Facesheet: 1. Request Information (1 of 2)

A. The **State** of **Arkansas** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program	
PASSE	Provider-Led Arkansas Shared Savings Entity	MCO;	

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):
Provider-Led Arkansas Shared Savings Entity (PASSE) Model

C. Type of Request. This is an:

☑ **Amendment request for an existing waiver.**

The amendment modifies (Sect/Part):
The Waiver, in its entirety was modified to transition from Phase I (PCCM Entity model) to Phase II (MCO model). Additionally, multiple sections were changed to reflect the concurrent 1915(i) State Plan Amendment for Services for Community Independence for the behavioral health population and the dually diagnosed behavioral health/developmental disability population. Specific changes were made, as follows:

1) Section A/Part I:
-Changed to reflect that only four (4) PASSE Entities went into Phase I of the model (all statewide).
-Changed to add in the Voluntary, Tier 1 population on July 1, 2019.
-Excluded the Medically Needy (spenddown) population.
2) Section A/Part II:
-Changed to require the Care Coordinator to develop the Person Centered Service Plan (PCSP).
-Changed to require Members have direct access to Behavioral Health and Developmental Disability Services listed on their PCSP.
3) Section A/Part III:
-Added an External Quality Review Organization to the model.
4) Section A/Part IV:
-Added a new open enrollment, Oct. 1-Oct. 31, 2018.
-Switched from attribution based on claims history to auto-assignment.
-Added an appeal process to the grievance system.
5) Section B/Part I:
-Made changes to the Monitoring Plan Chart.
6) Section B/Part II:
-Added several monitoring tasks.
7) Section C:
-No change
8) Section D:
-Redid cost effectiveness to reflect the full PMPM payment for all services under a MCO model.

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

○ **1 year** ○ **2 years** ○ **3 years** ○ **4 years** ◉ **5 years**

Draft ID:AR.055.00.01

D. Effective Dates: This amendment is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

Approved Effective Date of Base Waiver being Amended: 10/01/17

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

01/01/19

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name: Dawn Stehle **Phone:** (501) 682-6311 **Ext:** ☐ **TTY** **If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information. The State contact information is different for the following programs:**

☐ **Provider-Led Arkansas Shared Savings Entity**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.
There are no federally recognized tribes in the State of Arkansas.

Program History required for renewal waivers only.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):
   - **a.** ☑ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
     -- *Specify Program Instance(s) applicable to this authority*
     ☑ **PASSE**
   - **b.** ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
     -- *Specify Program Instance(s) applicable to this authority*
     ☐ **PASSE**
   - **c.** ☐ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
     -- *Specify Program Instance(s) applicable to this authority*
     ☐ **PASSE**
   - **d.** ☑ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent

with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
-- *Specify Program Instance(s) applicable to this authority*
☑ **PASSE**

The 1915(b)(4) waiver applies to the following programs
☑ **MCO**
☐ **PIHP**
☐ **PAHP**
☐ **PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
☐ **FFS** Selective Contracting program
Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):
   - **a.** ☐ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
     -- *Specify Program Instance(s) applicable to this statute*
     ☐ **PASSE**
   - **b.** ☑ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
     -- *Specify Program Instance(s) applicable to this statute*
     ☑ **PASSE**
   - **c.** ☑ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
     -- *Specify Program Instance(s) applicable to this statute*
     ☑ **PASSE**
   - **d.** ☐ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
     -- *Specify Program Instance(s) applicable to this statute*
     ☐ **PASSE**
   - **e.** ☐ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

-- Specify Program Instance(s) applicable to this statute

☐ **PASSE**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
Act 775 of the 2017 Arkansas Regular Session was signed into law by Arkansas Governor, Asa Hutchinson, on March 31, 2017. This Act, known as the "Medicaid Provider Led Organized Care Act," is an innovative approach to organizing and managing the delivery of services for Medicaid beneficiaries with high medical needs. Under this unique model of organized care, Arkansas provider-led and owned organizations, known as Risk-Based Provider Organizations (RBPOs) or Provider-Led Arkansas Shared Savings Entities (PASSEs), are responsible for integrating the physical health services, behavioral health services, and specialized developmental disability services for approximately 30,000 individuals who have intensive levels of treatment or care needs due to mental illness, substance abuse, or intellectual and developmental disability. These vulnerable Arkansans will benefit from the provision and continuity of all medically necessary services in a well-organized system of coordinated care.

Under this Act, the PASSEs do not assume full risk for the provision of care until January 1, 2019. Therefore, there are two phases of this model. The first phase is known as the "Arkansas Provider Led Care Coordination Program." In this Phase, which began on October 1, 2017, the PASSEs provide care coordination to each member attributed to the PASSE, but services are still provided on a fee for service basis. Readiness review activities began in October, 2017, including the drafting of the Provider Agreement. Readiness Review document review and site visits took place in the month of December. By January 15, 2018, three PASSE's were licensed and enrolled as a Medicaid Provider; and began receiving members through attribution. Care Coordination began on February 1, 2018. Within one month, another PASSE had been licensed and enrolled to begin receiving members through attribution. There are now a total of four licensed PASSEs who have enrolled with Medicaid to receive attributed members.

For Phase II, which will begin on January 1, 2019, the PASSEs will continue providing care coordination and will begin providing all other services under a "full-risk" MCO model. PASSE's will enter into a PASSE Provider Agreement for terms of one-year and will be held accountable for performance metrics during that year. After the last attribution is run on November 15, 2018, newly eligible Medicaid beneficiaries will no longer be attributed to a PASSE, but will be auto-assigned to a PASSE. Medicaid will pay the PASSE an actuarially sound per member per month (PMPM) that must be used to cover all needed services for each of its members. DHS has created a new Office of Innovation and Delivery System Reform (IDSR) which will provide monitoring and oversight of the services provided to PASSE members. The IDSR includes Beneficiary Support, which will provide guidance to beneficiaries on the PASSE system.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

1. **Delivery Systems.** The State will be using the following systems to deliver services:

   a. ☑ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

   b. ☐ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its

enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

- ○ **The PIHP is paid on a risk basis**
- ○ **The PIHP is paid on a non-risk basis**

c. ☐ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

- ○ **The PAHP is paid on a risk basis**
- ○ **The PAHP is paid on a non-risk basis**

d. ☐ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ☐ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ○ **the same as stipulated in the state plan**
- ○ **different than stipulated in the state plan**

Please describe:

f. ☐ **Other:** (Please provide a brief narrative description of the model.)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. **Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

☑ **Procurement for MCO**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ◉ **Other** (please describe)

Any entity that meets the licensure and provider standards may participate. First, the entity must be licensed by the Arkansas Insurance Department as a Risk Based Provider Organization (RBPO)/Provider-Led Arkansas Shared Savings Entity (PASSE). Each licensed entity must then sign a Provider Agreement with DHS to enroll as a Medicaid Provider with Arkansas Medicaid. In Phase I, a PASSE was a PCCM entity.

For Phase II, the RBPO/PASSE will be required to sign a new PASSE Provider Agreement, which will

incorporate the PASSE Medicaid Provider Manual and the Federal Medicaid Managed Care regulations. In Phase II, the PASSE will be a full risk MCO entity.

☐ **Procurement for PIHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PAHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PCCM**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for FFS**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

1. **Assurances.**

☑ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

☐ The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

2. **Details.** The State will provide enrollees with the following choices (please replicate for each program in waiver):

Program: " **Provider-Led Arkansas Shared Savings Entity.** *"*

☑ **Two or more MCOs**

☐ **Two or more primary care providers within one PCCM system.**

☐ **A PCCM or one or more MCOs**

☐ **Two or more PIHPs.**

☐ **Two or more PAHPs.**

☐ **Other:**

please describe

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. **Rural Exception.**

☐ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52 (b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. **1915(b)(4) Selective Contracting.**

○ **Beneficiaries will be limited to a single provider in their service area**

Please define service area.

◉ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- *Specify Program Instance(s) for Statewide*
     ☑ **PASSE**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*
     ☐ **PASSE**
2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide	MCO	Empower Healthcare Solutions, LLC
Statewide	MCO	Arkansas Total Care
Statewide	MCO	Forevercare, Inc.
Statewide	MCO	Arkansas Provider Coalition d/b/a Summit Community Care

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations.** The following populations are included in the Waiver Program:

   ☐ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
   - ○ **Mandatory enrollment**
   - ○ **Voluntary enrollment**

   ☐ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
   - ○ **Mandatory enrollment**
   - ○ **Voluntary enrollment**

☐ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☑ **Other** (Please define):

Enrollment in a PASSE is mandatory for Medicaid beneficiaries, regardless of eligibility group, that have been identified through the Independent Assessment (IA) system as in need of behavioral health services or services for individuals with developmental disabilities at Tier II and Tier III levels of care. This includes all clients enrolled in the concurrent 1915(i) State Plan Amendment or the 1915(c) Community and Employment Supports (CES) Waiver.

For individuals served by the Division of Behavioral Health, the tiers are as follows:

Tier I: Counseling Level Services (Voluntary)
At this level, limited behavioral health services (individual and group therapy and medication services) are provided by qualified licensed practitioners in an outpatient based setting for the purpose of assessing and treating mental health and/or substance abuse conditions. Counseling services settings mean a behavioral health clinic/office, healthcare center, physician's office, and/or school.

Tier II: Rehabilitative Level Services (Mandatory)
At this level of need, services are provided in a counseling services setting, but the level of need requires a broader array of services to address functional deficits.

Tier III: Intensive Level Services (Mandatory)
Eligibility for this level of need will be identified by additional criteria, which could lead to placement in residential settings for more intensive delivery of services.

For Division of Developmental Disabilities Clients, the tiers are as follows:

Tier I: Community Clinic Level of Care (Voluntary)

At this level of need, the individual receives services in a day habilitation setting, i.e., and EIDT or ADDT.

Tier II: Institutional Level of Care (Mandatory)
The individual scored high enough in certain areas to be eligible for paid services and supports.

Tier III: Institutional Level of Care (Mandatory)
The individual scored high enough in certain areas to be eligible for the most intensive level of services, including 24 hours a day/7 days a week paid services and supports.

For the existing BH and DD populations, an independent assessment (IA) was conducted during Phase I. The IA determined the tier level for the member so that they can be enrolled in a PASSE. The IA also generated a report that could be used to develop the care plans for those beneficiaries. The IA will continue to be used for all newly enrolled beneficiaries in Phase II.

Voluntary: Beginning July 1, 2019, any individual with a BH or DD service need and identified as Tier I on the IA may voluntarily enroll in a PASSE, but enrollment is not mandatory for this population.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

- ☐ **Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))
- ☐ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.
- ☐ **Other Insurance** --Medicaid beneficiaries who have other health insurance.
- ☐ **Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).
- ☐ **Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program
- ☐ **Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.
- ☐ **Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
- ☐ **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.
- ☐ **Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

☐ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

☑ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

☑ **Other** (Please define):
Individuals residing in a Human Development Center (HDC), skilled nursing home, or assisted living facility are excluded.

Individuals enrolled in the ARChoices or Arkansas Independent Choices, and Autism Waiver are excluded.

Individuals who are receiving Arkansas Medicaid healthcare benefits on a medical spend-down basis are excluded; as well as individuals who are eligible for Arkansas medicaid healthcare benefits under the 06, Medically Frail, Aid Category.

These services are excluded:

1. Nonemergency Medical Transportation (NET);
2. Dental Benefits (dental managed care); and
3. School-based services provided by school employees

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
All individuals who meet the mandatory criteria will be enrolled in a PASSE, unless:

1) They are residing in a human development center (HDC), a skilled nursing facility (SNF), or an assisted living facility (ALF);

2) They are enrolled in the ARChoices, Independent Choices, or Autism 1915(c) Waiver; or

3) They are Medicaid eligible through one of the excluded groups (i.e., 06 Medically Frail or Spend-down).

Individuals who wish to voluntarily enroll may do so, unless they are in one of the three categories above.

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

☑ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51 (b)

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

☑ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

   ☐ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

   Emergency Services Category General Comments (optional):

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

   ☑ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

   ☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

   ☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.

☐ Other (please explain):

☐ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

   ☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

   ☑ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:
   Each PASSE will be required to have at least one FQHC in their network.

   ☐ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

   FQHC Services Category General Comments (optional):

5. **EPSDT Requirements.**

   ☑ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

   EPSDT Requirements Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

☐ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

1915(b)(3) Services Requirements Category General Comments:

7. Self-referrals.

☑ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

The PASSE must allow self-referrals for family planning services in accordance with 42 CFR 431.51(b).

8. Other.

☑ Other (Please describe)

The PASSE must provide care coordination to each of its members. Act 775 of the 2017 Arkansas Regular Session defined care coordination to include the following activities:

1. Health education and coaching;
2. Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;
3. Assistance with social determinants of health, such as access to healthy food and exercise;
4. Promotion of activities focused on the health of a patient and the community, including without limitation outreach, quality improvement, and patient panel management; and
5. Coordination of community-based management of medication therapy.

As such, the care coordinator is responsible for the person centered service plan (PCSP) for each member assigned to him or her. The PCSP includes all services and service plans related to the client. The care coordinator must gather all existing treatment plans for the member in order to create the PCSP. This includes, but is not limited to:

1. Behavioral Health Treatment Plans;
2. Person Centered Service Plan for Waiver Clients;
3. Primary Care Physician Care Plan;
4. Individualized Education Program;
5. Individual Treatment Plans for developmental clients in day habilitation programs;
6. Nutrition Plan;
7. Housing Plan;
8. Any existing Work Plan;
9. Justice system-related plan;
10. Medication Management Plan;
11. Discharge Plan; and
12. Service needs identified as the results of the member's IA.

The PCSP must prevent duplication of services, ensure timely access to all needed services, and identify service gaps for the member, as well as provide any health education and health coaching identified. The PCSP should also set forth treatment goals and objectives, as well as the strategies, activities, and services received by the member to achieve these goals and objectives.

