyance period.

In order for beneficiaries to continue to be eligible for waiver services while they are in abeyance the following two requirements must be met:

A. It must be demonstrated that a beneficiary needs case management and at least one ~~waiver~~ other service as documented in their person centered service plan.

B. Beneficiaries must receive ~~at least one waiver service per month or~~ monthly monitoring of waiver services.

As stated in the Medical Services Manual, Section 1348, an individual living in a public institution is not eligible for Medicaid.

A. Public institutions include county jails, state and federal penitentiaries, juvenile detention centers, and other correctional or holding facilities.

B. Wilderness camps and boot camps are considered a public institution if a governmental unit has any degree of administrative control.

C. Inmate status will continue until the indictment against the individual is dismissed or until he or she is released from custody either as "not guilty" or for some other reason (bail, parole, pardon, suspended sentence, home release program, probation, etc.)

Thus, a person who is living in a public institution as defined above would be closed under Medicaid and also under the waiver program.

211.200 Risk Assessment ~~9-1-16~~7-1-17

A. DDS will not authorize or continue waiver services under the following conditions:

1. The health and safety of the beneficiary, the beneficiary's caregivers, workers or others are not assured;
2. The beneficiary or legally responsible person has refused or refuses to participate in the plan of care development or to permit implementation of the plan of care or any part thereof that is deemed necessary to assure health and safety;
3. The beneficiary or legally responsible person refuses to permit the on-site entry of: case manager to conduct required visits, caregivers to provide scheduled care, DDS, DMS, DHS or CMS officials acting in their role as oversight authority for compliance or audit purposes;
4. The beneficiary applying for, or receiving, waiver services requires 24 hour nursing care on a continuous basis as prescribed by a physician;
5. The beneficiary participating in the waiver program is incarcerated, adjudicated as guilty or is an inmate in a state or local correctional facility;
6. The person is deemed ineligible based on DDS Psychological Team assessment or reassessment for meeting ICF/IID level of care;
7. The beneficiary is deemed ineligible based on not meeting or not complying with requirements for determining continued Medicaid income eligibility.
8. The beneficiary does not undergo an independent assessment by a third-party vendor.

B. Safeguards concerning the use of Restraints or Seclusion:

1. ~~Personal~~ Physical restraints (use of a staff member's body to prevent injury to the consumer or another person) are allowed in cases of emergency. An emergency exists when:
   a. The individual has not responded to de-escalation techniques and continues to escalate behavior,
   b. The individual is a danger to self or others, or

c. The safety of the individual and those nearby cannot be assured through positive reinforcers.

An individual must be continuously under direct observation of staff members during any use of restraints.

If the use of personal restraints occurs more than three times per month, use should be discussed by the interdisciplinary team and addressed in the plan of care. When emergency procedures are implemented, plan of care revisions including but not limited to, psychological counseling, review of medications with possible medication change or a change in environmental stressors that are noted to precede escalation of behavior may be implemented.

1. ~~Mechanical restraints fall under the same requirements as the use of personal restraints in that they may only be used in emergency circumstances that place the individual or others around the individual at serious threat of violence or risk of injury if no intervention occurs. If emergency procedures are used more than three times in six months, the interdisciplinary team must meet to revise the plan of care.~~Use of mechanical or chemical restraint is not allowed. Seclusion is not allowed.

2. DDS standards require that providers will not allow maltreatment or corporal punishment (the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior) of individuals. Provider's policies and procedures must state that corporal punishment is prohibited.

~~3. Providers must develop a written behavior management policy to ensure the rights of individuals. The policy must include a provision for alternative methods to avoid the use of restraints and seclusions.~~

~~The behavior management plan must specify what behaviors will constitute the use of restraints or seclusion, the length of time to be used, who will authorize the use of restraints or seclusion and the methods for monitoring the individual.~~

~~Behavior management plans cannot include procedures that are punishing, physically painful, emotionally frightening, depriving or that put the individual at a medical risk.~~

~~When the behavior plan is implemented, all use of restraint must be documented in the individual's case record, including the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.~~

~~1. The use of restraints or seclusion must be reported to the DDS Quality Assurance section via an incident report form that must be submitted no later than the end of the second business day following the incident. The DDS Quality Assurance staff investigates each incident and monitors use of restraints for possible overuse or inappropriate use of restraints or seclusion. DDS Quality Assurance staff will notify entities involved with the complaint or service concern the results of their review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Failure to complete corrective action measures may result in the provider being placed on provisional status or revocation of certification.~~

~~2. Each person working within the provider agency must complete Introduction to Behavior Management, Abuse and Neglect and any other training as deemed necessary as a result of deficiencies or corrective actions.~~

C. Safeguards Concerning the Use of Restrictive Intervention

1. Restrictive interventions may be used.

2~~1~~. DDS standards require the use of a behavior management plan for all individuals whose behavior may warrant intervention. The behavior management plan must specify what will constitute the use of restrictive interventions, the length of time to be

used, who will authorize the use of restrictive intervention and the methods for monitoring the individual.

When the behavior plan is implemented, all use of restrictive interventions must be documented in the individual's case record and should include the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.

3~~2~~. Restrictive interventions include:

a. Absence from a specific social activity, ~~or~~

b. Temporary loss of a personal possession, or

c. Time out or separation.

4. Restrictive interventions cannot include:

a. Aversion techniques,

b. Restrictions to an individual's rights, including the right to physically leave,

c. Mechanical or chemical restraints, or

d. Seclusion.

These interventions might be implemented to deal with aggressive or disruptive behaviors related to the activity or possession. Staff, families and the individual are trained by the provider to recognize and report unauthorized use of restrictive interventions.

Before absence from a specific social activity or temporary loss of personal possession is implemented, the individual is first counseled about the consequences of the behavior and the choices they can make.

1. All personnel who are involved in the use of restrictive interventions must receive training in behavior management techniques, as well as, training in abuse and neglect laws, rules and regulations and policies. The personnel must be qualified to perform, develop, implement and monitor or provide direction intervention as applicable.

2. Use of restrictive interventions requires submission of an incident report that must be submitted no later than the end of the second business day following the incident. The DDS Quality Assurance staff investigates each incident and monitors use of restrictive interventions for possible overuse or inappropriate use. DDS Quality Assurance staff will notify entities involved with the complaint or service concern the results of their review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Failure to complete corrective action measures may result in the provider being placed on provisional status or revocation of certification.

D. Behavior Management Plans

Before use of restraints or restrictive interventions, Providers must develop a written behavior management plan to ensure the rights of individuals. The plan must include a provision for alternative methods to avoid the use of restraints and seclusions.

The behavior management plan must be written or supervised by a qualified professional who is at minimum a Qualified Developmental Disabilities Professional (QDDP):

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 as possible.

The behavior management plan must also specify the length of time the restraint or restrictive intervention is to be used, who will authorize the use of restraint or seclusion and the methods for monitoring the individual.

Behavior management plans cannot include procedures that are punishing, physically painful, emotionally frightening, depriving, or that puts the individual at medical risk.

E. Reports of Use of Restraints or Restrictive Intervention

All use of restraint must be documented in the individual's case record, including the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.

1. The use of restraint or seclusion must be reported to the DDS Quality Assurance section via an incident report form that must be submitted no later than the end of the second business day following the incident. The DDS Quality Assurance staff investigates each incident and monitors use of restraints for possible overuse or inappropriate use of restraints or seclusion. DDS Quality Assurance staff will notify entities involved with the complaint or service concern the results of their review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Failure to complete corrective action measures may result in the provider being place on provisional status or revocation of certification.
2, Each person working within the provider agency must complete Introduction to Behavior Management, Abuse and Neglect and any other training as deemed necessary as a result of deficiencies or corrective actions.

212.000 Description of Services ~~3-1-10~~7-1-17

DDS ~~ACS~~ CES services provide the support necessary for a beneficiary to live in the community. Without these services, the beneficiary would require institutionalization.

Services provided under this program are as follows:

A. Supportive Living

B. Respite Services

C. Supported Employment

D. Adaptive Equipment

E. Environmental Modifications

F. Specialized Medical Supplies

G. Supplemental Support Service

H. Case Management Services

I. Consultation Services

J. Crisis Intervention Services

K. Community Transition Services

213.000 Supportive Living ~~9-1-16~~7-1-17

Supportive living is an array of individually tailored services and activities provided to enable eligible beneficiaries to reside successfully in their own homes, with their family, or in an alternative living residence or setting. Alternative living residences include apartments, ~~homes of primary caregivers,~~ leased or ~~rented~~ owned homes, or provider group homes. Supportive living services ~~may also~~must be provided in clinic and integrated community settings. The services are designed to assist beneficiaries in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in the home and community based setting. Services are flexible to allow for unforeseen changes needed in schedules and times of service delivery. Services are approved as maximum days that can be adjusted within the annual plan year to meet changing needs. The total number of days cannot be increased or decreased without a revision. Waiver funding will not reimburse for overtime. ~~The payments for these services exclude the costs of the person's room & board expenses including general maintenance, upkeep or improvement to the person's home or their family's home.~~ Care and supervision for which payment will be made are those activities that directly relate to active treatment goals and objectives.

A. Residential Habilitation Supports

~~Care and supervision of activities that directly relate to treatment goals & objectives.~~Supports to assist the beneficiary to acquire, retain or improve skills in a wide variety of areas that directly affect the person's ability to reside as independently as possible in the community. The supports that may be provided to a beneficiary include the following:

1. Decision making including the identification of and response to dangerously threatening situations, making decisions and choices affecting the person's life and initiating changes in living arrangement or life activities;

2. Money management ~~consists of~~including training, assistance or both in handling personal finances, making purchases and meeting personal financial obligations;

3. Daily living skills including habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medications (to the extent permitted under state law) and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid and emergency procedures;

4. Socialization, including training, assistance or both, in participation in general community activities, and establishing relationships with peers. Activity training includes assisting the person to continue to participate on an ongoing basis;

5. Community integration experiences includ~~e~~inge activities intended to instruct the person in daily living and community living skills in ~~a clinic and~~an integrated setting. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. Community experiences include activities and supports to accomplish individual goals or learning areas including recreation and specific training or leisure activities. Each activity is then adapted according to the beneficiary's individual needs.

6. Non-medical transportation to or from community integration experiences is an integral part of this service and is included in the daily rate computation. DDS will assure duplicate billing between waiver services and other Medicaid state plan services will not occur. The habilitation objectives to be served by such training must be documented in the person's service plan. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized.

   Exclusions: Transportation to and from medical, dental and professional appointments inclusive of therapists. Non-medical transportation does not include transportation for other household members.

7. Mobility including training, assistance or both aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel or movement within the community;

8. Communication including training in vocabulary building, use of augmentative communication devices and receptive and expressive language;

9. Behavior shaping and management including~~es~~ training, assistance or both in appropriate expressions of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors;

10. Reinforcement of therapeutic services, including~~ which consist of~~ conducting exercises or reinforcing physical, occupational, speech and other therapeutic programs;

~~11. Performance of tasks to assist or supervise the person in such activities as meal preparation, laundry, shopping and light housekeeping that are incidental to (not to exceed 20% of the total weekly hours worked) the care and supervision of the beneficiary but cannot be performed separately from other waiver services.~~

   ~~a. Assistance is defined as hands-on care both of a supportive and health related nature, supports that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function; homemaker or chore services, fellowship and protection that includes medical oversight permitted under state law.~~

   ~~b. Services are furnished to persons who receive these services in conjunction with residing in an alternate living setting.~~

   ~~c. The total number of individuals (including persons served in the waiver) living in an alternate living setting who are unrelated to the principle care provider cannot exceed four except where congregate settings are used that were licensed by DDS prior to 1995.~~

11~~2~~. Health maintenance activities may be provided by a ~~designated care aide~~ (supportive living worker). All health maintenance activities~~ (to include oral medication administration or assistance, shallow suctioning, maintenance and use of intra-feeding and breathing apparatus or devices)~~, except injections and IV's, can be done in the home by a designated care aide, such as a supportive living worker. With the exception of injectable medication administration, tasks that beneficiaries would otherwise do for themselves, or have a family member do, can be performed by a paid designated care aide at their direction, as long as the criteria specified in the Arkansas Nurse Practices Consumer Directed Care Act has been met. Health maintenance activities are available in the Arkansas Medicaid State Plan as self-directed services. State plan services must be exhausted before accessing waiver funding for health maintenance activities.

B. Companion and Activities Therapy

Companion and activities therapy services provide reinforcement of habilitative training. This reinforcement is accomplished by using animals as modalities to motivate ~~persons~~ beneficiaries to meet functional goals. Through the utilization of an animal's presence,

enhancement and incentives are provided to ~~persons~~ beneficiaries to practice and accomplish such functional goals as follows:

1. Language skills;
2. Increase range of motion;
3. Socialization by developing the interpersonal relationships skills of interaction, cooperation and trust and the development of self-respect, self-esteem, responsibility, confidence and assertiveness;

~~NOTE~~Exclusions: This service does not include ~~the purchase of animals,~~ the cost of veterinary or other care, food, shelter or ancillary equipment that may be needed by the animal that is providing reinforcement.

C. Direct Care Supervision

The direct care supervisor employed by the supportive ~~ed~~ living provider is responsible for assuring the delivery of all supportive~~ed~~ living direct-care services including the following activities:

1. The coordination of all direct service workers who provide care through the direct service provider;
2. Serving as liaison between the beneficiary, parents, legal representatives, case management entity and DDS officials;
3. Coordinating schedules for both waiver and generic service categories;
4. Providing direct planning input and preparing all direct service provider segments of any initial plan of care and annual continued stay review;
5. Assuring the integrity of all direct care service Medicaid waiver billing;
6. Arranging for staffing of all alternative living settings;
7. Assuring transportation as identified in beneficiary's person-centered service plan specific to supportive living services;
8. Assuring ~~advance~~ timely collaboration with the case management entity to obtain comprehensive behavior and assessment reports, continued ~~stay reviews~~person-centered case plans~~,~~ with revisions as needs change, and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determination;
9. Reviewing the person's records and environments in which services are provided by accessing appropriate professional sources to determine whether the person is receiving appropriate support in the management of medication. Minimum components are as follows:

   The direct care supervisor has an on-going responsibility for monitoring beneficiary medication regimens. While the provider may not staff a person on a 24/7 schedule, the provider is responsible around the clock to ~~assure~~ ensure that the person-centered service plan identifies and addresses all the needs with other supports as necessary to assure the health and welfare of the beneficiary.

   a. Staff, at all times, are aware of the medications being used by the beneficiary.
   b. Staff are knowledgeable of potential side effects of the medications being used by the person through the prescribing physician, nurse and pharmacist at the time medications are ordered.
   c. All medications consumed are prescribed or approved by the beneficiary's physician or other health care practitioner.
   d. The beneficiary or legally responsible person is informed by the prescribing physician about the nature and effect of medication being consumed and consent

to the consumption of those medications prior to consumption.

e. Staff are implementing the service provider's policies and procedures as to medication management, appropriate to the beneficiary's needs as monitored by the direct care supervisor in accordance with acceptable personnel policies and practices and by the case manager at least monthly.

f. If psychotropic medications are being used for behavior, the direct care supervisor and case manager are responsible to assure appropriate positive behavior programming is present and in use with programming reviews at least monthly.

g. The consumption of medications is monitored at least monthly by the direct care supervisor to ensure that they are accurately consumed as prescribed.

h. Toxicology screenings are conducted on a frequency determined by the prescribing physician with case manager oversight.

i. Any administration of medication or other nursing tasks or activities are performed in accordance with the Nurse Practice and Consumer Directed Care Acts and are~~is~~ monitored by the direct care supervisor in accordance with acceptable personnel practices and by the case manager at least monthly.

j. Medications are regularly reviewed to monitor their effectiveness, to address the reason for which they were prescribed and for possible side effects.

k. Medication errors are effectively detected by the direct care supervisor by review of the medication log and with appropriate response up to and inclusive of incident reporting and reporting to the Nursing Board.

l. Frequency of monitoring is based on the physician's prescription for administration of medication.

m. The physician approving the service level of support and the person centered service plan is responsible for monitoring and determining contraindications when multiple medications are prescribed. A minimum review is at the annual continued stay review of the person centered service plan for approval and recertification.

Direct care staff are required to complete daily activity logs for activities that occur during the work timeframe with such activities linked to the person centered service plan objectives. The direct care supervisor is required to monitor the work of the direct care staff and to sign-off on timesheets maintained to document work performed. All monitoring activities, reviews and reports must be documented and available upon request from authorized DDS or DMS staff.

NOTE: Failure to satisfactorily document activities according to DMS requirements may result in non-payment of services.

Persons may access both supportive living and respite on the same date as long as the two services are distinct, do not overlap and the daily rate maximum is correctly prorated as to the portion of the day that each respective service was actually provided. DDS monitors this provision through retrospective annual look behind with providers responsible to maintain adequate time records and activity case notes or activity logs that support the service deliveries. Maximum daily rate is established in accordance with budget neutrality wherein both supportive living and respite ~~independently and collectively~~ cannot exceed the daily maximum.

Controls in place to assure payments are only made for services rendered include requirement by assigned staff to complete daily activity logs for activities that occurred during the work timeframe with such activities linked to the ~~plan of care~~person-centered case plan objectives; supervision of staff by the direct care supervisor with sign-off on timesheets maintained weekly; audits and reviews conducted by DDS Quality Assurance annually and at random; DDS Waiver Services annual retrospective reviews, random attendance at planning meetings and visits to the home; DMS random audits; and

oversight by the chosen and assigned case ~~Team~~manager. Retainer payments may be made to providers of habilitation while the waiver participant is hospitalized or absent from his/her home.

213.300 Benefit Limits for Supportive Living ~~9-1-16~~7-1-17

The maximum daily rate for the supportive living array, which includes both supportive living and respite services~~, collectively or individually~~ is based upon the ~~level~~ tier of support identified in the beneficiaries person centered service plan, after completion of the independent assessment. This daily rate includes provider indirect costs for each component of service. DDS must prior authorize daily rates for all levels of support.

~~Pervasive – maximum daily rate is $391.95 with a maximum annual rate of $143,061.75.~~

~~Extensive – maximum daily rate is $176.00 with a maximum annual rate of $64,240.00.~~

~~Limited – maximum daily rate is $176.00 with a maximum annual rate of $38,544.00.~~
Tier 3: Maximum Daily Rate is $391.95 with a maximum of $143, 061.75 annually.