For those members who are enrolled in the Community and Employment Supports (CES) 1915(c) waiver or the 1915(i) Services for Community Independence, the PASSE will also provide case management services, including:
1. Developing the Person Centered Service Plan (PCSP) in conjunction with the plan development team;
2. Coordinating and arranging all Waiver services, HCBS State Plan Services and other state plan services;
3. Identifying and accessing needed medical, social, educational and other publicly funded services (regardless of funding source);
4. Monitoring and reviewing services provided to the member to ensure all PCSP services are being provided and to ensure the health and safety of the participant;
5. Identifying and accessing informal community supports needed by eligible participants and their families;
6. Facilitating crisis intervention;
7. Providing guidance and support to meet generic needs;
8. Monitoring services provided to ensure quality of care and case reviews which focus on the participant's progress in meeting goals and objectives established on existing case plans;
9. Providing assistance relative to obtaining waiver Medicaid eligibility and ICF/IID level of care eligibility determinations;
10. Ensuring submission of timely (advanced) and comprehensive behavior and assessment reports, continued PCSP with revisions as needs change, and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;
11. Conducting appropriate needs assessments and referrals for resources;
12. Arranging for access to advocacy services, as requested by the member; and
13. Providing guidance upon receipt of a PASSE, DDS or DHS notice of denial on how to appeal that denial;
14. Providing assistance for reassessment of functional needs by the Independent Assessment Vendor; and
15. Engaging the member, family and caregivers in the treatment planning process with providers and ensuring members and their caregivers have access to all treatment plans for the beneficiary.

The PASSE must comply with Conflict Free Case Management rules in accordance with 42 CFR 441.330(c)(1)(iv).

Care coordination services must be available to enrolled members 24 hours a day, through a hotline or web-based application.

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
The PASSE is responsible for providing all services to its members, including services contained in:

1) The State Plan

2) The 1915(i) Services for Community Independence, which includes the following services:

-Supported Employment
-Behavior Assistance
-Adult Rehabilitation Day Treatment
-Peer Support
-Family Support Partners
-Pharmaceutical Counseling
-Supportive Life Skills Development
-Child and Youth Support
-Therapeutic Communities
-Residential Community Reintegration
-Outpatient Substance Abuse Treatment
-Crisis Intervention
-Planned Respite
-Emergency Respite

-Mobile Crisis Intervention
-Therapeutic Host Home
-Recovery Support Partners (for Substance Abuse)
-Substance Abuse Detoxification (Observational)
-Supportive Housing

3) The 1915(c) Community and Employment Supports Waiver for Home and Community Based Services, which includes the following services:

-Supported Employment
-Supportive Living
-Adaptive Equipment
-Community Transition Services
-Consultation
-Crisis Intervention
-Environmental Modifications
-Supplemental Support
-Respite
-Specialized Medical Supplies

These services are EXCLUDED and the PASSE will not be responsible for providing them:

1) Non-emergency medical transportation (NET)
2) Dental benefits in a capitated program
3) School-based services provided by school employees
4) Skilled nursing facility services
5) Assisted living facility services
6) Human Development Center Services
7) Waiver services provided to the elderly and adults with physical disabilities through the ARChoices in Homecare program or the Arkansas Independent Choices Program.

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

1. Assurances for MCO, PIHP, or PAHP programs

- [x] The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted

to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.
   - **a.** ☐ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.
     - **1.** ☐ PCPs

       Please describe:

     - **2.** ☐ Specialists

       Please describe:

     - **3.** ☐ Ancillary providers

       Please describe:

     - **4.** ☐ Dental

       Please describe:

     - **5.** ☐ Hospitals

       Please describe:

     - **6.** ☐ Mental Health

       Please describe:

     - **7.** ☐ Pharmacies

       Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. **Details for PCCM program.** (Continued)

b. ☐ **Appointment Scheduling**means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. **Details for PCCM program.** (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

3. **Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. **Assurances for MCO, PIHP, or PAHP programs**

☑ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.
   - **a.** ☐ The State has set **enrollment limits** for each PCCM primary care provider.

     Please describe the enrollment limits and how each is determined:

   - **b.** ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

     Please describe the State's standard:

   - **c.** ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

     Please describe the State's standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. **Details for PCCM program.** (Continued)
   - **d.** ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal

Please note any limitations to the data in the chart above:

e. ☐ The State ensures adequate **geographic distribution** of PCCMs.

Please describe the State's standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. **Details for PCCM program.** (Continued)

f. ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	

Please note any changes that will occur due to the use of physician extenders.:

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. **Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. Assurances for MCO, PIHP, or PAHP programs

☑ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. ☐ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

b. ☑ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

Please describe:

All individuals who have high behavioral health or developmental disability needs must undergo an Independent Assessment (IA) prior to being enrolled in a PASSE. This IA identifies areas of functional needs for each member and identifies the member as either a high needs behavioral health or developmental disabilities client. Additionally, all developmental disabilities clients who are enrolled in a PASSE will have already been deemed to meet the institutional level of care by either the Community and Employment Supports Waiver eligibility unit or the Office of Long Term Care.

c. ☑ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

In addition to the IA that beneficiaries receive prior to PASSE enrollment, each PASSE must complete a health questionnaire within 60 days of the member being enrolled in that PASSE and complete the Person Centered Service Plan (PCSP). The health screen must include a psycho-social evaluation.

d. ☑ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan.If so, the treatment plan meets the following requirements:

1. ☑ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee.
2. ☑ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. ☑ In accord with any applicable State quality assurance and utilization review standards.

Please describe:

The care coordinator should engage the member, family and caregivers in the treatment planning process with providers and ensure members and their caregivers have access to all treatment plans for the member.

e. ☑ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

Please describe:

The PASSE must have a process to allow members direct access to behavioral health and developmental disability services that are listed in the member's PCSP.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

b. ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

c. ☐ Each enrollee is receives **health education/promotion** information.

Please explain:

d. ☐ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. ☐ There is appropriate and confidential **exchange of information** among providers.

f. ☐ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g. ☐ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ☐ **Additional case management** is provided.

Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files.

i. ☐ **Referrals.**

Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.
All member who have an existing care plan will carry that care plan with them when they are enrolled into a PASSE. Each member will be assigned a Care Coordinator who must make contact with that member within 15 business days of enrollment. The PASSE Care Coordinator will then have 60 days to conduct a health questionnaire and coordinate a Person Centered Service Plan (PCSP) Development meeting. The PCSP must address any needs noted in the Independent Assessment, the health questionnaire, or any other assessment or evaluation used at the time of PCSP development.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs**

- [x] The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [x] Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:

(mm/dd/yy)

☑ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.

Please provide the information below (modify chart as necessary):

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	**Procuring through RFP (anticipated award date is Jul. 1, 2019)**	**X**	**X**	
PIHP				

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ☐ The State has developed a set of overall quality **improvement guidelines** for its PC□M program.

Please describe:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)
   - **b.** ☐ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.
     1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
     2. ☐ Initiate telephone and/or mail inquiries and follow-up
     3. ☐ Request PCCM's response to identified problems
     4. ☐ Refer to program staff for further investigation
     5. ☐ Send warning letters to PCCMs
     6. ☐ Refer to State's medical staff for investigation
     7. ☐ Institute corrective action plans and follow-up
     8. ☐ Change an enrollee's PCCM
     9. ☐ Institute a restriction on the types of enrollees
     10. ☐ Further limit the number of assignments
     11. ☐ Ban new assignments
     12. ☐ Transfer some or all assignments to different PCCMs
     13. ☐ Suspend or terminate PCCM agreement
     14. ☐ Suspend or terminate as Medicaid providers
     15. ☐ Other

         Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)
   - **c.** ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
     Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):
     1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
     2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
     3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
        - **A.** ☐ Initial credentialing
        - **B.** ☐ Performance measures, including those obtained through the following (check all that apply):
          - ☐ The utilization management system.
          - ☐ The complaint and appeals system.

- ☐ Enrollee surveys.
- ☐ Other.

Please describe:

4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:
The PASSE providers must be licensed by the Arkansas Insurance Department and meet their reserve requirements. Additionally, the PASSE providers must enroll as Medicaid Providers and demonstrate Network Adequacy in accordance with the PASSE Provider Manual and the PASSE Provider Agreement. Each PASSE will undergo a readiness review that will include a review of all information provided to beneficiaries, any PASSE marketing materials, member access to the PASSE's 24 hour care coordination hotline and Suicide Prevention Hotline, and the PASSE's ability to provide all services to the members, including care coordination.

DHS will monitor the activities of each PASSE and the PASSE program as a whole as defined in CFR 42 §438.66. This includes the conduct of hearings requested by a PASSE or a provider due to alleged anti-competitive practices.

As required by 42 CFR § 447.203, DHS will monitor PASSE organization network providers to ensure members have adequate access to care. DHS has established access standards which the PASSE is required to meet. DHS requires that the PASSE and contract provider networks cooperate with DHS's analysis for access and provide any requested data required to carry out DHS's process for monitoring access to care.

A separate analysis will be performed for each of the following provider types and types of service at least every

three years:
A. Primary care services – including those provided by a physician, federally qualified health center (FQHC), clinic, and community health centers;
B. Physician specialist services;
C. Behavioral health services – including mental health and substance use disorder;
D. Home health services,
E. Additional types of services where the state or the Centers for Medicare and Medicaid Services (CMS) has received a significantly higher than usual volume of beneficiary, provider, or other stakeholder access complaints, and
F. For any services that can prevent ambulatory care preventable emergency room visits, hospitalization, re-admissions or if it is determined that circumstances have change that would result in diminished access to care for enrollees.

DHS will seek public comment from time to time to identify any areas of concern about access to care or service availability. As required by federal regulation DHS shall perform an analysis of timely access to care at the end of the first year of the PASSE program and at least every three years thereafter

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. **Assurances**

- [x] The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. **Details**

   a. **Scope of Marketing**

   1. [ ] The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
   2. [x] The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

      Please list types of indirect marketing permitted:

The State permits the PASSE to market to potential enrollees through a website or printed material distributed through DHS choice counselors. Specifically, each PASSE may create and run a website for information regarding its PASSE, provider network, and care coordinator services. This website may be linked to the DHS PASSE webpage and is designed to provide information for beneficiaries when making a decision to change PASSEs.

The PASSE may also produce written marketing materials to distribute to enrollees and potential enrollees. The written materials may be distributed by DHS choice counselors.

All marketing materials and marketing strategies must be approved by DHS.

3. ☐ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

b. Description. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. ☑ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

This is prohibited and will be monitoring by the Medicaid PASSE Oversight Team.

2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ☑ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

All allowable, written marketing materials will be translated into Spanish. All PASSEs must be able to provide written materials in any language requested by the member.

The State has chosen these languages because (check any that apply):

a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b.

☑ The languages comprise all languages in the service area spoken by approximately 5.0 percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:
The PASSE must have the ability to translate marketing materials for beneficiaries who do not speak English or Spanish, either through the use of a voice translator or through some other translation service. The PASSE may choose to provide their marketing materials in other languages to fulfill this requirement.

A PASSE may only directly distribute information to a current member of their PASSE. Other than the welcome information if a member transitions to their PASSE, a PASSE cannot provide any information to a Medicaid member that is a member of another PASSE. Participating providers and direct service providers cannot distribute information to a Medicaid member about enrolling in a specific PASSE. The only allowable information that can be distributed to Medicaid beneficiaries by participating providers and direct service providers will be information that is provided by DHS choice counselors.

All marketing materials and activities must be approved by DHS in advance of use.

The PASSE may freely market to providers regarding joining the PASSE's provider network.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

☑ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. ☑ Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

Spanish

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

a. ☐ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines "significant.":

b. ☑ The languages spoken by approximately 5.00 percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

2. ☑ Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

Each PASSE must provide access to information in the member's spoken/written language, either through oral translation services or by providing the materials in that language.

3. ☑ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

DHS's PASSE Member support team will assist enrollees in making the choice of which PASSE to join and answer any questions regarding PASSE enrollment, the appeals and grievance process, and what rights they have as PASSE beneficiaries.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- [x] State
- [ ] Contractor

Please specify:

- [ ] There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. Details (Continued)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

- [ ] the State
- [ ] State contractor

Please specify:

- [x] The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
The State will leverage existing employees to provide initial information and choice counseling to enrolled members. These employees will receive notice of who has been enrolled from the DSS System and will then contact that member or their family to provide any information and conduct any choice counseling necessary.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

- [x] The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

☑ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

Websites for the Arkansas Waiver Association, the Developmental Disabilities Provider Association and Arkansas Medicaid contain
information about the Waiver amendments. The information was posted to the Arkansas Medicaid Website around September 1st, 2018. The link is https://humanservices.arkansas.gov/about-dhs/dms/passe/passe-beneficiary-support. Other websites would have posted the information soon thereafter. DMS and DDS staff participated at provider conferences and took comments by phone and email from providers and people receiving or applying for services.

DThe following meetings were held where agency representatives spoke regarding these amendments:

October 2017:
9-13: AFMC PASSE Webinars, statewide
10: Independent Assessment Informational Session, Little Rock
17: Parent Meeting, Searcy
25: School-Based Mental Health Task Force

December 2017:
6: Medicaid Educational Conference

January 2018:
19: Facebook Live presentation, statewide

February 2018:
16: Independent Assessment Information Session, Little Rock
28: Arkansas Department of Education, Little Rock

March 2018:

27: Independent Living, Inc. Conference, Harrison

April 2018:
20: Family Bistro for Title V Families and DD Stakeholders
25: ACAAA Annual Conference, Little Rock

May 2018:
25: Natural Wonders Committee presentation, Little Rock

June 2018:
20: Webinar on Care Coordinator Rules and Responsibilities, Statewide

July 2018:
5: Meeting with DCFS and PASSE Care Coordinators, Little Rock
11-13: Arkansas Waiver Association Conference, Hot Springs

August 2018:
20: DDS Staff training on PASSE, Little Rock
20: Public Hearing on PASSE Provider Manual, Little Rock
23: Webinar on PASSE for Medical Providers, Statewide

September 2018:
4: Public Hearing on PASSE Provider Manual, Monticello
6: Public Hearing on PASSE Provider Manual, Hope
11: Faceboook Live on PASSE, Statewide
11: Rate Setting Meeting with PASSE CEOs and Actuaries, Little Rock
17: Webinar on PASSE for Families, Statewide

Additionally, the state will ask for PASSE participation in outreach activities such as public forums or beneficiary/provider trainings. If the State asks for such participation, it will ask for a representative of each PASSE to be a part of the outreach.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

- [x] State staff conducts the enrollment process.
- [ ] The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.
  - [ ] The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

  Broker name:

  Please list the functions that the contractor will perform:
  - [ ] choice counseling
  - [ ] enrollment
  - [ ] other

  Please describe:

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

☐ This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

☑ This is an **existing program** that will be expanded during the renewal period.