Tier 2: Maximum Daily Rate is $184.80 with a maximum of $67,452.00 annually.

All units must be billed in accordance with the beneficiary's person-centered service plan. Extensions of benefits will be provided when extended benefits are determined to be medically necessary.

See Section 260.000 for billing information.

See Section 224.000 for payment guidelines of relatives or legal guardians.

214.000 Respite Services ~~7-15-12~~7-1-17

Respite services are provided on a short-term basis to beneficiaries unable to care for themselves due to the absence of or need for relief of non-paid primary caregivers. Room and board may not be claimed when respite is provided in the beneficiary's home or a private place of residence. Room and board is not a covered service except when provided as part of respite furnished in a facility that is approved by the State~~ as a respite care facility~~.

Receipt of respite services does not necessarily preclude a beneficiary from receiving other services on the same day. For example, a beneficiary may receive day services, such as supported employment, on the same day as respite services.

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite may not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.

Respite services may be provided through a combination of basic child care and support services required to meet the needs of a child~~. When respite is provided in a licensed day care facility, licensed day care home or other lawful child care setting, waiver will only pay for the support staff required by the beneficiary's developmental disability. Parents and guardians will remain responsible for the cost of basic child care fees.~~

~~Respite services are separate and distinct from educational services provided at a school where attendance is mandated and the primary focus of the institution is the accomplishment of specified educational goals.~~

Respite may be provided in the following locations:

A. Beneficiary's home or private place of residence.

B. The private residence of a respite care provider.

C. Foster home.

~~D. Medicaid-certified ICF/IID.~~

~~E. Group home.~~

D~~F~~. Licensed respite facility.

E~~G~~. Other community residential facility approved by the state, not a private residence.

F~~H~~. Licensed or accredited residential mental health facility.

~~I. Licensed day care facility, licensed day care home or other lawful child care setting. Waiver will only pay for support staff required due to the individual's developmental disability. Waiver will not pay for day care fees~~.

214.100 Benefit Limits for Respite Services ~~3-1-10~~7-1-17

The maximum daily rate for the supportive living array, which includes both supportive living and respite services, collectively or individually is based upon the level of support identified in the beneficiaries person centered service plan~~. –~~, after completion of the independent assessment. This daily rate includes provider indirect costs for each component of service. DDS must prior authorize daily rates for all ~~levels~~ tiers of support.

~~Pervasive~~ Tier 3 – maximum daily rate is $391.95 with a maximum annual rate of $143,061.75.

~~Extensive~~ Tier 2 – maximum daily rate is $~~176.00~~184.80 with a maximum annual rate of $~~64,240.00~~67,452.00.

~~Limited – maximum daily rate is $176.00 with a maximum annual rate of $38,544.00.~~

All units must be billed in accordance with the beneficiary's person-centered service plan. Extensions of benefits will be provided when extended benefits are determined to be medically necessary.

See Section 260.000 for billing information.

215.000 Supported Employment ~~3-1-10~~7-1-17

~~Supported employment services consist of intensive, ongoing supports that enable beneficiaries for whom competitive employment at or above the minimum wage is unlikely or who, because of their disabilities, need intensive ongoing support to perform in a competitive work setting.~~

~~Supported employment is paid employment that is conducted in a variety of settings, particularly work sites in which individuals without disabilities are employed. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by beneficiaries receiving waiver services as a result of their disabilities. Coverage does not included payment for the supervisor activities rendered as a normal part of the business setting. The employer is responsible for making reasonable accommodations in accordance with the Americans with Disabilities Act.~~ Supported employment is a tailored array of services that offers ongoing support to beneficiaries with the most significant disabilities to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for individuals for whom competitive employment has not traditionally occurred, or has been interrupted or

intermittent as a result of a significant disability, and who need ongoing supports to maintain their employment.

~~Supported employment is a collaborative service with Arkansas Rehabilitation Services (ARS). All waiver beneficiaries receiving supported employment must be prior certified by ARS to assure the beneficiary is qualified for supported employment and that ARS funding has been accessed first.~~

~~Integration requires that a beneficiary work in a place where no more than eight people with disabilities work together and where co-workers without disabilities are present in the work setting or in the immediate vicinity. Supported employment services may be furnished by a co-worker or other job site personnel provided that the services which are furnished are not part of the normal duties of the co-worker or other personnel and these individuals meet the qualifications to be a provider of the supported employment service.~~

The s~~S~~upported employment service array includes:

A. ~~Assisting the participant in locating a job or developing a job on behalf of the participant~~Discovery Career Planning: Information is gathered about a beneficiary's interests, strengths, skills, the types of supports that are the most effective, and the types of environments and activities where the participant is at his or her best. These services should result in the development of the Individual Career Profile which includes specific recommendations regarding the beneficiary's employment support needs, preferences, abilities and characteristics of optimal work environment. The following activities may be a component of Discovery/Career Plannin: review of the beneficiary's work history, interest and skills; job exploration; job shadowing; informational interviewing, including mock interview; job and task analysis activities; situational assessments to assess the beneficiary's interest and aptitude in a particular type of job; employment preparation (i.e. resume development); benefits counseling; business plan development for self-employment; and volunteerism.

B. ~~Activities needed to sustain paid work by waiver beneficiaries, including supervision and training;~~Employment Path: Beneficiary receiving these services must have goals related to employment in integrated community settings in their person-center service plan. Activities must be designed and developed to support the employment goals outlined in the person-centered service plan. Such activities should develop and teach soft skills utilized in integrated employment including, but not limited to, following directions, attending to tasks, problem-solving skills and strategies, mobility training, effective and appropriate communication (verbal and nonverbal) and time management.

   Employment Path is a time-limited service and requires prior authorization for the first 12 months. One reauthorization of up to twelve months is possible, but only in the beneficiary is also receiving job development services that indicate the beneficiary is actively seeking employment.

C. ~~Re-training for job retention or job enhancement;~~Employment Supports.

   1. Job Development: Individualized services that are specific in nature to obtaining a certain employment opportunity. The initial outcome of Job Development is the Job Development Plan. The Job Development Plan must be created and incorporated with the individual Career Profile no later than 30 days after Job Development services begin. The Job Development Plan must, at a minimum, specify:

      a. The short- and long-term employment goals

      b. Target wages

      c. Task hours

      d. Special conditions that apply to the worksite for the beneficiary

      e. Jobs that will be developed or tasks that will be customized through negotiations with potential employers

f. Initial list of employer contacts

g. The plan for how many employers will be contacted each week, and

h. The conditions for use of on-site job coaching.

2. Job Coaching: On-site activities that may be provided to a beneficiary once employment is obtained. Activities provided under this service may include, but are not limited to, completing job duty and task analysis; assisting the beneficiary to learn to do the job by the least intrusive method available; developing compensatory strategies if needed to cue beneficiary to complete the job; analyzing the work environment during initial training/learning of the job and making determinations regarding modifications or assistive technology. Services are authorized for twelve months. A fading plan must be developed for Job Coaching Services that show how the goals of this service will be achieved in 12 months. Additional authorizations of Job Coaching with no additional fading gains will require additional documentation of level of need for service.

Job Coaching may also be utilized when the beneficiary chooses self-employment. Activities such as assisting the beneficiary to identify potential business opportunities, develop a business plan, as well as develop and launch a business are included. Waiver funds may not be used to defray expenses associated with starting or operating a business, such as capital expenses, advertising, hiring or training of employees.

2. Extended Services: The expected outcome of extended services is sustained paid employment at or above minimum wage with associated benefits and the opportunity for advancement in a job that meets the beneficiary's personal and career planning goals. Employment supports: Extended Services allows for the continued monitoring of employment outcomes through regular contact with the beneficiary and the employer. A minimum of one contact per quarter with the employer is required.

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

E. Job maintenance visits with the employer for purposes of obtaining, maintaining or retaining current or new employment opportunities.

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

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

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

A. Aiding the beneficiary to identify potential business opportunities;

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

C. Identification of the supports that are necessary for the beneficiary to operate the business; and

~~D. Ongoing assistance, counseling and guidance once the business is launched.~~

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

215.100 Supported Employment Exclusions ~~3-1-10~~7-1-17

Supported employment requires related activities to be identified and included in outcomes with an accompanying work plan submitted as documentation of need for service.

Payment for employment services excludes:

A. Incentive payments made to an employer of waiver beneficiaries to encourage or subsidize an employer's participation in the program.

B. Payments that are passed through to waiver beneficiaries.

C. Payments for training that are not directly related to the waiver beneficiary's employment.

D. Reimbursement if the beneficiary is not able to perform the essential functions of the job. The functions of a job coach are to "coach," not to do the work for the person.

E. ~~ACS~~ CES waiver supported employment services when the same services are otherwise funded under the Rehabilitation Act of 1973 or Public Law 94-142. This means that such services must be exhausted before waiver-supported employment services can be approved or reimbursement can be claimed.

F. Services provided in a sheltered workshop or other similar type of vocational service furnished in a specialized facility.

215.200 Documentation Requirements for Supported Employment 3-1-10

Supported employment providers must maintain documentation in each waiver beneficiary's file to demonstrate the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Individual with Disabilities Education Act (20 U.S.C. 1401 et.seq).

Documentation must include proof from the funded provider where services were exhausted.