Please describe: Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

Beginning on January 1, 2019, all beneficiaries already enrolled in a PASSE and receiving care coordination service will begin receiving all services through the PASSE. This includes beneficiaries who have been designated as a Tier II or Tier III behavioral health or developmental disability client by the Independent Assessment (IA) and mandatorily enrolled in a PASSE.

Also, beginning on January 1, 2019, those beneficiaries who meet the eligibility requirements to enroll in the 1915(i) Services for Community Independence will be enrolled in the PASSE program. Once enrolled, all services for those beneficiaries will be provided by the assigned PASSE.

Beneficiaries who have already been attributed to a PASSE will be offered an open enrollment period during the first quarter of PASSE implementation.

Those beneficiaries who are eligible to voluntarily enroll may begin doing so on July 1, 2019.

All assigned beneficiaries will have 90 days from date of initial assignment to change their PASSE. DHS's Beneficiary Support will assist with this process.

☐ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i.

☐ Potential enrollees will have ☐ ○ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

☑ The State automatically enrolls beneficiaries.

- ☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).
- ☐ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).
- ☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

☐ The State provides **guaranteed eligibility** of _____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

☐ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

☑ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

☑ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- **i.** ☑ Enrollee submits request to State.
- **ii.** ☑ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- **iii.** ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

☐ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

☑ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of 12 months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

For all of the reasons listed in 42 C.F.R. 438.56(d)(2).

☐ The State does not have a **lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

☐ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

i. ☐ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

ii. ☐ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii. ☐ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv. ☐ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:
Each beneficiary who undergoes an IA and is determined to be a Tier 2 or Tier 3 BH or DD client will automatically be assigned to a PASSE by DHS. Auto assignment will be proportionally distributed across all four PASSE's. Market share will be taken into account to ensure fair competition among PASSE's. Once a PASSE reaches a certain percentage of the market share, that PASSE will be removed from the auto-assignment algorithm until their market share falls below that percentage. Beginning in 2020, DHS anticipates the auto-assignment algorithm will also remove a PASSE from participation in auto-assignment if quality metrics are not met.

After auto-assignment, the member will have 90 days to dis-enroll from their assigned PASSE and re-enroll in another PASSE. DHS will provide choice counseling to each assigned member and direct them to approved informational websites or provide them with written material to help them choose between PASSE's. If the member elects to change PASSE's, the change will take effect seven days after the request is processed.

The member will be locked-in to that PASSE until open enrollment, at which time they will be given thirty (30) days to select a new PASSE.

A member may switch PASSE's at any time for cause. For cause is defined as the reasons listed in 42 CFR 438.56(d)(2).

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

☑ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

☑ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

    a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

    b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

    c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

    ☑ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

☑ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. **Details for MCO or PIHP programs**

a. Direct Access to Fair Hearing

☑ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.
☐ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. Timeframes

☑ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 30 days (between 20 and 90).
☑ The State's timeframe within which an enrollee must file a **grievance** is 45 days.

c. Special Needs

☑ The State has special processes in place for persons with special needs.

Please describe:

Each PASSE must provide auxiliary aids and services to beneficiaries with special needs upon request, including, but not limited to, interpreter services and toll-free numbers with TTY/TTD capability.

If an oral inquiry or request for a grievance or appeal is made, the PASSE or State must treat it as a formal request and begin the grievance or appeal process.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

☐ The State has a grievance procedure for its ☐ PCCM and/or ☐ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

The grievance procedures are operated by:

- ☐ the State
- ☐ the State's contractor.

  Please identify:
- ☐ the PCCM
- ☐ the PAHP

☐ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

☐ Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

☐ Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

☐ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

☐ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

☐ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
It is the responsibility of DHS to inform the person or the legally responsible representative of appeal rights specific to the applicant or of program denial.

It is the responsibility of DHS 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. When the applicant is determined to meet eligibility criteria, DHS informs 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.

Thereafter, the PASSE care coordinator provides continued education at each annual review regarding the PASSE's appeal process. The member or the legal representative may file an appeal with the PASSE. The member or legal representative may appeal the PASSE's decision to DHS following those processes, which the care coordinator must also inform the member of. Before an appeal may be brought to DHS, the member or care giver must exhaust the PASSE's appeal process.

All PASSE appeal processes must meet the requirements of CMS's managed care regulations. Additionally, DMS will use an appeal process in accordance with the Medicaid Provider Manual, Section 191.000 and the Arkansas Administrative Procedures Act, A.C.A. 25-15-201 et seq. Each PASSE must make its members aware of the appeal process and the members' appeal rights.

Each PASSE must have a process by which a member can file a complaint or grievance regarding, at a minimum, the type of services available to PASSE members, the denial of a specific service or provider, the quality of service provide, or regarding a provider in the PASSE's network, including a care coordinator.

Each PASSE must have a process by which a member can file a complaint or grievance regarding, at a minimum, the type of services available to PASSE members, the denial of a specific service or provider, the quality of service provide, or regarding a provider in the PASSE's network, including a care coordinator.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. **Assurances**

☑ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

☑ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915 (b) waiver programs to exclude entities that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. Employs or contracts directly or indirectly with an individual or entity that is
   a. excluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

☑ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

☐ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☑ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
The Arkansas Insurance Department will require background checks for each PASSE officer, owner, and partner. Additionally, the PASSE will provide an attestation of compliance with the criminal background check requirements each year at the time of the review and recertification as a PASSE.

All PASSE providers will be required to enroll as Medicaid Providers and undergo criminal background checks, and child maltreatment and adult maltreatment registry checks.

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability			

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

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  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other			

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☑ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
PASSE	MCO;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Provider-Led Arkansas Shared Savings Entity

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**

Please describe:

b. ☐ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

- [ ] **NCQA**
- [ ] **JCAHO**
- [ ] **AAAHC**
- [ ] **Other**

Please describe:

c. [x] **Consumer Self-Report data**

Activity Details:

1) Responsible personnel is the The DHS Office of Innovation and Delivery System Reform (IDSR).
2) The CAHPS and portions of the NCI to develop a state administered consumer survey, participants will be chosen randomly based on sample created by the DHS Division of Research and Statistics.
3) The survey will occur annually.
4) The survey will be used to monitor member satisfaction and ensure adequate and appropriate services are being provided that meet the member's needs.

- [x] **CAHPS**

Please identify which one(s):
The HCBS CAHPS survey.

- [x] **State-developed survey**
- [ ] **Disenrollment survey**
- [ ] **Consumer/beneficiary focus group**

d. [x] **Data Analysis (non-claims)**

Activity Details:

1) Responsible personnel is IDSR.
2) Data analysis will be run on all data listed below submitted by the PASSE either directly to IDSR or through the MMIS system.
3) Data analysis will be conducted on a quarterly basis.
4) If initial analysis indicates a quality or program issue may exist, the ISDR will refer the data to the EQR or another program integrity unit, such as OMIG or the Ombudsmen.

- [x] **Denials of referral requests**
- [x] **Disenrollment requests by enrollee**
  - [x] **From plan**
  - [ ] **From PCP within plan**
- [x] **Grievances and appeals data**
- [x] **Other**

Please describe:
Choice counseling contacts and number of notices sent.
Quarterly reports provided by the PASSE and encounter data collected through MMIS.

e. [x] **Enrollee Hotlines**

Activity Details:

1) Personnel responsible is a DHS procured contract vendor.
2) The Vendor operates a hotline that provides high level information on choice of PASSEs to potential members.
3) The hotline operates on an ongoing basis.
4) The contract vendor provides data to the state regarding call volume, subject and dispositions of call, and other standard call center metrics, which allows the state to track member requests to change PASSEs.

f. [x] **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:
1) IDSR and DDS personnel will conduct focused studies.
2) Focused studies will monitor the following activities:
• Enrollment/Disenrollment, specifically individuals who are disenrolled due to loss of Medicaid eligibility.
• Coverage/Authorization, studies will be conducted on specific services as needed to ensure that savings are not achieved through across the board rate cuts or discouraging use of certain services.
• Quality of Care, studies will center on quality of services provided to subpopulations to ensure the PASSE is providing evidence-based services that demonstrate quality outcomes.
3) The Frequency will be as needed.
4) The focused study will be designed to yield information relevant to the question being asked by the study.

g. ☑ **Geographic mapping**

Activity Details:
1) IDSR is responsible for geographic mapping.
2) Geographic mapping us conducted by mapping all providers in the PASSE network across the state by provider type.
3) At a minimum, mapping will occur annually.
4) Geographic mapping will ensure that all PASSEs are meeting the network adequacy requirements.

h. ☑ **Independent Assessment** (Required for first two waiver periods)

Activity Details:
1) The EQR procured by DHS will conduct an independent assessment of the PASSE program.
2) The activities will be designed by the EQR.
3) Activities will be conducted at a minimum, annually.
4) The purpose of EQR activities is to analyze the PASSE program with regards to the four pillars.

i. ☐ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☑ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:
1) The PASSE is the responsible party.
2) The PASSE must update their network with IDSR
3) Network updates must occur at least monthly.
4) Network updates provide assurance of the adequacy of the PASSE's network.

k. ☑ **Ombudsman**

Activity Details:
1) IDSR will house a PASSE Ombudsman
2) The Ombudsman will take complaints and monitor PASSE activities for the following areas:
• Information to Beneficiaries
• Grievances
• Timely Access
• Coordination/Continuity
3) Will occur on an on-going basis.
4) The purpose of the Ombudsman is to monitor quality of the services provided by the PASSE and ensure the protection of members enrolled in the PASSE.

l. ☑ **On-Site Review**

Activity Details:
1) IDSR and DDS personnel are responsible for on-site review.
2) During the on-site review, DHS staff will review the PASSE's systems and process.
3) On-site review will occur annually.
4) The purpose of the onsite review is to ensure that the PASSE can provide timely access to services, PCP and specialist capacity to meet members' needs, and appropriate care coordination to ensure continuity of care.

m. ☑ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:
1) The PASSE will be responsible for conducting Performance Improvement Projects (PIP).
2) Specific PIP activities will be determined by the PASSE and approved by DHS and will be designed to collect the information needed based on the area of focus.
3) PIPs will occur annually.
4) The PASSE will provide outcome data on the PIP to the EQR, who will review Performance Improvement Projects (the specifications of which will be set forth in the Provider Agreement).

- ☑ **Clinical**
- ☑ **Non-clinical**

n. ☑ **Performance Measures** [Required for MCO/PIHP]

Activity Details:
1) The PASSE is the responsible party.
2) Data on the quality metrics, as described below, will be reported by each PASSE to the IDSR.
3) Each PASSE will be required to report performance metrics on a quarterly basis.
4) The quality metrics will be used to determine the success of the PASSE and the quality of the services being provided.

- ☑ **Process**
- ☑ **Health status/ outcomes**
- ☑ **Access/ availability of care**
- ☑ **Use of services/ utilization**
- ☑ **Health plan stability/ financial/ cost of care**
- ☑ **Health plan/ provider characteristics**
- ☑ **Beneficiary characteristics**

o. ☐ **Periodic Comparison of # of Providers**

Activity Details:

p. ☑ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:
1) IDSR is the responsible party.
2) IDSR will evaluate encounter data provided by the PASSE through MMIS.
3) This will occur on an ongoing basis.
4) The data will be used to determine utilization and outliers and to monitor program integrity, quality of care, and coverage/authorization of services by PASSEs.

q. ☑ **Provider Self-Report Data**

Activity Details:
1) The PASSEs are required to report encounter data reports on quality metrics.
2) The reports are self-reported data on the quality metrics laid out below, and encounter

data collected through MMIS on the types of encounters members are experiencing.
3) The reports must be provided quarterly.
4) These self-reported data will track:

• Enrollment/disenrollment
• Program integrity
• Information to beneficiaries
• Grievances
• Timely Access
• PCP/Specialists Capacity
• Coordination/Continuity of Care
• Coverage/Authorization of Services
• Provider Selection
• Quality of Care

☐ **Survey of providers**

☐ **Focus groups**

r. ☑ **Test 24/7 PCP Availability**

Activity Details:
1) IDSR is the responsible party.
2) IDSR will monitor the PASSE's network adequacy and the encounter data submitted.
3) This will be done on an on-going basis as new updates are made to the network adequacy.
4) The purpose of this monitoring is to ensure access to PCP's by members.

s. ☑ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:
1) IDSR is the responsible party.
2) Encounter data provided by the PASSEs will be analyzed.
3) This will be done on an ongoing basis.
4) The purpose is to monitor the coverage and authorization of services and the quality of care provided to PASSE members.

t. ☑ **Other**

Activity Details:
1) IDSR is one of the responsible parties.
2) It will approve and monitor:
• all marketing materials and strategies used by the PASSEs;
• That enrollment and disenrollment from PASSE's happens in a timely manner;
• That all information is provided to members and potential enrollees timely and in an appropriate format; and
• Utilization of services to ensure that they are being properly authorized by the PASSEs.
3) These activities will occur on an ongoing basis.
4) The various activities are done for the purposes listed above. Additionally, a readiness review will ensure that all PASSE monitoring functions are in place, and that PASSE's are able to provide all needed member services on January 1, 2019. IDSR will assess the PASSE's ability to provide 24/7 access to care coordination at initial readiness review, and through analysis of quarterly reports and encounter data.

1) Another responsible party is The Office of Medicaid Inspector General (OMIG)
2) OMIG will monitor PASSE program integrity, as part of their statutory duty to ensure the integrity of the State Medicaid Program.
3) This monitoring occurs on an ongoing basis.
4) The monitoring ensures the integrity of the PASSE program.

1) IDSR is also responsible for the PASSE Member Support System.
2) This system will collect data on choice, enrollment and disenrollment, grievances, continuity of care, PCP and specialist capacity and selection, and the quality of care, as

well as provide information to beneficiaries.
3) This will occur on an ongoing basis.
4) This data will be analyzed by IDSR to improve the Member Support System and the PASSE program.

Section C: Monitoring Results

Initial Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is an Initial waiver request.