For Discovery Career Planning, the provider must create and maintain an individual Career Profile-Discovery Staging Record to demonstrate compliance and delivery of service.

For Employment Path Services, the provider must maintain the Job Development Plan and beneficiary's remuneration statement.

For Extended Services, the Provider must maintain the Arkansas Rehabilitation Services letter of closure, beneficiary's remuneration (paycheck stub) statement, and beneficiary's work schedule, if available, to demonstrate compliance with and delivery of this service.

See Section 202.200 for other information to be retained for beneficiary's file.

215.300 Benefit Limits for Supported Employment 3-1-10

~~Beneficiaries are limited to a maximum of $3.59 per 15 minute unit with a maximum of 32 units (8 hours) of supported employment services per date of service.~~

~~Supported employment, provided as long term support, requires monitoring at a minimum of two meetings with the beneficiary and one employer contact each month. The person is required to work a minimum of 15 hours per week in accordance with ARS regulation. Exceptions must be~~

~~justified by the beneficiary's case manager and must be prior approved by ARS. ARS must approve any exception with monthly monitoring. The beneficiary's case manager must prepare in writing a justification citing why the person cannot work at least 15 hours per week and submit to the ARS counselor assigned to the case.~~

Discovery/Career Planning: Allowed maximum is 25 hours per week alone or combined with Employment Supports in a small group. Only twelve months of service may be authorized with one reauthorization allowed if the beneficiary is receiving Job Development Services that indicate he or she is actively seeking employment. A milestone payment is available if the beneficiary obtains individualized, competitive integrated employment or self-employment during the first 12-month authorization.

Employment Supports Job Development: This is outcome-based reimbursement, payable in stages to incentivize retention of the job. The total outcome payment is $3000. The payment schedule is as follows:

A. 60% at the end of the beneficiary's first pay period.

B. 25% when the beneficiary has completed four (4) weeks on the job.

C. 15% when the beneficiary has completed eight (8) weeks on the job.

Employment Supports—Job Coaching: Allowed maximum of 40 hours per week. Twelve months of services are authorized, and the provider must have a fading plan. Provider must document necessity of additional services to have additional services authorized without a fading plan.

Employment Supports—Extended Services: Allowed maximum of 20% of the beneficiary's weekly scheduled work hours.

See Section 260.000 for billing information.

216.000 Adaptive Equipment ~~3-1-10~~7-1-17

The adaptive equipment service includes an item or a piece of equipment that is used to increase, maintain or improve functional capabilities of individuals to perform daily life tasks that would not be possible otherwise. The adaptive equipment service provides for the purchase, leasing, and as necessary, repair of adaptive, therapeutic and augmentative equipment that enables individuals to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Adaptive equipment needs for supportive employment are included. This service may include specialized equipment such as devices, controls or appliances that will enable the person to perceive, to control or to communicate with the environment in which they live.

Adaptive equipment includes "enabling technology," that empowers the beneficiary to gain independence through customizable technologies to allow them to safely perform activities of daily living without assistance, while still providing for monitoring and response for those beneficiaries, as needed. Enabling technology must be shown to meet a goal of the beneficiary's person-centered service plan , ensure beneficiary's health and safety, and provide for adequate monitoring and response for beneficiary's needs. Before enabling technology will be provided, it must be documented that an assessment was conducted and a plan was created to show how the enabling technology will meet those requirements.

Equipment may only be covered if not available to the beneficiary from any other source. Professional consultation must be accessed to ensure that the equipment will meet the needs of the beneficiary when the purchase will at a minimum, but not necessarily, exceed $500.00. Consultation must be conducted by a medical professional as determined by the beneficiary's

condition for which the equipment is needed. All items must meet applicable standards of manufacture, design and installation.

All adaptive equipment must be solely for the waiver beneficiary. All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids with the lowest bid with comparable quality being awarded; however, DDS may require three bids for any requested purchase.

Computer equipment may be approved when it allows the beneficiary control of his or her environment, assists in gaining independence or when it can be demonstrated that it is necessary to protect the health and safety of the person. The waiver does not cover supplies.~~Computers will not be purchased to improve socialization or educational skills.~~ Printers may be approved for non-verbal persons.

Communication boards are allowable devices. Computers may be approved for communication when there is substantial documentation that a computer will meet the needs of the person more appropriately than a communication board.

Software will be approved only when required to operate the accessories included for environmental control or to provide text-to-speech capability.

~~**NOTE: Adaptive equipment must be an item that is modified to fit the needs of the beneficiary. Items such as toys, gym equipment, sports equipment, etc. are excluded as not meeting the service definition.**~~

Conditions: The care and maintenance of, adaptive equipment, vehicle modifications, and personal emergency response systems are entrusted to the beneficiary or legally responsible person for whom the aids are purchased. Negligence (defined as failure to properly care for or perform routine maintenance of) shall mean that the service will be denied for a minimum of two plan years. Any abuse or unauthorized selling of aids by the beneficiary or legally responsible person shall mean the aids will not be replaced using waiver funding.

Exclusions:

A. Swimming pools (in-ground or above ground) and hot tubs are not allowable as either an environmental modification or adaptive equipment.

B. Therapeutic tools similar to those therapists employ during the course of therapy are not included.

C. Educational aids are not included.

~~D. Computers will not be purchased to improve socialization or educational skills.~~

D~~E~~. Computer supplies.

E~~F~~. Computer desk or other furniture items are not covered.

F~~G~~. Medicaid purchased equipment cannot be donated if the equipment being donated is needed by another waiver beneficiary residing in the residence.

216.100 Adaptive Equipment: Vehicle Modifications ~~1-1-16~~7-1-17

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

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

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

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

Lifts that require vehicle modification and the modifications 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:~~

Exclusions:

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

B~~2~~. Purchase, down payment, monthly car payment, or lease cost of a vehicle~~ as documented by the vehicle sales contract and requested invoices~~

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

216.200 Adaptive Equipment: Personal Emergency Response System (PERS) ~~3-1-10~~7-1-17

PERS may be approved when it can be demonstrated as necessary to protect the health and safety of the beneficiary. PERS is ~~an~~ a stationary or portable electronic device that is used in the beneficiary's place of residence that allows the beneficiary ~~enables beneficiaries at high risk of institutionalization~~ to secure help in an emergency. The system must be connected to a response center staffed by trained professionals who respond upon activation of the PERS. The beneficiary may also wear a portable "help" button to allow for mobility. ~~The system is connected to the beneficiary's telephone and programmed to signal a response center once the "help" button is activated. The response center must be staffed by trained professionals.~~ PERS services are limited to beneficiaries who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision. Included in this service are assessment, purchase, installation, testing, and monthly rental fees. PERS shall include cost of installation and testing, as well as monthly monitoring performed by the response center.

216.300 Benefit Limits for Adaptive Equipment ~~3-1-10~~7-1-17

The maximum annual expenditure for adaptive equipment, including vehicle modifications and PERS, and environmental modifications is $7,687.50 per person per year. ~~If the person is also receiving environmental modification services, the COMBINED annual expenditure cannot exceed $7,687.50.~~

The maximum allowed can be increased upon showing a medical necessity, with the difference in the total required amount and the allowed maximum ($7,687.50) being deducted from the supportive living maximum allowance.

216.400 Required Documentation for Adaptive Equipment 7-1-17

When the adaptive equipment modification will be over $1,000.00, the provider must document that it obtained at least three bids, and that the lowest bid with comparable quality was awarded, DDS may require three bids for any requested purchase.

217.000 Environmental Modifications ~~3-1-10~~7-1-17

Environmental modifications are made to or at the waiver beneficiary's home, required by the person centered service plan and are necessary to ensure the health, welfare and safety of the beneficiary or that enable the beneficiary to function with greater independence and without which the beneficiary would require institutionalization.

Environmental modification may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities , installation of specialized electric and plumbing systems to accommodate medical equipment, installation of sidewalks or pads to accommodate ambulatory impairments, and home property fencing when medically necessary to assure non-elopement, wandering or straying of persons who have dementia, Alzheimer's disease or other causes of memory loss or confusion as to location or decreased mental capacity or aberrant behaviors.

Expenses for the installation of the environmental modification and any repairs made necessary by the installation process are allowable. Portable or detachable modifications that can be relocated with the beneficiary and that have a written consent from the property owner or legal representative will be considered. Requests for modification must include an original photo of the site where modifications will be done; to scale sketch plans of the proposed modification project; identification of other specifications relative to materials, time for project completion and expected outcomes; labor and materials breakdown and assurance of compliance with any local building codes. Final inspection for the quality of the modification and compliance with specifications and local codes is the responsibility of the waiver case manager. Payment to the

contractor is to be withheld until the work meets specifications including a signed customer satisfaction statement.

All services must be provided as directed by the beneficiary's person centered service plan and in accordance with all applicable state or local building codes.

Environmental modifications must be made within the existing square footage of the residence and cannot add to the square footage of the building.

Modifications are considered and approved as single, all-encompassing projects and, as such, cannot be split whereby a part of the project is submitted in one service plan year and another part submitted in the next service plan year. Any such activity is prohibited. All modifications must be completed within the plan of care year in which the modifications are approved.

All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 will require three bids with the lowest bid with comparable quality being awarded, however, DDS may require three bids for any requested modification.