☑ **The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.**

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Behavioral Health (Adult)	
Behavioral Health (Child)	
DD/ID & Dual Diagnosis (Adult)	
DD/ID & Dual Diagnosis (Child)	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	10/01/0017	12/31/0018		
Enrollment Projections for the Time Period*	01/01/0019	09/30/0022		

**Include actual data and dates used in conversion - no estimates
*Projections start on Quarter and include data for requested waiver period

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Care Coordination	☐	☐	☑	
Inpatient	☑	☐	☑	
Inpatient-Psych	☑	☐	☑	
Day Treatment	☑	☐	☑	
Outpatient	☑	☐	☑	
Professional	☑	☐	☑	
PT/OT/Speech	☑	☐	☑	
Family Planning	☑	☐	☑	
HH/Personal Care	☑	☐	☑	
ICF	☑	☐	☑	
Dental/Vision/Hearing	☑	☐	☑	
Pharmacy	☑	☐	☑	
Other	☑	☐	☑	
OBH Community Support and Psycho-social Rehab	☑	☐	☑	
OBH Evaluation	☑	☐	☑	
OBH Other	☑	☐	☑	
OBH Therapy	☑	☐	☑	
DDS Waiver Community Support	☑	☐	☑	
DDS Waiver Case Management	☑	☐	☑	
DDS Waiver-Other	☑	☐	☑	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

Signature:

State Medicaid Director or Designee

Submission Date:

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

b. Name of Medicaid Financial Officer making these assurances:

David McMahon

c. Telephone Number:

(501) 396-6421

d. E-mail:

David.McMahon@dhs.arkansas.gov

e. The State is choosing to report waiver expenditures based on

- (●) **date of payment.**
- ( ) **date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in A.I.b.

- **a.** [x] **MCO**
- **b.** [ ] **PIHP**
- **c.** [ ] **PAHP**
- **d.** [ ] **PCCM**
- **e.** [ ] **Other**

Please describe:

The PASSEs will become Medicaid enrolled providers and will have to enter into a PASSE Provider Agreement, as part of this agreement, the PASSE' will be required to follow the PASSE provider manual.

Section D: Cost-Effectiveness

Part I: State Completion Section

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. ☐ **Management fees are expected to be paid under this waiver.**

The management fees were calculated as follows.

1. ☐ **Year 1: $** _____ **per member per month fee.**
2. ☐ **Year 2: $** _____ **per member per month fee.**
3. ☐ **Year 3: $** _____ **per member per month fee.**
4. ☐ **Year 4: $** _____ **per member per month fee.**

b. ☐ **Enhanced fee for primary care services.**

Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ☐ **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. ☐ **Other reimbursement method/amount.**

$ _____

Please explain the State's rationale for determining this method or amount.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☑ Population in the base year data

1. ☑ Base year data is from the same population as to be included in the waiver.
2. ☐ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b. ☑ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

We are phasing in enrollment over the first year and an half of the waiver. Approximately, 1,298,495 member months will be served over the 5 year life of this Waiver approval. As eligible individuals receive the Independent Assessment, they will be attributed to and enrolled in a PASSE. We anticipate enrolling everyone during calendar year 2018 (or quarters 2-5 of the Waiver).

c. ☑ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

Base year members months were overestimated. Based upon the implementation of the independent assessment, the count of PASSE eligible enrollees has been updated.

d. ☐ [Required] Explain any other variance in eligible member months from BY to P2:

e. ☑ [Required] List the year(s) being used by the State as a base year:

2016

If multiple years are being used, please explain:

f. ☑ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
Federal Fiscal Year

g. ☐ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

Appendix D1 – Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

F. Appendix D2.S - Services in Actual Waiver Cost

For Conversion or Renewal Waivers:

a. ☐ **[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.**
Explain the differences here and how the adjustments were made on Appendix D5:

b. ☐ **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**
For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

The intent is to limit services for the cost effectiveness analysis to solely care coordination because care coordination is the only service being provided by the PASSE.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Care Coordination	☑	☐	☐	☐	☐	☐	☐
Inpatient	☐	☐	☐	☐	☐	☐	☐
Inpatient-Psych	☐	☐	☐	☐	☐	☐	☐
Day Treatment	☐	☐	☐	☐	☐	☐	☐
Outpatient	☐	☐	☐	☐	☐	☐	☐
Professional	☐	☐	☐	☐	☐	☐	☐
PT/OT/Speech	☐	☐	☐	☐	☐	☐	☐
Family Planning	☐	☐	☐	☐	☐	☐	☐
HH/Personal Care	☐	☐	☐	☐	☐	☐	☐
ICF	☐	☐	☐	☐	☐	☐	☐
Dental/Vision/Hearing	☐	☐	☐	☐	☐	☐	☐
Pharmacy	☐	☐	☐	☐	☐	☐	☐
Other							

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
	☐	☐	☐	☐	☐	☐	☐
OBH Community Support and Psycho-social Rehab	☐	☐	☐	☐	☐	☐	☐
OBH Evaluation	☐	☐	☐	☐	☐	☐	☐
OBH Other	☐	☐	☐	☐	☐	☐	☐
OBH Therapy	☐	☐	☐	☐	☐	☐	☐
DDS Waiver Community Support	☐	☐	☐	☐	☐	☐	☐
DDS Waiver Case Management	☐	☐	☐	☐	☐	☐	☐
DDS Waiver-Other	☐	☐	☐	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*
The allocation method for either initial or renewal waivers is explained below:

- **a.** ☐ **The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees***Note: this is appropriate for MCO/PCCM programs.*
- **b.** ☑ **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.***Note: this is appropriate for statewide PIHP/PAHP programs.*
- **c.** ☑ **Other**
  Please explain:

  The state is only allocating direct administrative costs. This approach is only used for BY-Q5.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

- **a.** ☐ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.
- **b.** ☐ **The State is including voluntary populations in the waiver.**
  Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:
- **c.** ☑ **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require

MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. ☑ **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**
2. ☐ **The State provides stop/loss protection**

   Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

d. ☐ **Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:**

1. ☐ **[For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program.** The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

   Document

   i. **Document the criteria for awarding the incentive payments.**
   ii. **Document the method for calculating incentives/bonuses, and**
   iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.**

2. ☐ **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).**). For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

   Document:

   i. **Document the criteria for awarding the incentive payments.**
   ii. **Document the method for calculating incentives/bonuses, and**
   iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.**

Appendix D3 – Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. State Plan Services Trend Adjustment – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ☑ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present)

The actual trend rate used is:

0.00

Please document how that trend was calculated:

The Waiver BY is SFY 2016. However, the projection of all service costs begins in Q6 due to the start of full-risk managed care on January 1, 2019. As a result, the Q6-P4 estimates use SFY 2017 data as a starting point.

2. ☑ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (i.e., trending from present into the future)

i. ☐ State historical cost increases.

Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii. ☑ National or regional factors that are predictive of this waiver's future costs.

Please indicate the services and indicators used.

We used high level total cost trend cost trend rates based on national data included in the 2016 Actuarial Report on the Financial Outlook for Medicaid, published by CMS Office of the Actuary. We reviewed the annual trend rates beginning in FFY 2017 derived from Table 19 of this report. The annual trend rates range from 4.5% to 5.3% for the adult, child, and disabled populations. As such, we selected an annual trend rate of 5.0% for all populations to trend from SFY 2017 to Q6-P4.

Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
Based on the use of the Medicaid Actuarial Report for 2016, the projections shown in this cost effectiveness "should be regarded only as a reasonable indication of future Medicaid costs under current law and from today's perspective." Additionally, we "recognize that actual costs in the future could differ significantly from these projections, as a result of (i) unanticipated developments in demographic, economic, or health cost growth trends and (ii) any further changes in the legislation governing Medicaid."

3. ☐ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

Section D: Cost-Effectiveness

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I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- **Additional State Plan Services (+)**
- **Reductions in State Plan Services (-)**
- **Legislative or Court Mandated Changes to the Program Structure or fee**

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ☑ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i. ☐ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☐ Other:
Please describe

ii. ☐ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. ☐ Changes brought about by legal action:
Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Other
Please describe

iv. ☐ Changes in legislation.
Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA

PMPM size of adjustment

D. ☐ Other

Please describe

v. ☑ Other

Please describe:
Included in the Q6-P4 projections:
1) 10/1/16-Cap on group therapy services, reducing utilization.
2) 2/1/18-PASSE Phase I-DHS paid a care coordination PMPM of $173.97.
3) 2/1/19-PASSE Phase 2-PASSEs take full risk for enrolled members. Include: managed care savings, administrative cost allowance, replacing Care Coord. PMPM with allocated expenses, margin allowance, & premium tax allowance.

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.

Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.

PMPM size of adjustment

D. ☑ Other

Please describe
Adjustments are based on actual historical data and expected future program changes.
-The group therapy cap is based on the state fiscal impact note and observed service utilization.
-The Care Coord. PMPM are based on actual fee development and currently paid rates.
-Phase 2 implementation adjustments are based on preliminary assumptions including the CY19
capitation rate development.

Section D: Cost-Effectiveness

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I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

c. Administrative Cost Adjustment*: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.

2. ☑ An administrative adjustment was made.

i. ☐ FFS administrative functions will change in the period between the beginning of P1 and the end of P2.
Please describe

A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP)
Please describe

C. ☐ Other
Please describe

ii. ☑ FFS cost increases were accounted for.

A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ☑ Other
Please describe
Administrative expenses are trended to Q6-P4 at the same annual trend rate as the state plan service costs, as well as an adjustment to account for the change in administrative allocation methodoly beginning in Q6.

iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate.

Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from Section D.I.I.a. above

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

Section D: Cost-Effectiveness

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I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in ***Section D.I.H.a*** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ☐ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
The actual documented trend is:

Please provide documentation.

2. ☐ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from Section D.I.I.a. above

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked **Section D.I.H.d ,** then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a

2. List the Incentive trend rate by MEG if different from Section D.I.I.a

3. Explain any differences:

f. Graduate Medical Education (GME) Adjustment: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1. ☑ We assure CMS that GME payments are included from base year data.

2. ☐ We assure CMS that GME payments are included from the base year data using an adjustment.
Please describe adjustment.

3. ☐ Other
Please describe

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5.**

1. ☐ GME adjustment was made.

i. ☐ GME rates or payment method changed in the period between the end of the BY and the beginning of P1.
Please describe

ii. ☐ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2.
Please describe

2. ☑ No adjustment was necessary and no change is anticipated.

Method:

1. ☐ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2. ☐ Determine GME adjustment based on a pending SPA.
3. ☐ Determine GME adjustment based on currently approved GME SPA.
4. ☐ Other
Please describe

Section D: Cost-Effectiveness

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I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

g. ***Payments / Recoupments not Processed through MMIS Adjustment:*** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in ***Appendix D5.***

1. ☑ Payments outside of the MMIS were made.
Those payments include (please describe):
Hospital supplemental and settlement payments.

2. ☐ Recoupments outside of the MMIS were made.
Those recoupments include (please describe):

3. ☐ The State had no recoupments/payments outside of the MMIS.

h. ***Copayments Adjustment:*** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1. ☑ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. ☐ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. ☐ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. ☐ Other

   Please describe

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1. ☑ No adjustment was necessary and no change is anticipated.
2. ☐ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

***Method*:**

1. ☐ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. ☐ Determine copayment adjustment based on pending SPA.
3. ☐ Determine copayment adjustment based on currently approved copayment SPA.
4. ☐ Other

   Please describe

Section D: Cost-Effectiveness

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I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1. ☐ No adjustment was necessary
2. ☑ Base Year costs were cut with post-pay recoveries already deducted from the database.
3. ☐ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4. ☐ The State made this adjustment:*
   - i. ☐ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in Appendix D5.
   - ii. ☐ Other

     Please describe

j. Pharmacy Rebate Factor Adjustment: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

***Basis and Method*:**

1. ☑ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population which includes accounting for Part D dual eligibles. Please account for this adjustment in Appendix D5.
   Please describe
   Used SFY17 prescription drug expenses and rebate data to develop a pharmacy rebate percentage of 54.9%, which was applied to the prescription drug portion of the expenses included in the Q4-P4 projections.
2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS or Part D for the dual eligibles.
3. ☐ Ohter
   Please describe

k. Disproportionate Share Hospital (DSH) Adjustment: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1. ☑ We assure CMS that DSH payments are excluded from base year data.
2. ☐ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3. ☐ Other
   Please describe

l. Population Biased Selection Adjustment (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. ☑ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2. ☐ This adjustment was made:
   - **i.** ☐ Potential Selection bias was measured.
     Please describe
   - **ii.** ☐ The base year costs were adjusted.
     Please describe

m. FQHC and RHC Cost-Settlement Adjustment: Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1. ☑ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs.
   Payments for services provided at FQHCs/RHCs are reflected in the following manner:
   FQHC and RHC costs are not part of the BY services. They are included in the Q6-P4 projections as projections of the encounter rates reported in MMIS and paid at the time of service without any adjustments.
2. ☐ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3. ☐ We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.
4. ☐ Other
   Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

Special Note Section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a. ☑ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b. ☐ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only:

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain capitated-only adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program	

Section D: Cost-Effectiveness

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I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

n. ***Incomplete Data Adjustment (DOS within DOP only)*** – The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods.

Documentation of assumptions and estimates is required for this adjustment.:

1. ☐ Using the special DOS spreadsheets, the State is estimating DOS within DOP.

Incomplete data adjustments are reflected in the following manner on Appendix D5 for services to be complete and on Appendix D7 to create a 12-month DOS within DOP projection:

2. ☐ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3. ☐ Other

Please describe

o. ***PCCM Case Management Fees (Initial PCCM waivers only)*** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on ***Appendix D5.***

1. ☐ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2. ☐ Other

Please describe

p. ***Other adjustments:*** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1. ☐ No adjustment was made.

2. ☐ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5.

Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

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J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

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K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

Appendix D5 – Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

Appendix D6 – RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

   Please see the discussion of enrollment changes found in Section D.I.E.c.
2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in Section D.I.I and D.I.J:

   Please see the discussion of trends in Section D.I.I. and D.I.J.
3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in Section D.I.I and D.I.J:

   Please see the discussion of trends in Section D.I.I. and D.I.J.