Environmental modifications may only be funded through the waiver if not available to the beneficiary from any other source. If the beneficiary may receive environmental modifications through the Medicaid State Plan, a denial by Utilization Review will be required prior to approval for funding through the waiver.

217.100 Environmental Modifications Exclusions ~~3-1-10~~7-1-17

Modifications or improvements made to or at the beneficiary's home which are of general ~~repair~~ utility and are not of direct medical or remedial benefit to the beneficiary (e.g., carpeting, roof repair, central air conditioning, etc.) are excluded as covered services. Also excluded are modifications or improvements that are of aesthetic value such as designer wallpaper, marble counter tops, ceramic tile, etc.

Outside fencing is limited to one fence per lifetime. Total perimeter fencing is excluded.

Expenses for remodeling or landscaping which are cosmetic, designed to hide the existence of the modification, or result from erosion are not allowable.

Environmental modifications that are permanent fixtures will not be approved for rental property without prior written authorization and a release of current or future liability by the residential property owner.

Environmental modifications may not be used to adapt living arrangements that are owned or leased by providers of waiver services.

Swimming pools (both in and out of ground) and hot tubs (spas) are not allowable.

The moving of modifications, such as fencing or ceiling tracks and adaptive equipment that may be permanently affixed to the structure or outside premises is not allowable.

~~**Conditions:** The care and maintenance of environmental modifications is entrusted to the beneficiary or legally responsible person for whom the modifications are purchased. Negligence (defined as failure to properly care for or perform routine maintenance of) shall mean that the service will be denied for a minimum of two plan years. Any abuse or unauthorized selling of aids by the beneficiary or legally responsible person shall mean the aides will not be replaced using waiver funding.~~

217.200 Benefit Limits for Environmental Modifications ~~3-1-10~~7-1-17

A beneficiary's annual expenditure for environmental modifications and adaptive equipment cannot exceed $7,687.50 per person per year.~~ If the beneficiary is also receiving adaptive equipment services, the COMBINED total cannot exceed $7,687.50.~~

218.000 Specialized Medical Supplies ~~3-1-10~~7-1-17

A physician must order or document the need for all specialized medical equipment. All items must be included in the person-centered service plan. Specialized medical equipment and supplies include:

A. Items necessary for life support or to address physical conditions along with the ancillary supplies and equipment necessary for the proper functioning of such items.

B. Durable and non-durable medical equipment not available under the Arkansas Medicaid State Plan that is necessary to address beneficiary functional limitations.

C. Necessary medical supplies not available under the Arkansas Medicaid State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design and installation. The most cost-effective item will be considered first.

~~D. A physician must order or document the need for all specialized medical supplies.~~

Additional supply items are covered as a waiver service when they are considered essential and medically necessary for home and community care. Covered items include:

A. Nutritional supplements

B. Non-Prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage.

C. Prescription drugs, minus the cost of drugs covered by Medicare Part D, when extended benefits are available under the Arkansas Medicaid State Plan.

~~Item(s) must be included in the person centered service plan.~~ When the items are included in Arkansas Medicaid State Plan services, a denial of extension of benefits by DMS Utilization Review will be required prior to approval for waiver funding by DDS.

218.100 Benefit Limits for Specialized Medical Supplies ~~3-1-10~~7-1-17

The maximum annual allowance for specialized medical supplies, supplemental supports and community transition services is $3690.00 per year~~, collectively or individually~~.

When a non-prescription or prescription medication is necessary to maintain or avoid health deterioration, the $3,690.00 limit may be increased with the difference in the specialized medical supplies maximum allowance and the required amount deducted from the supportive living maximum daily allowance. All such requests must be prior approved by the DDS Assistant Director of Waiver Services.

See Section 260.000 for billing information.

219.000 Supplemental Support Service ~~3-1-10~~7-1-17

The supplemental support service helps improve or enable the continuance of community living. ~~This service is only available in response to crisis, emergency or life threatening situations.~~ Supplemental support service will be based on demonstrated needs as identified in a

beneficiary's person centered service plan as ~~emergencies~~ unforeseen problems arise that, unless remedied, could cause disruptions in the beneficiarie's services, placement, or place him or her at risk of institutionalization~~.~~ Waiver funds will be used as the payer of last resort.

~~Supplemental support service includes:~~

~~A. Ancillary supports such as non-recurring set-up expenses for beneficiaries in the event of a disaster, crisis, emergency or life threatening situation. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:~~

~~1. Security deposits that are required to obtain a lease on an apartment or home;~~

~~2. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;~~

~~3. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;~~

~~4. Services necessary for the beneficiary's health and safety such as pest eradication and one-time cleaning prior to occupancy;~~

~~5. Moving expenses.~~

~~These services are furnished only to the extent that it is reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.~~

~~B. Drug and alcohol screening in accordance with the beneficiary's treatment plan. A physician, psychologist or court of law must order drug and alcohol screening~~

~~C. Activity fees such as dues at YMCA, Weight Watchers, etc. used for behavior reinforcement (may include weight control or health related conditions) or sensory simulation. Fees may be paid only for the waiver beneficiary and for such time as to abate the life threatening condition. These services must be prescribed and monitored by medical professionals.~~

219.100 Reserved~~Supplemental Support Service Exclusions~~ ~~3-1-10~~7-1-17

~~The supplemental support service is not allowed for monthly rental, lease or mortgage expenses, regular utility charges, household appliances, items that are intended for purely diversional or recreational in nature (televisions, cable TV access, VCRs or DVD players), therapy or educational aids.~~

~~Supplemental support may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service the provider is already delivering. Supplemental support may not be used for these or any other room and board service.~~

219.200 Supplemental Support Service Benefit Limits ~~3-1-10~~7-1-17

This service can be accessed only as a last resort. Lack of other available resources must be proven.

The maximum annual allowance for supplemental support, community transition services, and specialized medical supplies is $3,690.00 ~~, collectively or individually~~per year.

220.000 Case Management Services ~~9-1-16~~7-1-17

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

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

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

A. All proposed waiver services

B. Other Medicaid state plan services

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

D. Informal community supports needed by beneficiaries and their families

Case management services consist of the following activities:

A. Arranging for the provision of services and additional supports

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

C. Facilitating crisis intervention

D. Guidance and support to obtain generic services and supports

E. Case planning

F. Needs assessment and referral for resources

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

H~~I~~. Providing assistance relative to obtaining Waiver Medicaid eligibility and ICF/~~IID~~ ID/DD level of care eligibility determinations

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

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

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

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

~~N~~M. Upon receipt of DDS approvals or denials of requested services, ~~the case manager~~ ensure~~s~~ that a copy is provided to the beneficiary or legal representative

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

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

Case Management will be provided up to a maximum of a 90 day transition period for all persons who seek to voluntarily withdraw from waiver services unless the individual does not want to continue to receive the service. The transition period will allow for follow up to assure that the person is referred to other available services and to assure that the person's needs can be met through optional services. It also serves to assure that the person understands the effects and outcomes of withdrawal and to ascertain if the person was coerced or otherwise was unduly influenced to withdraw. During this 90 day timeframe, the person remains enrolled in the waiver, the case remains open, and waiver services will continue to be available until the beneficiary finalizes their intent to withdraw.

The State of Arkansas adheres to CMS regulation as it relates to conflict-free case management. Case Management services may not include the provision of direct services to the beneficiary that are typically or otherwise covered as service under ~~ACS~~ CES Waiver of State Plan. The organization may not provide case management services to any person to whom they provide any direct services without adhering to the following firewalls and protections:

A. The individual who performs the annual needs-based assessment may not be a provider of services on the person-centered service plan and may not provide direct care~~.~~

B. Participant should be encouraged to advocate or have an advocate present during all planning meetings

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

~~Service gaps of thirty (30) consecutive days must be reported to the DDS Specialist assigned to the case with a copy of the report sent to the DDS Program Director. The report must include the reason for the gap and identify remedial action to be taken.~~

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

A. ~~Pervasive – Minimum of one face-to-face visit AND one other contact with the beneficiary or legal representative monthly. At least one visit must be made annually at the beneficiary's place of residence.~~Tier 3: Requiring care 24 hours per day, seven (7) days per week

B. ~~Extensive – Minimum of one face-to-face visit with the beneficiary or legal representative each month. At least one visit must be made annually at the beneficiary's place of residence.~~Tier 2: Requiring care of less than 24 hours per day, seven (7) days per week

~~C. Limited – Minimum of one face-to-face visit with the beneficiary or legal representative each quarter and a minimum of one contact monthly for the months when a face-to-face visit is not made. At least one visit must be made annually at the beneficiary's place of residence.~~

~~The level of support is determined by the needs or options of the person receiving waiver services as defined in Sections 230.211, 230.212 and 230.213.~~

The minimum requirement for service contacts is as follows:

A. At least one contact monthly

B. At least one face-to-face contact per quarter

Abeyance: It is sometimes necessary to place a case in abeyance to allow the case to remain open while the beneficiary is temporarily placed in a licensed or certified treatment program for the purpose of behavior, physical, or health treatment of stabilization. On a monthly basis, the case manager must conduct a monitoring contact and report the status to DDS.

See Section 260.000 for billing information.

220.100 Transitional Case Management 3-1-10

Case Management services may be available during the last 180 consecutive days of a Medicaid eligible person's institutional stay to allow case management activities to be performed related to transitioning the person to the community. The person must be approved and in the waiver program for case management to be billed. ~~All transition services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the waiver participant's service plan. Once the beneficiary has been approved to transition to the waiver, a prior authorization for this service will be issued.~~

~~If the individual does not enroll in the waiver due to death or significant change in condition, transition activities may be reimbursed, depending on all eligibility factors.~~

220.200 Benefit Limits for Case Management 3-1-10

The~~re is a~~ maximum reimbursement limit per beneficiary is~~of~~ $117.70 per month and $1,412.40 ~~annually per person~~ per year.

Abeyance will be approved in three-month increments when the beneficiary will be out of service for at least one month. Abeyance cannot exceed one year.

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

221.000 Consultation Services ~~9-1-16~~7-1-17

Consultation services are clinical and therapeutic services which assist waiver beneficiaries, parents, guardians, legally responsible individuals, and service providers in carrying out the beneficiary's person centered service plan.

A. Consultation activities may be provided by professionals who are licensed as:

1. Psychologists
2. Psychological examiners
3. Mastered social workers
4. Professional counselors
5. Speech pathologists
6. Occupational therapists
7. Physical therapists
8. Registered nurses
9. Certified parent educators or provider trainer
10. Certified communication and environmental control specialists
11. Dieticians
12. Rehabilitation counselors

13. Recreational therapists

14. Qualified Developmental Disabilities~~-~~Professional (QDDP)

15. Positive Behavioral Supports (PBS) Specialist

16. Behavior Analyst

These services are indirect in nature. The parent educator or provider trainer is authorized to provide the activities identified below in items 2, 3, 4, 5, 7, and 13. The provider agency will be responsible for maintaining the necessary information to document staff qualifications. Staff who meet the certification criteria necessary for other consultation functions may also provide these activities. Selected staff or contract individuals may not provide training in other categories unless they possess the specific qualifications required to perform the other consultation activities. Use of this service for provider training cannot be used to supplant provider trainer responsibilities included in provider indirect costs.

B. Activities involved in consultation services include:

1. Provision of updated psychological and adaptive behavior assessments

2. Screening, assessing and developing therapeutic treatment plans

3. Assisting in the design and integration of individual objectives as part of the overall individualized service planning process as applicable to the consultation specialty

4. Training of direct services staff or family members in carrying out special community living services strategies identified in the person centered service plan as applicable to the consultation specialty

5. Providing information and assistance to the individuals responsible for developing the beneficiary's person centered service plan as applicable to the consultation specialty

6. Participating on the interdisciplinary team, when appropriate to the consultant's specialty

7. Consulting with and providing information and technical assistance with other service providers or with direct service staff and/or family members in carrying out a beneficiary's person centered service plan specific to the consultant's specialty

8. Assisting direct services staff or family members in making necessary program adjustments in accordance with the ~~person's~~ beneficiary's person-centered service plan as applicable to the consultation specialty

9. Determining the appropriateness and selection of adaptive equipment to include communication devices, computers and software consistent with the consultant's specialty

10 Training and/or assisting ~~persons~~beneficiaries, direct services staff or family members in the set up and use of communication devices, computers and software consistent with the consultant's specialty

11. Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment and modification of the positive behavior support plan consistent with the consultant's specialty

12. Training of direct services staff and/or family members by a professional consultant in:

    a. Activities to maintain specific behavioral management programs applicable to the ~~person~~beneficiary

    b. Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the ~~person~~beneficiary

    c. The provision of medical procedures not previously prescribed but now necessary to sustain the ~~person~~ beneficiary in the community

13. Training or assisting by advocacy to beneficiaries and family members on how to self-advocate

14. Rehabilitation counseling for the purposes of supported employment supports that do not supplant the Federal Rehabilitation Act of 1973 and PL 94-142 and the supports provided through Arkansas Rehabilitation Services

15. Training and assisting ~~persons~~beneficiaries, direct services staff or family members in proper nutrition and special dietary needs.

221.100 Benefit Limits for Consultation Services ~~3-1-10~~7-1-17

The maximum amount payable per year for consultation services, per person is $1,320.00. It is reimbursable at no more than ~~or~~ $136.40 per hour.

See Section 260.000 for billing information.

222.000 Crisis Intervention Services ~~3-1-10~~7-1-17

Crisis intervention services are defined as services delivered in the beneficiary's place of residence or other local community site by a mobile intervention team or professional.

Intervention services must be available 24 hours a day, 365 days a year and must be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geographic area conducive to rapid intervention as defined by the provider responsible to deploy the team or professional. Services may be provided in a setting as determined by the nature of the crisis, i.e., residence where behavior is happening, neutral ground, local clinic or school setting, etc. The following criteria must be met:

A. The beneficiary is receiving waiver services

B. The beneficiary needs non-physical intervention to maintain or re-establish behavior management or positive programming plan

C. Intervention is on-site in the community

~~A beneficiary may require one hour or a maximum of twenty-four hours of service during any one day.~~ The maximum rate of reimbursement for this service is $127.10 per hour. The annual maximum is $2,640.00.

Crisis intervention services are only provided as a waiver service to individuals who are age 21 and over. All medically necessary crisis intervention services for children under age 13 are covered as part of the Medicaid State Plan EPSDT benefit.

See Section 260.000 for billing information.

223.000 Community Transition Services ~~3-1-10~~7-1-17

Community transition services are non-recurring set-up expenses for beneficiaries who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the ~~person~~ beneficiary or his or her guardian is directly responsible for his or her own living expenses. Waiver funds can be accessed once it has been determined that the waiver is the payer of last resort.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

A. Security deposits that are required to obtain a lease on an apartment or home

B. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens

C. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water

D. Services necessary for the beneficiary's health and safety such as pest eradication and one-time cleaning prior to occupancy

E. Moving expenses

~~F. Necessary home accessibility adaptations.~~

Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the person-centered service plan development process, clearly identified in the person centered service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Duplication of environmental modifications will be prevented through DDS control of prior authorizations for approvals.

Costs for community transition services furnished to beneficiaries returning to the community from a Medicaid institutional setting through entrance to the waiver, are considered to be incurred and billable when the person ~~leaves the institutional setting and enters~~is determined to be eligible for the waiver services. The beneficiary must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the beneficiary does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid ~~as an administrative cost~~.

Exclusions: Community transition services may not include payment for room and board; monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional or recreational purposes. Community transition services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Diversionary or recreational items such as televisions, cable TV access, VCRs or DVD players are not allowable.

~~All transition services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the waiver participant's service plan. Once the beneficiary has been approved to transition to the waiver, a prior authorization for this service will be issued.~~

~~If the individual does not enroll in the waiver due to death or significant change in condition, transition activities may be reimbursed, depending on all eligibility factors.~~

223.100 Benefit Limits for Community Transition Services ~~3-1-10~~7-1-17

The maximum annual allowance for supplemental support, community transition services, and specialized medical supplies is $3,690.00~~, collectively or individually~~.

See Section 260.000 for billing information.

230.000 ELIGIBILITY ASSESSMENT ~~9-1-16~~7-1-17

The intake and assessment process for the DDS ~~ACS~~ CES Waiver Program includes:

A. Determination of categorical eligibility

B. Level of care determination

C. Comprehensive diagnosis and evaluation, including an independent assessment

D. Development of a person-centered service plan

E. Cost comparison to determine cost-effectiveness

F. Notification of a choice between home and community-based services and institutional services

230.100 Categorical Eligibility Determination 3-1-10

Current eligibility for the Arkansas Medicaid Program must be verified as part of the intake and assessment process for admission into the ACS CES Waiver Program. Medicaid eligibility is determined by the Division of Developmental Disabilities Services or by the Social Security Administration for SSI Medicaid eligibles.

Failure to obtain any required eligibility determination, whether initial or subsequent (time bound) reassessments, will result in the beneficiary's case being closed. Once closure has occurred, and the appeals processes are exhausted, the affected person will have to make a new request for services through the waiver program intake process.

For the supportive living arrangements, the Medicaid eligibility date is retroactive to the date the Medicaid application is received at the DDS Medicaid Unit or no more than three months prior to the receipt of the Medicaid application, whichever is less.

230.200 Level of Care Determination 9-1-167-1-17

Based on intellectual and behavioral assessment submitted by the provider, the ICF/ID/DD level of care determination is performed by the Division of Developmental Disabilities. The ICF/ID/DD level of care criteria provides an objective and consistent method for evaluating the need for institutional placement in the absence of community alternatives. The level of care determination must be completed and the beneficiary determined to:deemed eligible for ICF/ID/DD level of care prior to receiving ACS Waiver services.

A. Require the level of care provided in an ICF/ID/DD, and

B. Need institutionalization in an ICF/ID/DD in the near future (in a month or less) but for the provision of waiver services.

Recertification, based on intellectual and behavioral assessments submitted by the provider at appropriate age milestones, will be performed by DDS to determine the beneficiary's continuing need for an ICF/ID/DD level of care.

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

230.210 Levels Tiers of Support 3-1-107-1-17

Coverage is provided within three levelstwo tiers of support. Levels of support are defined as pervasive, extensive and limited and are based on the amount of need for assistance. The beneficiary can move from one level of support to another if there is documentation supporting the need for a higher degree of support. No exceptions are made if documentation does not support the beneficiary's need for a higher level of support.