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

Appendix D7 - Summary

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. **Program Title:**
Community and Employment Support Waiver

C. **Waiver Number:AR.0188**
Original Base Waiver Number: AR.0188.

D. **Amendment Number:**

E. **Proposed Effective Date:** *(mm/dd/yy)*
01/01/19
Approved Effective Date of Waiver being Amended: 09/01/16

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
To implement the full-risk model of the Provider-led Shared Savings Entity (PASSE) program and to revise the methodology used to devise rates for CES Waiver Services.

Specifically this amendment:

-Changes the provision of care coordination so that it is provided administratively by the PASSE.
-Updates the methodology used to devise rates of all services provided through the 1915(c) Community and Employment Supports (CES) Waiver based on a rate-study conducted by an actuarial firm.

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ **Waiver Application**	2; A.1; A.2
☑ **Appendix A – Waiver Administration and Operation**	3; 5; 6; 7; QI
☑ **Appendix B – Participant Access and Eligibility**	6; 7

Component of the Approved Waiver	Subsection(s)
☑ Appendix C – Participant Services	1/3, 2, QI, 5
☑ Appendix D – Participant Centered Service Planning and Delivery	1; 2; QI
☐ Appendix E – Participant Direction of Services	
☑ Appendix F – Participant Rights	1; 3
☑ Appendix G – Participant Safeguards	1; 2; 3; QI
☑ Appendix H	
☑ Appendix I – Financial Accountability	1; QI; 2; 3; 5
☐ Appendix J – Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
This amendment makes care coordination an administrative function of a PASSE and changes the rate methodology used for waiver services based on an actuarial rate-study conducted in 2018.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

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

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

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: AR.0188
Draft ID: AR.006.05.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 09/01/16
Approved Effective Date of Waiver being Amended: 09/01/16

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- ☐ **Hospital**

Select applicable level of care

- ○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ��440.40 and 42 CFR ��440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:
Not applicable.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☑ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:
The Provider-Led Arkansas Shared Savings Entity (PASSE), a 1915(b)(1)/(b)(4) Waiver application, which will be submitted simultaneously with this Waiver Amendment.

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☑ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☑ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The purpose of the Community and Employment Support (CES) 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 CES Waiver are to support beneficiaries in all major life activities, promote community inclusion through integrated employment options and community experiences, and
provide comprehensive care coordination and service delivery under the 1915(b) PASSE Waiver Program.

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

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

All CES Waiver beneficiaries are assigned to a Provider-led Arkansas Shared Savings Entity (PASSE), which is a full-risk organized care organization responsible for providing all services to its enrolled members, except for non-emergency transportation in a capitated program, dental benefits in a capitated program, school-based services provided by school employees, skilled nursing facility services, assisted living facility services, human development center services, or waiver services provided through the ARChoices in Homecare program or the Arkansas Independent Choices program. The PASSE also provides care coordination services administratively through the § 1915(b) Waiver.

All services must be delivered based on an individual person-centered service plan (PCSP), which is based on an Independent Assessment by a third party vendor, the health questionnaire given by the PASSE care coordinator, and other psychological and functional assessments. The PCSP must have measurable goals and specific objectives, measure progress through data collection, be created by the member's PASSE care coordinator, in conjunction with the member, his or her caregivers, services providers, and other professionals.

3. Components of the Waiver Request

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

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

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

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

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

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

○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

◉ **No**
○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the

service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

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

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
Due to space limitations in this section, actual comments and responses have been added to this document and can be located in the section titled "Optional."

Websites for the Arkansas Waiver Association, the Developmental Disabilities Provider Association and Arkansas Medicaid contain
information about the Waiver amendments. The information was posted to the Arkansas Medicaid Website from _____. Other websites would have posted the information soon thereafter. DDS staff participated at provider conferences and took comments by phone and email from providers and people receiving or applying for services.

DDS conducted a formal public comment period, with a public hearing held on _____. Written comments were received and considered by DDS, and oral comments were made at the public hearing. Public comments are located in the section title Optional, along with DDS's responses.

Prior to the formal public comment period, meetings were organized and held for participants and their families to ask

any
questions and make any comments. The following meetings were held where the DDS director or her designated Assistant Director spoke regarding these amendments:

October 2017:
9-13: AFMC PASSE Webinars, statewide
10: Independent Assessment Informational Session, Little Rock
11: DDS Provider Information Session, Fort Smith
17: Parent Meeting, Searcy
18: Stakeholder Information Session, Hope
25: School-Based Mental Health Task Force
26: Stakeholder Information Session, Paragould
30: Stakeholder Information Session, Monticello

November 2017:
17: DDPA Conference, Little Rock

December 2017:
6: Medicaid Educational Conference

January 2018:
8: Independent Assessment Training Session
19: Facebook Live presentation, statewide

February 2018:
16: Independent Assessment Information Session, Little Rock
28: Arkansas Department of Education, Little Rock

March 2018:
27: Independent Living, Inc. Conference, Harrison

April 2018:
20: Family Bistro for Title V Families and DD Stakeholders
25: ACAAA Annual Conference, Little Rock

May 2018:
17: DDPA Conference
25: Natural Wonders Committee presentation, Little Rock

June 2018:
29: Youth Move Arkansas Conference, Jonesboro

After review and approval from CMS and 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 Arkansas Medicaid website.

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

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

7. Contact Person(s)

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

Last Name: Mills

First Name: Dave

Title: Director, Office of Policy Development

Agency: Office of Legislative and Intergovernmental Affairs, Arkansas Department of Human Servic

Address: P O Box 1437, Slot S295

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 320-6303 **Ext:** ☐ **TTY**

Fax: (501) 404-4619

E-mail: dave.mills@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 CES Waiver Services

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

Address: P O Box 1437, Slot N502

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 683-0575 **Ext:** ☐ **TTY**

Fax: (501) 682-8380

E-mail: regina.davenport@dhs.arkansas.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Stehle

First Name: Dawn

Title: Deputy Director for Health and Medicaid Director

Agency: Arkansas Department of Human Services

Address: P.O. Box 1437

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203

Phone: (501) 682-8650 **Ext:** ☐ **TTY**

Fax:

(501) 682-6836

E-mail: dawn.stehle@dhs.arkansas.gov

Attachments

Attachment #1: Transition Plan

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

- [ ] **Replacing an approved waiver with this waiver.**
- [ ] **Combining waivers.**
- [ ] **Splitting one waiver into two waivers.**
- [x] **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:

While care coordination will no longer be offered as a CES Waiver service, it will be provided administratively to all CES Waiver participants through the PASSE 1915(b) Waiver. All current CES Waiver participants are currently being enrolled in a PASSE through an attribution algorithm and will begin receiving care coordination through the PASSE program prior to January 1, 2019. Clients currently on the CES Waiver Waitlist are also being enrolled in a PASSE and will begin receiving care coordination, so as those clients are placed in a CES Waiver slot, the care coordinator will continue working with them to create a PCSP under the CES Waiver.

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

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

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

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

This Waiver, along with the concurrent 1915(b) PASSE Waiver and 1915(i) State Plan Amendment for Services for Community Independence, will be subject to the HCBS Settings requirements and therefore must be included in the State Wide Transition Plan.

The Division of Medical Services (DMS) is the State Medicaid Agency (SMA) and the Division of Developmental Disabilities Services (DDS) is the operating agency responsibly for operating the CES Waiver impacted by the HCBS Settings Rule. The purpose of this waiver is to support individuals of all ages who have a developmental disability and meet institutional level of care, and who choose to receive services within their community. The person-centered service plan (PCSP) offers an array of services that allow flexibility and choice for the Waiver participant. Services are provided in the participant's home and community with coordination and oversight from the their PASSE.

Individuals served by the CES Waiver choose to reside in the community and receive HCBS services in their home. The home

may be the person's home, the home of a family member or friend, a group home, a provider owned or controlled apartment, or the home of a staff person who is employed by the HCBS provider. It is assumed that people who live in their own home or the home of a family member or friend who is not paid staff receive services in a setting that complies with requirements found at 42 CFR 441.301(c)(4).

The Provider-Led Arkansas Shared Savings Entity (PASSE) to which the member is enrolled provides care coordination and develops the PCSP. The PASSE's care coordinator assesses the person's needs and wants and facilitates the development of the person-centered plan, including the selection of services providers in the PASSE's network. DMS, DDS and their agents will monitor the development of the PCSP and the provision of services by the PASSE. Information on the HCBS Settings rule will be included in annual training opportunities for PASSE care coordinators and monitoring staff.

The PASSE is responsible for credentialing their HCBS providers; as such they must ensure that homes where those provides serve members comply with the HCBS settings rule. As the SMA, DMS has set up an inter-divisional work group who has met since 2014, and will continue to meet. The work group has reviewed the regulations.

Assessment of Compliance with Residential and Non-Residential Settings Requirements

The inter-divisional work group consists of representatives from DAAS, DDS, and DMS within the Arkansas Department of Human Services. The work group initially met to review the new regulations and develop the initial STP and corresponding timeline. DMS will convene this work group to set applicable standards for PASSE HCBS settings. It will be expected that PASSE organizations implement these standards, and the federal HCBS Settings Rule into their provider agreements and credentialing standards.

Agents of DMS will be assigned to review teams. The review teams will conduct reviews of randomly selected provider owned or controlled apartments and group homes.

Upon completion of the review, notes from the review team member will be summarized in a standard report and sent to the Provider and the PASSE. The report will summarize the visit, noted areas needing improvement that were observed and documented, requested clarification of provider policies and procedures and/or a corrective action plan. A deadline will be given to the provider and the PASSE to provide this information and technical assistance for DMS and the Settings working group will be provided.

Ongoing Training

DMS and the HCBS Settings working group will develop and conduct PASSE and provider trainings, as well as provided tailored technical assistance to partially compliant and non-compliant providers.

Heightened Scrutiny

DMS recognizes that certain settings are presumed non-compliant with the HCBS Settings requirements. Specifically, some home and community based settings have institutional qualities – those settings that are publicly or privately owned facilities that provide inpatient treatment, those settings that are located on the grounds of, or immediately adjacent to, a public institution, or those settings that have the effect of isolating individuals from the broader community. These settings include those that are located on or near the grounds of an institution and settings which may isolate individuals from the community. These settings include group homes located on the grounds of or adjacent to a public institution, numerous group homes co-located on a single site, a disability-specific farm-like service setting and apartments located in apartment complexes also occupied by persons who do not receive HCBS services. DMS will identify these settings and require the PASSE implement heightened scrutiny for those settings presumed not to be home and community based.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

○ **The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:
Division of Developmental Disabilities Services

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The Division of Medical Services (DMS), within the Department of Human Services (DHS), is the State Medicaid agency (SMA) and has administrative authority for the CES Waiver including the following:
1) Develop and Monitor the Interagency Agreement to ensure that provisions specified are executed;
2) Oversee the CES 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 CES Waiver and monitoring their implementation;
4) Promulgate any applicable Medicaid Manuals that govern participation in the CES Waiver program, in accordance with the Arkansas Administrative Procedures Act;

5) Insure that a specified number of PCSPs are reviewed by DMS or their designated representative;
6) Provide to DDS relevant information pertaining to the Medicaid program and any federal requirements governing applicable waiver programs;
7) Monitor compliance with the interagency agreement; and
8) Complete and Submit the CMS 372 Annual Report.

The Division of Developmental Disabilities Services (DDS), also within DHS, is responsible for operation of the CES 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 PASSE care coordinators and HCBS providers regarding provision of Waiver services and development of the PCSP;
4) Establish and monitor the person center service plan (PCSP) requirements that govern the provision of services;
5) Coordinate the collection of data and issuance of reports through MMIS with DMS as needed to complete the CMS 372 Annual Report;
6) Provide to DMS the results of all monitoring activities conducted by DDS; and
7) 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; and
2) Providing technical assistance to PASSE care coordinators and HCBS providers, as well as consumers on CES Waiver requirements, policies, procedures and processes.

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 orso as to maintain an efficient administration of the Waiver.

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

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   DMS and DDS contract with a Third Party Vendor to conduct Independent Assessments that will be used to determine the beneficiaries' service tier for the purpose of attribution to a PASSE and will generate a risk and needs report that can be used to create his or her PCSP.

   PASSEs provide care coordination to all enrolled members, arrange for the provision of all medically necessary services to enrolled members, certify HCBS providers, and set reimbursement rates for services provided to its enrolled members.

   ○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
DDS is the division in charge of operational management of the Waiver and is responsible for oversight the Independent Assessment Vendor and development of the PCSP by the PASSE care coordinators. DMS, as the State Medicaid Agency, retains authority over the CES Waiver in accordance with 42 CFR §431.10(e). DMS's Contracting Official will oversee the contract between DHS and the Third Party Independent Assessor. The Contract will have performance measures that the Vendor will be required to meet.

DMS's Office of Innovation and Delivery System Reform (IDSR), with the assistance of DDS, will have responsibility for monitoring the performance of the PASSE entities and the provision of Care Coordination, as well as the provision of all other services authorized under 1915(b) Waiver.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Third Party Independent Assessor must submit monthly contractor reports to DMS and DDS that include:
1. Demographics about the Beneficiaries 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 Independent Assessor 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.

The PASSEs must submit quarterly reports that includes data on the quality of services provided, utilization data, and encounter data. Additionally, an External Quality Review Organization will do an annual evaluation of each PASSE in

accordance with CMS regulations. These quarterly reports are described in the Concurrent 1915(b) waiver for the Provider-led Arkansas Shared Savings Entities, Section B-II-q.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	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	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
AA1: Number and percent of unduplicated participants served within approved limits specified in the approved HCBS Waiver. Numerator: Number of unduplicated participants served within approved limits specified in the HCBS Waiver. Denominator: Number of approved unduplicated participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

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

Data Aggregation and Analysis:

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

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

Performance Measure:
AA2: Number and percentage of applicants who had an initial LOC determination completed before receipt of services. Numerator: Number of applicants who had an initial LOC determination completed before receipt of services. Denominator: Number of LOC determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC Determination Report

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

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

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

Data Aggregation and Analysis:

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

Performance Measure:
AA3: Number and percentage of participants for whom the appropriate process and instruments were used to determine initial eligibility. Numerator: Number of participants' packets with appropriate process and instruments used to determine initial eligibility; Denominator: Number of participants' packets reviewed.

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

DDS Quarterly QA Report

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

Data Aggregation and Analysis:

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

Performance Measure:
AA4: Number and percentage of PCSPs completed in the time frame specified in the agreement with the PASSE entities. Numerator: Number of PCSPs completed in the time frame specified; Denominator: Number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE quarterly reports

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: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 20% of the charts are reviewed.
	☐ **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:

AA5: Number and percentage of participants with delivery of at least one care coordination contact per month as specified in the PCSP. Numerator: Number of participants with delivery of at least one care coordination contact per month; Denominator: Number of participants served by the CES Waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE encounter data

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: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
AA6: Number and percentage of providers certified and credentialed by the PASSE. Numerator: Number of provider agencies that obtained annual certification in accordance with PASSE's standards. Denominator: Number of HCBS provider agencies reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report (Validation Reviews of Provider Certification Files)

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE credentialing and certification 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: PASSE	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
AA7: Number and percentage of policies developed by DDS that are reviewed and approved by the Medicaid Agency prior to implementation . Numerator: Number of policies and procedures by DDS reviewed by Medicaid before implementation; Denominator: Number of policies and procedures developed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PD/QA Request Forms

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Interagency Agreement for measures related to administrative authority of the CES Waiver.

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

In cases where there are problems with level of care determinations completed by a qualified evaluator, where instruments and processes were not followed as described in the waiver, or were not completed within specified time frames, additional staff training, staff counseling or disciplinary action may be part of remediation.

Similarly, remediation for PCSPs not completed in specified time frames includes completing the PCSP upon discovery, additional training for PASSE care coordinators, and possible corrective or remedial action taken against the PASSE.

Remediation to address beneficiaries not receiving at least one care coordination contact a month in accordance with the PCSP includes closing a case, conducting monitoring visits, revising a PCSP to add a service, providing training to the PASSE care coordinators, and possible corrective or remedial action against the PASSE.

Remediation associated with provider credential and certification that is not current would include additional training for the PASSE, as well as remedial or corrective action, including possible recoupment of PMPM payments.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Both persons with intellectual disability and persons with developmental disability are recognized as target groups. Developmental disability diagnoses include Cerebral Palsy, Epilepsy, Autism, Down Syndrome, and Spina Bifida as categorically qualified diagnoses. Onset must occur before the person is 22 years old and must be expected to continue indefinitely. Other diagnoses will be considered if the condition causes the person to function as though they have an intellectual disability.

DDS eligibility is established by Arkansas Code Annotated, Section 20-48-101. The statute applies to Intermediate Care Facilities for Intellectual or Developmental Disability (ICF/IDD) and the CES Waiver. DDS interprets a developmental disability to be (1) a categorically qualifying diagnosis and three (3) significant adaptive behavior deficits related to this diagnosis. Following are the categorically qualifying diagnoses:

Cerebral Palsy as established by the results of a medical examination provided by a licensed physician. Epilepsy as established by the results of a neurological examination provided by a licensed physician.

Autism as established as a result of a team evaluation by at a minimum a licensed physician, a psychologist or psychological examiner, and speech pathologist.

Down syndrome as established by the results of a medical examination provided by a licensed physician.

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

Intellectual Disability as established by significant intellectual limitations that exist concurrently with deficits in adaptive behavior that are manifested before the age of 22. "Significant intellectual limitations" are defined as a full

scale intelligence score of approximately 70 or below as measured by a standard test designed for individual administration. Group methods of testing are unacceptable.

The qualifying disability must constitute a substantial handicap to the person's ability to function without appropriate support services including, but not limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment. When the age of onset of the qualifying disability is indeterminate, the Assistant Director or the Director for Developmental Disabilities Services will review evidence and determine if the disability was present before age 22.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

- **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

  - **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- **The participant is referred to another waiver that can accommodate the individual's needs.**
- **Additional services in excess of the individual cost limit may be authorized.**

  Specify the procedures for authorizing additional services, including the amount that may be authorized:

- **Other safeguard(s)**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4303
Year 2	4803
Year 3	4863
Year 4	4883
Year 5	4903

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	4183
Year 2	4723
Year 3	4743
Year 4	4763
Year 5	4783

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ○ **Not applicable. The state does not reserve capacity.**

◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Community Transition of children in foster care	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Community Transition of children in foster care

Purpose *(describe):*

Two hundred waiver openings (slots) are reserved for persons in foster care in the care or custody of the Department of Human Services, Division of Children and Family Services, including children adopted since July 1, 2010.

Describe how the amount of reserved capacity was determined:

The reserved capacity was determined based on the need for children to live in a caring community setting; capacities determined by existing children waiting for waiver services, factored by transition to regular capacity at time of reaching adulthood and upon existence of regular capacity vacancy.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	200
Year 2	200
Year 3	200
Year 4	200
Year 5	200

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

1) General Requirements: DDS policy requirements for information release, choice of community versus institution (102 choice form),and social history documents are executed.

2) Selection for participation is as follows:

a) In order of waiver application eligibility determination date for persons determined to have successfully applied for the waiver, but who through administrative error were or are inadvertently omitted from the Waiver wait list.

b) In order of waiver application eligibility determination date of persons for whom waiver services are necessary to permit discharge from an institution, e.g. persons who reside in ICFs/IID, Nursing Facilities, and Arkansas State Hospital patients; or admission to or residing in a Supported Living Arrangement (group homes and apartments).

c) In order of date of Department of Human Services (DHS) custodian choice of waiver services for eligible persons in the custody of the DHS Division of Children and Family Services or DHS Adult Protective Services.

d) In order of waiver application determination date for all other persons.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (•) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- (•) **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Adults newly eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

Children who are receiving Title IV-E subsidy services or funding.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ **The following standard included under the State plan**

  Select one:

  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ○ **A percentage of the Federal poverty level**

    Specify percentage:
  - ○ **Other standard included under the State Plan**

    Specify:
- ○ **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:**

  Specify:
- ◉ **Other**

  Specify:

  The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process including income that is placed in a Miller Trust.

ii. Allowance for the spouse only (*select one*):

- ◉ **Not Applicable (see instructions)**
- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

  Specify:
- ( ) **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- ( ) **The State establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ **The following standard included under the State plan**

  Select one:

  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ○ **A percentage of the Federal poverty level**

    Specify percentage:
  - ○ **Other standard included under the State Plan**

    Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

◉ **Other**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process including income that is placed in a Miller Trust.

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○ **The State does not establish reasonable limits.**
○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):
○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

○ **The following formula is used to determine the needs allowance:**

Specify formula:

◉ **Other**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process including income that is placed in a Miller Trust.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**
○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○ **The State does not establish reasonable limits.**
○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires

regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

The PASSE care coordinator must monitor the member monthly, at a minimum.

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 CES 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, 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 beneficiary's Care Coordinator 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.

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 beneficiary. 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 a beneficiary disagrees with an eligibility determination, they may appeal to the Assistant Director for CES Waiver for an administrative review of the findings. Beneficiaries 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 the Care Coordinator at the PASSE organization prepares and signs documentation annually to request from DDS annual level of care redetermination. The care coordinator must meet the qualifications set out in the 1915(b) Waiver.

DDS staff who review this annual documentation will meet QDDP qualifications or have their reviews signed by a staff person who meets QDDP qualifications.

DDS staff who perform periodic redeterminations of eligibility (not level of care) will meet the qualifications of a Psychological Examiner.

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

The PASSE is responsible for generating a monthly report of 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.

The PASSE care coordinator must gather all necessary documents and submit them to DDS for the annual level of care review. CES Waiver staff then make the level of care redetermination.

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:

At DDS, all records are maintained in an electronic environment with protected security and access. This system includes level of care records. All electronic records are housed by the Department of Information Systems in the state designated storage medium. The responsibility for day to day operations remains with DDS.

The PASSE's will also be responsible for maintaining all level of care documentation for assigned beneficiaries in a secure manner that is compliant with HIPAA.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

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

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

Performance Measure:
LOC A1: Number and percentage of applicants for whom an application packet is completed and submitted timely to the DDS psychology team for an LOC initial determination. Numerator: Number of applicants for whom an application packet is completed and submitted timely to the DDS psychology team for an LOC initial determination; Denominator: Number of application packets submitted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Intake and Referral Report of Timely Application Submissions

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

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

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

Data Aggregation and Analysis:

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

Performance Measure:
LOC A2: Number and percentage of applicants who had an initial LOC determination completed before receipt of services. Numerator: Number of applicants who had an initial LOC determination completed before receipt of services; Denominator: Number of initial LOC determinations reviewed.

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

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

		95% with a +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

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

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

Performance Measure:
LOC C1: Number and percentage of participants for whom the appropriate process and instruments were used to determine initial eligibility. Numerator: Number of participants' packets with appropriate process and instruments used to determine initial eligibility; Denominator: Number of participant's packets reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
(LOC A1) The Intake and Referral (I&R) Application Tracking system tracks all applications on an ongoing basis. At 45 days, the Intake Specialist sends a notice to families to notify them that the information is due. For applications over 90 days old, the Intake Manager reviews overdue applications for cause and then contacts Intake staff to develop a corrective action plan, which will be implemented within 10 days. The Intake Manager will submit an I&R Report of Timely Application submissions to the I&R administrator monthly for review to identify any systemic issues and to determine if there is a need for corrective action. The I&R administrator will submit a quarterly report to the QA Assistant Director and describes any corrective actions.

(LOC A2) The system in place for new applicants to enter the CES waiver program does not allow for services to be delivered prior to an initial determination of Level of Care.

(LOC C1) The DDS Psychology Team manager reviews 100% of all initial waiver application determinations submitted within the previous month for process and instrumentation review. A Requirement checklist form for each application in the sample is completed for procedural accuracy and appropriateness of testing instruments utilized in adjudications. Results are tracked. The Psychology Supervisor contacts Psychology staff to develop corrective action plan, which will be implemented within 10 days. The Psychology supervisor submits a quarterly report to the CES Waiver Assistant Director and outlines corrective actions.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Waiver intake and referral is the responsibility of DDS intake and referral staff. The DDS staff person explains the service options of the Waiver or ICF/IID to each beneficiary or their legal guardian by phone, personal visit, email, or mail. The beneficiary or legal guardian completes the HCBS Services Choice Form and selects either the Community and Employment Supports (CES) Waiver program or ICF/IID placement. For persons residing in an ICF/IID, choice between the programs is offered annually at the time of their annual PCSP review. Anyone residing in an ICF/IID can request Waiver services at any time by contacting DDS directly, or by contacting their PASSE care coordinator. Transition Coordinators work with the PASSE care coordinators and DDS Waiver staff. Annual choice is offered by DDS staff prior to the individual's annual review. The choice form provides a means to track whether choice was offered. It also provides supporting evidence that the options elicit an informed choice as attested to by the signature of the DDS representative.

Beneficiaries may change individual service providers within their PASSE network, at anytime, by contacting their PASSE care coordinator. Individuals do have a choice of their PASSE. All beneficiaries are auto-assigned to a PASSE and given 90 days to change that PASSE for any reason. Every year, the beneficiary will have an open enrollment period, where they can change their PASSE for any reason. And, at any time, a beneficiary may change their PASSE for cause (as described in 42 CFR 438.56(d)(2)).

The PASSE must have transition supports in place to assist individuals in transitioning between an ICF/IID and HCBS services.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Individual Community and Employment Support Waiver application packets including the choice form are maintained in an electronic format during the application process. Each applicant's electronic case file is maintained by the assigned DDS Specialist who is located in a designated DHS county offices. Documentation of the beneifciary's annual choice following initial entrance into the Waiver program is maintained in the electronic case files. The files must also be maintained by the beneficiary's assigned PASSE.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
DDS provides information in an alternate format once the need for accommodation is identified. Identification of need is made through observation, document review for diagnosis and other case related information, and self or third-party notification. Awareness is provided through training, employee technical assistance, communications with provider organizations and consumer advocates, and Department of Human Services (DHS) electronic medias. A HCBS Waiver handbook is available in Spanish, hardcopy and online. In addition, the handbook will be made available in any other language, large print or any other medium to reasonably accommodate needs as identified by the individual. DHS contracts for interpreter services when needed.

DDS also operates a TDD line to assist those individuals with hearing or speech difficulties.

The PASSEs are also required to offer all material in English and Spanish and provide translations or other assistance as requested or needed.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

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 Definition *(Scope):*

Respite services are provided on a short term basis to members unable to care for themselves due to the absence of or need for relief to the non-paid primary caregiver. Respite services do not include room and board charges.

Receipt of respite does not necessarily preclude a member from receiving other services on the same day. For example, a member 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 should 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.

Respite may be provided in the following locations:

1) Member'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 member's PASSE, 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:
N/A

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Cannot be on the National or State Excluded Provider List.
Individuals who perform respite services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry checks, and
1) Have a high school diploma,
2) Have at least one year of experience working with persons with developmental disabilities or behavioral health diagnoses;
3) Be certified to perform CPR and first aid; and
4) Have training in use of behavioral support plans and de-escalation techniques.

Verification of Provider Qualifications

Entity Responsible for Verification:
PASSE

Frequency of Verification:
Annually. Proof of credentialing must be submitted to DMS.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	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 Definition *(Scope):*
Supported Employment is a tailored array of services that offers ongoing support to members 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 member's interests, strengths, skills, the types of supports that are most effective, and the types of environments and activities where the member 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 member'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 member'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 member'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 ideal documentation of this service is the Individual Career Profile-Discovery Staging Record.

2) Employment Path-Members receiving Employment Path services must have goals related to employment in integrated community settings in their Person Centered Support Plan (PCSP). 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 ideal documentation for this service is the PCSP, progress notes, and a 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. The 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 member; jobs that will be developed and/or a 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 ideal documentation for this service is the Job Development Plan and participant's remuneration statement.

Employment Supports Job Coaching services are on-site activities that may be provided to a member 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 member in learning to do the job by the least intrusive method; develop compensatory strategies if needed to cue member 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 member chooses self-employment. Activities such as assisting the member 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.
Ideally, the provider will develop a fading plan for this service to be achieved within 12 months to 24 months.