Once the pervasive level of support is reached and all other funding sources have been accessed, if the provider cannot assure the health, safety and welfare of the beneficiary in the community, case closure proceedings are initiated.The two tiers are as follows:

Tier 3: Institutional Level of Care; 24/7

Tier 2: Institutional Level of Care; less than 24/7

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

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

The independent assessment must be used in conjunction with the application packets and other applicable functional assessments to create the person centered service plan.

230.211 Pervasive Level of Support **9-1-167-1-17**

The pervasive level of support is defined as needs that require constant supports provided across environments that are intrusive, long term and include a combination of any available waiver supports provided 24 hours a day, 7 days a week for 365 days a year.

A. This level may include persons in need of priority consideration who are currently served through Act 609; Department of Human Services (DHS) integrated supports; are civil commitments; are children in custody of the Division of Children and Family Services (DCFS) and who are receiving services through the Children's Adolescents Special Services Programs; Intermediate care facility/mental retardation; nursing facilities and persons who have compulsive behavior disorders.

~~B. People who meet the pervasive level of support definition are determined eligible based on the Inventory for Client and Agency Planning (ICAP) assessment process.~~

~~C. Procedures for requesting pervasive level of support:~~

~~1. To request pervasive level of support, the Case Manager must submit the following items to the DDS Waiver Specialist:~~

~~a. Documentation of changes in medical, behavioral or other condition that would justify the need for pervasive level of support. Include all incident reports.~~

~~b. Copy of the current person centered service plan.~~

~~c. Copy of the person's case management and supportive living staff notes for the past year if request is due to behavior or medical.~~

~~d. If the reason for pervasive level of support is in whole or in part due to behavior issues, a copy of the most recent psychological information on behavioral intervention efforts to include:~~

~~(1) A functional behavior analysis of inappropriate behavior including possible antecedents~~

~~(2) Description of inappropriate behaviors and consequences~~

~~(3) Information related to increases or decreases in inappropriate behavior including time involved and frequency~~

~~(4) Positive programming changes to include a description of the behaviors attempting to be established to replace the inappropriate behavioral expression.~~

~~e. Copy of the computer generated or signed narrative report for the ICAP results which includes:~~

~~(1) ICAP Domain scores (age scores and standard scores)~~

~~(2) Information on problem behaviors recorded in the ICAP~~

~~(3) ICAP Maladaptive Behavior Index Scores~~

~~(4) ICAP Service Score/Level~~

~~(5) The name and relationship of respondent must be clearly noted.~~

~~(6) The name and credentials of the person administering and writing the report must be clearly noted.~~

~~2. Upon receipt of a request for pervasive level of support~~

~~a. The DDS Waiver Specialist will check with DDS Licensure unit to determine if any incident reports have been filed related to the beneficiary. If incident reports have been filed, a copy will be obtained for the plan of care meeting.~~

~~b. The DDS Waiver Area Manager will check the Incident Reporting Information System (IRIS) to see if reports have been filed related to the beneficiary. If any reports have been filed on IRIS, a summary will be compiled for the plan of care meeting. The summary will include any variances between the submitted reports and those found or not found in the DDS reporting systems.~~

~~c. The DDS Waiver Specialist will check the Medicaid Management Information System (MMIS) and all waiver prior authorizations issued and payments for waiver services for the past year. The case manager will be required to justify any under utilization.~~

~~3. If the request packet is not complete, it will not be accepted. Retroactive approval will not be granted on pervasive level of support although emergency approval, pending receipt of required documents and determination, may be obtained from the Assistant Director of Adult and Waiver Services. Emergency requests may be made via secure e-mail. For emergency requests, all the required documentation listed in this rule must be submitted within two working days. If the documentation does not~~

~~support there was an emergency, the emergency approval will be suspended or rescinded.~~

4. ~~If the Plan of Care Review Team cannot make a decision on pervasive level of support and needs additional information, they will request assistance from the DDS Psychological Team.~~

5. ~~If assistance is requested from the DDS Psychological Team, they will convene within five working days following the Plan of Care Team meeting.~~

6. ~~If the Plan of Care Review Team requires additional information based on incident reports or IRIS summaries, the timeframe for approving pervasive level of support will start over.~~

7. ~~All requests for pervasive level of support will be reviewed at the weekly Plan of Care Review Team meetings.~~

~~230.212 Extensive Level of Support~~ ~~3-1-10~~

~~The extensive level of support is defined as needs that require daily supports in one or more environments (work, home or community). Supports are less intrusive than the pervasive supports and may require a schedule of weekly supports that may be needed daily, but less than 24 hours a day, seven days a week.~~

~~230.213 Limited Level of Support~~ ~~3-1-10~~

~~The limited level of support is defined as needs that are anticipated to be consistent for a foreseeable future period of time, individually time-limited and may be intermittent in nature, subject to re-evaluation every 12 months. This level of support is less because of parental support, group settings and community assistance available to the beneficiary.~~

230.300 Comprehensive Diagnosis and Evaluation ~~3-1-10~~7-1-17

A comprehensive diagnosis and evaluation (D&E) must be administered in order to determine that applicants are persons with a developmental disability prior to receiving ~~ACS~~ CES Waiver services from the DDS.

The comprehensive diagnosis and evaluation includes a series of examinations and observations performed or validated and approved by professionals leading to conclusions and findings.

The examinations and/or assessments include, but are not limited to:

A. A thorough medical examination and other evaluations deemed necessary by the physician

B. A psychological assessment

C. A social history/sociological examination

D. An educational assessment, if applicable

E. An appraisal of adaptive behavior

F. All other examinations, assessments and evaluations necessary to describe the beneficiary's needs

G. Areas of Need form

Failure to submit the reassessments in advance of eligibility expiration date will result in the denial of case management reimbursement for the period the determination is overdue. Failure

to obtain any required eligibility determination, whether initial or subsequent time-bound reassessments, may result in the beneficiary's case being closed.

When a beneficiary's case has been closed, the affected person must make a new request for services through the waiver program intake process in order for services to continue. This will be considered a new application to the waiver program.

230.400 Person-Centered Service Plan 9-1-167-1-17

During the initial sixty (60) days of DDS ACS CES waiver services, a beneficiary receives services based on a DDS pre-approved initial person-centered service plan that provides for case management at the prevailing rate, up to sixty (60) days; and supportive living services for direct-care supervision at a rate of $100.00 per month, up to sixty (60) days. It may include transitional funding when the person is transitioning from an institution to the community. Persons residing in a Medicaid-reimbursed facility may receive case management the last 180 consecutive days of the institutional stay.

NOTE: The fully-developed person-centered service plan may be submitted, approved and implemented prior to the expiration of the initial person-centered service plan. The initial plan period is simply the maximum time frame for developing, submitting, obtaining approval from DDS and implementing the person-centered service plan. An extension may be granted when there is supporting documentation justifying the delay.

Prior to expiration of the interim plan of careservice plan, each beneficiary eligible for ACS CES waiver services must have an individualized, specific, written person-centered service plan developed by a multi-agency team and approved by the DDS authority. The members of the team will determine services to be provided, frequency of service provision, number of units of service and cost for those services while ensuring that the beneficiary's desired outcomes, needs and preferences are addressed. Team members and a physician, via the DDS 703 form, certify the beneficiary's condition (level of care) and appropriateness of services initially and at the annual continued-stay review. The person-centered service plan development is conducted once every 12 months in accordance with the continued stay review date or as changes in the beneficiary's condition require a revision to the person-centered service plan.

The person-centered service plan must be designed with consideration given to the independent assessment results and to assure that services provided will be:

A. Specific to the beneficiary's unique circumstances and potential for personal growth.

B. Provided in the least restrictive environment possible.

C. Developed within a process assuring participation of those concerned with the beneficiary's welfare. Participants of the multi-agency team included the beneficiary's chosen case manager, the beneficiary or legal representative and additional persons whom the beneficiary chooses to invite to the planning meeting, as long as all rules pertaining to confidentiality and conflict of interest are met. If invited, the DDS Waiver Specialist attends the planning meetings randomly, in an effort to assure an annual 10% attendance ratio. If invited, the DDS Waiver Specialist must attend all planning meetings if the beneficiary is believed to be eligible for the pervasive level of support. Mandatory attendance by the case manager is required to assure the written person-centered service plan meets the requirements of regulations, the desires of the beneficiary or legal representative, is submitted timely, and is approved by DDS prior to service delivery.

D. Monitored and adjusted to reflect changes in the beneficiary's needs. A person-centered service plan revision may be requested at any time the beneficiary's needs change.

E. Provided within a system which safeguards the beneficiary's rights.

F. Documented carefully, with assurance that appropriate records will be maintained.

G. Will assure the beneficiary's and others' health and safety. The person-centered service plan development process identifies risks and makes sure that they are addressed through backup plans and risk management agreements, including how and who will be responsible for ongoing monitoring of risk level and risk management strategies, and how staff will be trained regarding those risks. A complete description of backup arrangements must be included in the person-centered service plan. All strategies must be designed to respect the needs and preferences of the beneficiary. All risk management strategies must be analyzed by the team at least quarterly as part of the PCSP review.

H. Consider cost-efficient options that foster independence, such as shared staffing and other adaptions. When such options are not utilized in the PCSP for a Tier 3 participant, it must be documented that the participant's health and safety require one-on-one staffing, 24 hours a day.