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 member's personal and career planning goals. This service allows for the continued monitoring of the employment outcome through maintenance of regular contact with the member and employer. Activities allowed under this service may include, but are not limited to, a minimum of one contact per quarter with the employer.

Transportation between the member's place of residence and the employment site is included as a component of

supported employment services when there is no other resource for transportation available.

The service provider must maintain the following documents to demonstrate compliance and delivery of this service-any job development plan or transition plan for job supports, remuneration statement (paycheck stub) and member's work schedule.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Must be documented in the PCSP.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency

Provider Type:
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Cannot be on the National or State Excluded Provider List.
Individuals who perform supported employment services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry checks.

Verification of Provider Qualifications

Entity Responsible for Verification:
PASSE

Frequency of Verification:
Annually. Proof of credentialing must be submitted to DMS.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Supportive Living

HCBS Taxonomy:

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

Service Definition *(Scope):*

Supportive living is an array of individually tailored services and activities to enable members to reside successfully in their own home, with family or in an alternative living setting (apartment, or provider owned group home). Supportive living services must be provided in an integrated community setting.

Supportive living includes care, supervision, and activities that directly relate to active treatment goals and objectives set forth in the member's PCSP. It excludes room and board expenses, including general maintenance, upkeep, or improvement to the home.

Supportive living supervision and activities are meant to assist the member 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 habilitation objective to be served by each activity should be documented in the member's PCSP. Examples of supervision and activities that may be provided as part of supportive living include:

1) Decision making, including the identification of and response to dangerously threatening situations, making decisions and choices affecting the member's life, and initiating changes in living arrangements or life activities;
2) Money management, including training, assistance or both in handling personal finances, making purchase and meeting personal financial obligations;
3) Daily living skills, including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medication (to the extent permitted by state law), proper use of adaptive and assistive devices and household appliances, training on home safety, first aid, and emergency procedures;
4) Socialization, including training and assistance in participating in general community activities and establishing relationships with peers. Activity training includes assisting the member to continue to participate in an ongoing basis;
5) Community integration experiences, including activities intended to instruct the member in daily living and

community living in integrated settings, such as shopping, church attendance, sports, and participation sports.
6) Mobility, including training and assistance aimed at enhancing movement within the member's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel or movement within the community;
7) Communication, including training in vocabulary building, use of augmentative communication devices, and receptive and expressive language;
8) Behavior shaping and management, including training and assistance in appropriate expression of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors;
9) Reinforcement of therapeutic services, including conducting exercises reinforcing physical, occupational, speech, behavioral or other therapeutic programs;
10) Companion activities and therapies, or the use of animals as modalities to motivate members to meet functional goals established for the member's habilitative training, including language skills, increased range of motion, socialization, and the development of self-respect, self-esteem, responsibility, confidence, an assertiveness; and
11) Health maintenance activities, which include tasks that members would otherwise do for themselves or have a family member do, with the exception of injections and IV medication administration.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
All units must be documented in the member's PCSP.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supportive Living

Provider Category:
Agency

Provider Type:
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The Provider must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.

(3) Not be on the National or State Excluded Provider List.

Individuals who perform supportive living services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry checks, and
1) Have a high school diploma,
2) Have at least one year of experience working with persons with developmental disabilities or behavioral health diagnoses;
3) Be certified to perform CPR and first aid; and
4) Have training in use of behavioral support plans and de-escalation techniques.

Verification of Provider Qualifications

Entity Responsible for Verification:
PASSE

Frequency of Verification:
Annually, proof of verification must be submitted to DMS.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Specialized Medical Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11060 prescription drugs
Category 3:	**Sub-Category 3:**
17 Other Services	17990 other
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Specialized medical equipment and supplies include:

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

2) Such other durable and non-durable medical equipment not available under the State plan that is necessary to address the member's 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 member. All items shall meet applicable standards of manufacture, design and installation. The most cost effective item should 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.

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:
Must be documented in the member's PCSP.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Supplies

Provider Category:
Agency
Provider Type:
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.

Verification of Provider Qualifications
Entity Responsible for Verification:

PASSE
Frequency of Verification:
Annually. Proof of credentialing must be submitted to DMS.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Adaptive Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Adaptive equipment is a piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of members, whether commercially purchased, modified, or customized. The adaptive equipment services include adaptive, therapeutic, or augmentative equipment that enables a member to increase, maintain, or improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Consultation by a medical professional must be conducted to ensure the adaptive equipment will meet the needs of the member.

Adaptive equipment includes enabling technology, such as safe home modifications, that empower members 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 members, as needed. Enabling technology allows members to be proactive about their daily schedule and integrates member choice.

Adaptive equipment also includes Personal Emergency Response Systems (PERS), which is a stationary or portable electronic device used in the member's place of residence and that enables the member to secure help in an emergency. The system is connected to a response center staffed by trained professionals who respond to activation of the device. PERS services may include the assessment, purchase, installation, and monthly rental fee.

Computer equipment, including software, can be included as adaptive equipment. Specifically, computer

equipment includes equipment that allows the member increased control of their environment, to gain independence, or to protect their health and safety.

Vehicle modification are also included as adaptive equipment. Vehicle modifications are adaptions to an automobile or van to accommodate the special needs of the member. The purpose of vehicle modifications is to enable the member to integrate more fully into the community and to ensure the health, safety, and welfare of the member. Vehicle modifications exclude: adaptations or modifications to the vehicle that are of general utility and not of direct medical or habilitative benefit to the member; purchase, down payment, monthly car payment or lease payment; or regularly scheduled maintenance of the vehicle.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Must be documented in the member's PCSP.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Equipment

Provider Category:
Agency
Provider Type:
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.

Verification of Provider Qualifications
Entity Responsible for Verification:
PASSE
Frequency of Verification:
Annually. Proof of credentialing must be submitted to DMS.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Transition Services are non-recurring set-up expenses for members 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 member or his or her guardian is directly responsible for his or her own living expenses.

Community Transition service activities include those necessary to enable a member to establish a basic household, not including 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 member's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses.

Community Transition Services should not include payment for room and board; monthly rental or mortgage expense; regular food expenses, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

Must be documented in the member's PCSP.

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**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Agency

Provider Type:
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.
Individuals who perform community transition services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry checks, and
--have at least two years of college credit and at least two years' experience working with persons with developmental disabilities or have four years of experience as a case manager/care coordinator.

Verification of Provider Qualifications

Entity Responsible for Verification:
PASSE

Frequency of Verification:
Annually. Proof of credentialing must be provided to DMS.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consultation

HCBS Taxonomy:

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

Service Definition *(Scope):*

Consultation services are clinical and therapeutic services which assist the individual, parents, legally responsible persons, responsible individuals and service providers in carrying out the member'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 Disabled Professional (QDDP)

11) Positive Behavior Support (PBS) Specialist

12) Physical therapist

13) Rehabilitation counselor

14) Dietitian

15) Recreational Therapist

16) Applied Behavior Analyst (ABA)

These services are direct in nature. The PASSE will be responsible for maintaining the necessary information to document staff qualifications. Staff, who meets the certification criteria necessary for other consultation functions, may also provide these activities. These activities include, but are not limited to:

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 member's PCSP as applicable to the consultation specialty;

5) Providing information and assistance to the persons responsible for developing the member's 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 member'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 member's PCSP and 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 members, 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 member,

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

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

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

14) Rehabilitation Counseling for the purposes of supported employment supports.

15) Training and assisting members, 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:
Must be documented in the member's PCSP.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultation

Provider Category:
Individual

Provider Type:
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.
Individuals who perform consultation services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry checks, and hold a current Arkansas license or certification from the appropriate licensing or certification organization, if applicable (i.e., a physical therapist must be licensed by the Arkansas State Board of Physical Therapy).

Verification of Provider Qualifications

Entity Responsible for Verification:
PASSE

Frequency of Verification:
Annually. Proof of credentialing must be submitted to DMS.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Crisis Intervention

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	T1030 crisis intervention
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	T1040 behavior support
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Crisis Intervention is delivered in the member'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:
N/A

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:

Agency

Provider Type:

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.
Individuals who perform Crisis Intervention for the PASSE must be a Masters or Doctoral level clinician, an Advanced Practice Nurse, or a Physician.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Quality Assurance

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*
Modifications made to the member's place of residence that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence and without which, the member would require institutionalization. Examples of environmental modifications include the installation of wheelchair ramps, widening doorways, modification of bathroom facilities, installation of specialized electrical and plumbing systems to accommodate medical equipment, installation of sidewalks or pads, and fencing to ensure non-elopement, wandering or straying of members with decreased mental capacity or aberrant behaviors.

Exclusions include modifications or repairs to the home which are of general utility and not for a specific medical or habilitative benefit; modifications or improvements which are of an aesthetic value only; and modifications that add to the total square footage of the home.

Environmental modifications that are permanent fixtures to rental property require written authorization and release of current or future liability from the property owner.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Must be documented on the member's PCSP.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency
Provider Type:
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities

and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.
(4) Appropriately licensed and bonded in the state of Arkansas, as required, and possess all appropriate credentials, skills, and experience to perform the job (i.e., licensed plumbers, electricians, and HVAC techs)

Verification of Provider Qualifications

Entity Responsible for Verification:
PASSE

Frequency of Verification:
Annually. Proof of credentialing must be submitted to DMS.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Supplemental Support

HCBS Taxonomy:

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

Service Definition *(Scope):*
Supplemental Support services meet the needs of the member to improve or enable the continuance of community living. Supplemental Support Services will be based upon demonstrated needs as identified in a member's PCSP as unforeseen problems arise that, unless remedied, could cause a disruption in the member's services or placement, or place the member at risk of institutionalization.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplemental Support

Provider Category:
Agency

Provider Type:
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.
Individuals who perform Supplemental support services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry check, and
--have at least two years of college credit and at least two years' experience working with persons with developmental disabilities or have four years of experience as a case manager/care coordinator.

Verification of Provider Qualifications

Entity Responsible for Verification:
PASSE

Frequency of Verification:
Annually. Verification of credentialing must be submitted to DMS.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☑ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

PASSE care coordinators provide care coordination (the case management service) to all CES waiver recipients.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Arkansas Code Ann. §20-38-101 et seq., Standards for Conducting Criminal Record Checks for Employees of Developmental Disabilities Service Providers, requires Home and Community Based Services Providers for Persons with Developmental Disabilities and Behavioral Health Diagnoses (HCBS Providers) to conduct criminal background checks for all employees, as defined in statute and standards. In certain circumstances a PASSE may waive disqualification of an applicant or employee in accordance with section the statute.

Employee is defined as a person who:
1) is employed by a service provider to provide care to individuals with disabilities served by the service provider; or
2) provides care to individuals with disabilities served by a service provider on behalf of, under supervision of, or by arrangement with the service provider; or
3) submits an application to a service provider for the purposes of employment; or
4) is a temporary employee placed by an employment agency with a service provider to provide care to individuals with disabilities served by the service provider; or
5) submits an application to the PASSE for the purpose of being credentialed service provider; or
6) resides in an alternative living home in which services are provided to individuals with developmental disabilities; and
7) has or may have unsupervised access to individuals with disabilities served by a service provider.

Criminal record checks are required for all employees and shall include both a state and national record check. A "state only" criminal record check is allowed if the provider can verify the applicant has lived continuously in the State of Arkansas for the past five years.

The provider may extend an offer of conditional employment pending the outcome of the DDS determination of employment eligibility, unless the applicant has self-reported a disqualifying offense. If the provider receives a criminal record report on an employee from the Arkansas State Police that shows no criminal record, the provider may continue to employ the person. If the provider receives a criminal record report on an employee from the Arkansas State Police that shows a criminal record, the provider must remove the person from unsupervised access to persons served.

DDS checks the Arkansas State Police website for criminal records. If DDS finds a criminal record on a provider

employee, DDS makes a determination for employment eligibility based on the record and sends notice to the provider. If a FBI record check is required, the FBI report is sent to DDS Quality Assurance. DDS makes a determination of employment eligibility based on the record and sends notice to the provider.

The DDS determination of employment eligibility is based on comparison of the conviction noted in the Arkansas State Police or FBI criminal record report with those offenses identified in Arkansas Code Ann. §20- 38-101 et seq. as disqualifying offenses. A person who is defined as an employee in this statute is not eligible to work for a DDS provider if they have a disqualifying offense. The provider is required to terminate employment of a person who has been disqualified. DDS Quality Assurance staff reviews evidence of criminal record checks by providers and employment determinations by DDS during the annual review of all certified providers.

DDS staff also have access to persons served and are also required to undergo criminal background checks. If a disqualifying criminal conviction is found, the individual's employment with DDS is terminated.
In certain narrowly prescribed circumstances, a provider may waive DDS disqualification of an applicant or employee in accordance with Section 504 of the DDS Criminal Record Check Standards.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Arkansas maintains two statewide Central Registries of substantiated cases of abuse and neglect. The DHS Division of Children and Family Services (DCFS) maintains the registry for children and DHS Adult Protective Services (APS) maintains the adult abuse registry. All PASSE HCBS Providers must initiate a check of all employees on both registries. PASSEs or the Provider must also check any adult over the age of 18 residing in an alternative living home or group home, including employees' spouses. This check will provide documentation that the prospective employee's name and any adult family members' names do not appear on the statewide central registry.

Each PASSE is required to adopt policies that address 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 PASEE or employer/provider is notified that an individual's name is on either Registry, the PASSE or employer/provider must take corrective measures that comply with their internal policies and A.C.A. 20-38-101 et seq. The Office of Innovation and Delivery System Reform (IDSR), in conjunction with DDS staff, review evidence of central registry checks for each credentialed PASSE 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 PASSE review includes review of credentialing files for compliance.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

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

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The State has undertaken activities as described in the transition plan to ensure that all residential settings comply with the characteristics described in the Final Rule. The group homes are community based and located in residential areas. The homes provide access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, and provide for privacy and easy access to resources and activities in the community. Each group home contains bedrooms and bathrooms that allow privacy. Members are allowed free use of all space within the group home with due regard for privacy, personal possessions of other residents and staff and reasonable house rules. The living and dining areas are provided with furnishings that promote the functions of daily living and social activities. Members are provided access to community resources and supports and are encouraged to build community relationships. Members are granted access to visitors at times convenient to the individual. Members are allowed a choice of roommates, if they are in a shared bedroom.