230.410 Person Centered Service Plan Required Documentation 9-1-167-1-17

A. General Information

Identification information must include:

1. Beneficiary's full name and address
2. Beneficiary's Medicaid number
3. Guardian or Power of Attorney with an address (when applicable)
4. Number of individuals with MR/DD residing in home of waiver beneficiary and type of residence
5. Physician Level of Care Certification
6. Names, titles and signatures of the multi-agency team members responsible for the development of the beneficiary's person centered service plan
7. Results of the independent assessment and any other functional assessments used to develop the person-centered service plan

B. Budget Sheet, Worksheets and Provider Information

Information must include:

1. Identification of the type of waiver services to be provided
2. The name of the provider delivering the service
3. Total amount by service
4. Total plan amount authorized
5. Beginning and ending date for each service
6. Supported Living Array worksheet listing units and total cost by service and level of support
7. Adaptive Equipment, Environmental Modifications, Specialized Medical Supplies, Supplemental Support, and Community Transition worksheets listing units and total cost by service
8. Provider Information sheet showing case management provider, case manager, supportive living provider, and direct care supervisor

C. Narrative justification for the revision to the initial plan of care must, at a minimum justify the need for requested services. Narrative justification for annual continued stay reviews

must address utilization of services used or unused within the past year, justify new services requested and address risk assessment.

D. The person-centered service plan must include:

1. Identification of individual objectives
2. Frequency of review of the objectives
3. List of medical and other services, including waiver and non-waiver services necessary to obtain expected objectives
4. Expected outcomes including any service barriers

E. Product and service cost effectiveness certification statement, with supporting documentation certifying that products, goods and services to be purchased meet applicable codes and standards and are cost-competitive for comparable quality.

240.000 PRIOR AUTHORIZATION ~~3-1-10~~7-1-17

~~ACS~~ CES waiver services require prior authorization by the Division of Developmental Disabilities Services. **In the absence of prior authorization, reimbursement will be denied and will not be approved retroactively.**

241.000 Approval Authority ~~9-1-16~~7-1-17

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

A. The DDS prior authorization process requires that all pervasive level of support service plans, problematic service plans, or plans not clearly based on documented need must have approval by DDS Plan of Care Review Team.

1. Problematic is based on individual circumstances, a change in condition, or a new service request as determined by the DDS Waiver Specialist or by request of the case manager.
2. The DDS Plan of Care Review Team consists of the DDS Waiver Program director or designee, DDS Waiver Area Managers, DDS Psychology Team member and other expert professionals such as nurses, physicians or therapists. The DDS Waiver Specialist is responsible for presenting the case to the team. The waiver participant or legal representative is permitted to attend the meeting and present supporting evidence why the services requested should be approved, as long as all rules pertaining to confidentiality and conflict of interest are met.
3. The DDS Waiver Specialist must conduct an in-home visit for all ~~pervasive level of support requests~~Tier 3 service plans and may conduct an in-home visit for problematic service plans or plans that are not based on documented need~~ed~~. Failure of the beneficiary or legal representative to permit DDS from conducting the in-home visit may result in the denial of service request and may result in case closure.

B. ~~All extensive and limited~~Tier 2 service plans will be subject to a local-level approval process.

C. All waiver services must be needed to prevent institutionalization.

D. All beneficiaries receiving medications must also receive appropriate support in the management of medication(s). The use of psychotropic medications for behavior will require the development, implementation and monitoring of a written positive behavior plan.

E. Service requests that will supplant Department of Education responsibilities WILL NOT be approved. This includes voluntary decisions to withdraw from, or never enter the Department of Education, public school system. The waiver does not provide educational services, including educational materials, equipment supplies or aids.

F. All person centered service plans are subject to review by a qualified physician and random audit scrutiny by DDS Specialists, DDS Area Managers, DDS Licensure staff or DMS Quality Assurance staff. In addition, the following activities will occur:

1. Review of provider standards and actions that provide for the assurance of a ~~person's~~ beneficiary's health and welfare

2. Monitoring of compliance with standards for any state licensure or certification requirement for persons furnishing services provided under this waiver

3. Assurance that the requirements are met on the date that the service is furnished

4. Quality assurance reviews by DDS staff include announced and unannounced quarterly on-site home visits.

5. Random review equal to a percent as prescribed by DDS Licensure Unit's certification policy.

G. All service requests are subject to review by DDS and may necessitate the gathering and submission of additional justification, information and clarification before prior approval is made. In this event, it is the primary responsibility of the case management provider, with cooperation from the procurement source, to satisfy the request(s) within the prescribed time frames.

H. It is the responsibility of the case management services provider with cooperation from the direct services providers to ensure that all requests for services are submitted in a timely manner to allow for DDS prior authorization activities prior to the expiration of existing plans or expected implementation of revisions.

I. Initially, a beneficiary receives up to three months of DDS ~~ACS~~ CES waiver services based on a DDS pre-approved interim ~~person centered~~ service plan. The pre-approved interim plan will include case management and supportive living service for direct care supervision and may include community transition services when the person is transitioning from an institution to the community. For transitional case management, the three month interim plan begins with the date of discharge.

1. At any time during the initial three months or transitional case management period, the case manager will complete the planning process and submit a detailed person centered service plan that identifies all needed, medically necessary services for the remainder of the plan of care year. Once approval is obtained, these services may be implemented.

2. Waiver services will not be reimbursed for any date of service that occurs prior to the date the beneficiary's person centered service plan is approved, the date the beneficiary is determined to be ICF/IID eligible, or the date the beneficiary is deemed Medicaid waiver eligible, whichever date is last.

3. All changes of service or ~~level of support~~tier revisions must have prior authorization. Services that are not prior authorized will not be reimbursed.

J. Emergency approvals may be obtained via telephone, facsimile or e-mail, with retroactive reimbursement permitted as long as the notice of emergency, with request for service change, is received by DDS within 24 hours from the time the emergency situation was known. All electronically transmitted requests for emergency services must be followed with written notification and requests must be supported with documented proof of emergency. Failure to properly document proof of emergency shall result in approval being rescinded.

251.000 Method of Reimbursement ~~3-1-10~~7-1-17

The reimbursement rates for DDS ~~ACS~~ CES waiver services will be according to the lesser of the billed amount or the Title XIX (Medicaid) maximum for each procedure.

The maximum supportive living daily rate is inclusive of administration costs that cannot in any event exceed 20% of the total supportive living array for a beneficiary.

If fringe benefits exceed 25%, documentation must be submitted with person centered service plan and budget request. Fringe benefits cannot exceed 32%.

The administration and fringe costs are subject to audit and must be documented to support the rate charged.

261.000 Introduction to Billing ~~3-1-10~~7-1-17

DDS ~~ACS~~ CES waiver providers use the CMS-1500 claim form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim should contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

262.000 DDS ~~ACS~~ CES Waiver Procedure Codes ~~3-1-10~~7-1-17

The following procedure codes and any associated modifier(s) must be billed for DDS ~~ACS~~ CES Waiver Services. Prior authorization is required for all services.

Procedure Code	M1	M2	PA	Description	Unit of Service	National POS Codes
H2016			Y	Supportive Living	1 Day	12, 99, 14
H2023			Y	Supported Employment	15 Minutes	99
S5151			Y	Respite Services	1 Day	12, 99, 14, 54
T2020	UA		Y	Supplemental Support Services	1 ~~Month~~Package	12, 99, 14
T2022			Y	Case Management Services	1 Month	12, 99, 14
T2025			Y	Consultation Services	1 Hour	12, 99, 14
T2028			Y	Specialized Medical Supplies	1 ~~Month~~Package	12, 99,14
T2020	UA	U1	Y	Community Transition Services	1 Package	99, 14, 54

Procedure Code	M1	M2	PA	Description	Unit of Service	National POS Codes
T2022	U2		Y	Transitional Case Management	1 Month	99, 14, 54
T2034	U1	UA	Y	Crisis Intervention Services	1 Hour	99,12
K0108			Y	~~ACS~~ CES environmental modifications	1 Package	12
S5160			Y	Adaptive equipment, personal emergency response system (PERS), installation and testing,	1 Package	12, 14
S5161			Y	Adaptive equipment, personal emergency response system (PERS), service fee, per month, excludes installation and testing	1 ~~Month~~Package	12, 14
S5162			Y	Adaptive equipment, personal emergency response system (PERS), purchase only	1 Package	12, 14
S5165	U1		Y	~~ACS~~CES adaptive equipment, per service	1 Package	12, 14

262.210 Completion of CMS-1500 Claim Form ~~9-1-14~~7-1-17

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's date of birth as given on the Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary resides.
	STATE	Two-letter postal code for the state in which the beneficiary resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's telephone number or the number of a reliable message/contact/emergency telephone.

Field Name and Number	Instructions for Completion
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured beneficiary.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.

Field Name and Number	Instructions for Completion
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for DDS ~~Alternative Community Services (ACS)~~Community and Employment Supports (CES) Waiver services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.

Field Name and Number	Instructions for Completion
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's inpatient hospitalization, enter the beneficiary's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.100 for codes.

Field Name and Number	Instructions for Completion
C. EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Section 262.000.
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any beneficiary of the provider’s services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
NPI	Not required.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider’s Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT’S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as “MRN.”
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do **not** include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.