Group homes, owned and operated by HCBS Providers, must meet all the applicable state and federal laws and regulations. Existing group homes licensed by DDS prior to July 1, 1995 may serve groups of no more than fourteen unrelated adults, age 18 years and above, with developmental disabilities. Arkansas imposed a moratorium and no additional group homes have been approved since July 1, 1995. Group homes built after July 1, 1995 are limited to a capacity of no more than 4 unrelated adults with developmental disabilities.

The capacity for supported living apartments owned and operated by waiver providers, regardless of date of DDS licensing, may serve a number of persons consistent with the number of bedrooms each apartment contains, but in no event more than four unrelated adults, age 18 and above, with developmental disabilities in each self-contained apartment unit.

Group Homes and Supported living arrangement apartments must be credentialed by the PASSE to provide services to PASSE members.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Supplemental Support	☐
Consultation	☑
Respite	☐
Supported Employment	☑
Adaptive Equipment	☑

Waiver Service	Provided in Facility
Environmental Modifications	☐
Specialized Medical Supplies	☑
Community Transition Services	☐
Supportive Living	☑
Crisis Intervention	☑

Facility Capacity Limit:

14 beds

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Staff resident ratios are determined for each individual and included in their person-centered service plan. If they may share staff in a living arrangement, that is also documented in their person-centered service plan.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Supported living arrangement apartments owned and operated by waiver providers

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Supplemental Support	☐
Consultation	☑
Respite	☐

Waiver Service	Provided in Facility
Supported Employment	☑
Adaptive Equipment	☑
Environmental Modifications	☐
Specialized Medical Supplies	☑
Community Transition Services	☐
Supportive Living	☑
Crisis Intervention	☑

Facility Capacity Limit:

No more than 4 unrelated adults in each self contained apartment

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Staff resident ratios are determined for each individual and included in their person-centered service plan. If they may share staff in a living arrangement, that is also documented in their person-centered service plan.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

  Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

  [ ] **Self-directed**

  [ ] **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

- (●) **Other policy.**

  Specify:

  Relatives/guardians may provide CES Waiver services; however, the state does not pay relatives or guardians directly. Instead, the State pays the PASSE a per member per month (PMPM) prospective payment for each attributed member. The PASSE may then utilize qualified relatives or guardians to provide the services. These individuals will need to be credentialed through the PASSE and meet the minimum qualifications established in this Waiver.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Each PASSE is responsible for credentialing its own HCBS providers based on the minimum qualifications set forth in this Waiver. Under the 1915(b) waiver, the PASSE is required to ensure statewide access to services for each attributed member. The PASSE is also subject to Arkansas's Any Willing Provider law found at Ark. Code Ann. 23-99-201 et seq. This law states that the insurer (PASSE) cannot prohibit or limit a provider who is qualified and willing to accept its terms from participating in its health plan.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
QP A1: Number and percentage of HCBS providers who were properly credentialed according to the minimum qualifications set out in this Waiver and according to the PASSE's internal policies. Numerator: Number of HCBS providers who were properly credentialed; Denominator: Total number of credentialed providers reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:
On-site review of PASSE credentialing files.

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

	☑ **Continuously and Ongoing**	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: PASSE administration	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
QP C1: Number and percentage of HCBS Provider entities that meet criteria for abuse and neglect reporting training for staff. Numerator: Number of provider agencies investigated who complied with required Abuse and neglect training set out

in the Waiver and the PASSE provider agreement; Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

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: PASSE	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: In addition to annual credentialing review, when DHS receives a complaint on a PASSE or a provider it will be investigated regarding this training.
	☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Other** Specify: PASSE	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP C2: Number and percentage of HCBS provider agencies that meet the requirements for training staff on the specific needs of the persons they serve. Numerator: Number of provider agencies who complied with training requirements set out in this Waiver or in the PASSE provider agreement; Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

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: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Individual PASSEs and providers will be reviewed when a compliant is received.
	☐ **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: PASSE	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
IDSR and DDS verify annually, during an on-site PASSE provider review that each credentialed HCBS provider meets and adheres to promulgated and contractual standards regarding HCBS providers, and identifies and rectifies situations where providers do not meet the requirements.

In addition, IDSR and DDS review credentialing of providers when a compliant is received regarding that provider of HCBS services.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
(PM QP A1)If deficiencies are cited as a result of the on-site review of a provider, DDS or DMS gives the provider an opportunity to develop a plan of correction. Within 30 days after receipt of an acceptable plan of correction, DDS or DMS staff returns for a follow-up onsite review. If the provider has not achieved substantial compliance, DDS informs the PASSE that the provider has not met the minimum qualifications and cannot be credentialed.

(PM QP C1,C2)When DDS or DMS determines, during a credentialing review or an investigation, that the PASSE or HCBS provider has not provided required abuse and neglect reporting training, or has not provided required training on the specific needs of the person the staff serves, the PASSE and provider is cited and must submit an acceptable plan of correction. The plan must include an attestation that the identified staff has been trained, as well as a description of the processes the PASSE and provider will put in place to assure the deficiencies do not occur again in the future.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Please Refer to Main, Attachment # 2

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Person Centered Services Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - ☐ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - ☐ **Licensed physician (M.D. or D.O)**
   - ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
   - ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
     Specify qualifications:
   - ☐ **Social Worker**
     Specify qualifications:
   - ☑ **Other**
     Specify the individuals and their qualifications:

The PASSE care coordinator, which must meet the following qualifications:

A. Be a Registered Nurse (R.N.), a physician, or have a bachelor's degree in a social science or health-related field;
OR
Have at least one (1) year of experience working with developmentally or intellectually disabled clients;
B. Successfully complete a background check, that includes a criminal background and child and adult maltreatment registry check;
C. Successfully pass an initial drug screen prior to and working directly with beneficiaries;
D. Successfully pass an annual drug screen; and
E. Cannot be excluded or debarred under any state or federal law, regulation or rule or not eligible or prohibited to enroll as a Medicaid provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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

From the time an individual makes contact with DHS Beneficiary Support regarding receiving HCBS state plan services, DHS informs the individual and their care givers of their right to make choices about many aspects of the services available to them and their right to advocate for themselves or have a representative advocate on their behalf. It is the responsibility of everyone at DHS, the PASSE who receives assignment and provides care coordination, and the service providers to make sure that the PASSE member is aware of and is able to exercise their rights and to ensure that the member and their caregivers are able to make choices regarding their services.

The PASSE care coordinator is responsible for arranging the PCSP development meeting and ensuring that the enrolled member is able to participate to the fullest extent possible. During the PCSP development meeting, everyone in attendance is responsible for supporting and encouraging the member to express their wants and desires and to incorporate them into the PCSP when possible. The care coordinator is responsible for managing and resolving any disagreements which arise during the PCSP development meeting.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated;

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A. Before the Person Centered Service Plan (PCSP):
1. Independent Assessments
Every applicant must undergo an Independent Assessment that will determine whether the individual is a Tier 2 (requires paid care or services less than 24 hours per day, seven days a week) or Tier 3 (requires paid care or services 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. The Independent Assessment must be completed every three (3) years.

2. Interim Service Plan (ISP):

Immediately following enrollment in a PASSE, the PASSE care coordinator must develop an Interim Service Plan (ISP) for the member. If the member was already enrolled in the Waiver prior to being enrolled in a PASSE, that member's current Person Centered Service Plan (PCSP) will remain effective as the ISP for that member. The ISP may be effective for up to 60 days from enrollment, pending completion of the full PCSP. For newly enrolled members, the ISP must, at a minimum, address the needs identified on the member's Independent Assessment.

B.PCSP:
1. Development, Participation and Timing

The PASSE's care coordinator is responsible for scheduling and coordinating the PCSP development meeting. As part of this responsibility the care coordinator must ensure that anyone the member wishes to be present is invited. Typically, the development team will consist of the member and their caregivers, the care coordinator, service providers, professional who have conducted assessments or evaluations, and friends and persons who support the member. The care coordinator must ensure that the member does not object to the presence of any participants to the PCSP development meeting. If the member or the caregiver would like a party to be present, the care coordinator is responsible for inviting that individual to attend.

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

After enrollment, and prior to the PCSP development meeting, the care coordinator must conduct an in-person health questionnaire with the member. The care coordinator must also secure any other information that may be needed to develop the PCSP, including, but not limited to:

a) Results of any evaluations that are specific to the needs of the member;
b) The results of any psychological testing;
c) The results of any adaptive behavior assessments;
d) Any social, medical, physical, and mental health histories; and
e) A risk assessment.

The PCSP development team must utilize the results of the independent assessment, the health questionnaire, and any other assessment information gathered. The PCSP must include the member's goals, needs (behavioral, developmental, and health needs), and preferences. All needed services must be noted in the PCSP and the care coordinator is responsible for coordinating and monitoring the implementation of the PCSP.

Licensed professionals conduct applicable assessments. Other assessments which do not require a licensed person, are conducted by persons who are most familiar with the beneficiary.

The PCSP must be developed within 60 days of enrollment into the PASSE. At a minimum, the PCSP must be updated annually.

3. Information regarding availability of services

The PASSE the member was assigned to will provide the member with information regarding the available services under the Waiver. Additionally, the Care Coordinator assigned to that member will be responsible for answering any questions the member or the care giver may have regarding available services and discussing appropriate services for the

member in light of the results of the independent assessment and other evaluations.

4. Addressing goals, needs and preferences and assignment of responsibilities

All individual's present at the PCSP's development meeting are responsible for assuring that the service plan developed addresses the member's goals, needs, and preferences (including health care goals, needs and preferences). The Care Coordinator is responsible for implementation of and monitoring the PCSP. During the annual onsite review of each PASSE, DMS and DDS staff review PCSPs to make sure all elements are included.

Each PASSE must include a PCSP update on its Quarterly Report. This update must include the number of new PCSPs developed and the number updated; as well as the number of PCSP development meetings scheduled.

C. After the PCSP
5. Coordination of services

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

6. Updating PCSP

The PASSE Care Coordinator is responsible for making sure that the PCSP is updated at least annually. The PCSP Development Team uses the data gathered by the Care Coordinator as they work with the beneficiary to determine if goals should change. The beneficiary may request an update of their PCSP at any time. If their is a change in circumstances such that the beneficiary's tier level may have changed, he or she (or their provider) may request a new independent assessment be done.

7. Participant Engagement

The PASSE Care Coordinator must consider input from the member and anyone there to represent the member regarding PCSP goals and objectives. During the course of the plan year, the member has a say in whether they want to work on new or revised goals. Each PCSP must contain a description of member engagement in the development process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The PCSP Development Team must address risks to the member during the PCSP development process, including the risk of institutionalization, risk to personal safety, risk of homelessness, suicide risk, health risks, and overall functional capacity. In conjunction with the member and their care giver, the team must address health and behavioral risks and risks to personal safety, either real or perceived, and known or potential. The team must document each identified risk and write the PCSP with individualized mitigation strategies. The strategies must be designed to respect the needs and preferences of the member. The team must identify how and who will be responsible for the ongoing monitoring of risk levels and risk management strategies as well as addressing how key staff will be trained regarding those risks.

Providers must document practices and decisions regarding risk assessment and the ongoing management of risks. Providers must specify the tool they use. Members enrolled in the CES Waiver, as they exercise their rights about their services, make choices about the amount of risk they wish to take. In negotiating trade-offs between choice and safety, care coordinators and providers are required to document the concerns of the team members, the negotiation process and the analysis and rationale for the decisions made and the actions taken.

Care Coordinators, in conjunction with direct service providers, must develop and implement behavior management plans to address behavioral risks. The specific details of behavior management plans are addressed in Appendix G2.Ai. Care Coordinators and providers must minimize certain personal safety risks by imposing certain "physical environment" requirements without compromising the natural, home-like atmosphere in any setting in which the member resides. All PASSE care coordinators must be trained in the development of PCSPs.

Providers must develop backup plans to address contingencies such as emergencies, including the failure of a support worker to appear when scheduled. Complete descriptions of backup arrangements must be included in the PCSP. Each provider must specify the type of back-up arrangements that are employed, and make sure that each PCSP addresses the unique needs and circumstances of the member.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Before a PASSE member can access CES Waiver services, they must be enrolled in a PASSE under the 1915(b) Provider Led Shared Savings Entities Waiver. Beginning on the first day of enrollment, the PASSE is responsible for providing all needed services to all enrolled members and may limit a member's choice of providers based on its provider network. The provider network must meet minimum adequacy standards set forth in the 1915(b) Waiver, the PASSE Provider Manual, and the PASSE provider agreement.

The member has 90 days after initial enrollment to change their assigned PASSE. Once a year, there is a 30-day open enrollment period, in which the member may change their PASSE for any reason. At any time during the year, a member may change their PASSE for cause, as defined in 42 CFR 438.56.

The State has a Beneficiary Support Office to assist the member in changing PASSE's, including informing the member of their rights regarding choosing another PASSE and how to access information on each PASSE's provider network. The Beneficiary Support Office will begin reaching out to a beneficiary once it is determined he or she meets the qualifications to be enrolled in a PASSE.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DMS, or its designated agent, arranges for a specified number of PCSP's to be reviewed annually, using the sampling guide, "A Practical Guide for Quality Management in Home and Community-Based Waiver Programs," developed by Human Services Research Institute and the Medstat Group for CMS in 2006. A systematic random sampling of the active case population is drawn whereby every "nth" name in the population is selected for inclusion in the sample. The sample size is based on a 95% confidence interval with a margin of error of +/- 8%. 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.

DMS, or its agent, then requires the PASSE to submit the PCSP for all individuals in the sample. DMS or its agent conducts a retrospective review of provided PCSPs based on identified program, financial, and administrative elements critical to quality assurance. DMS or its agent reviews the plans to ensure they have been developed in accordance with applicable policies and procedures, that plans ensure the health and welfare of the member, and for financial and utilization components. DMS or its agent communicates findings from the review to the PASSE for remediation. Systemic findings may necessitate a change in policy or procedures. A pattern of non-compliance from one PASSE may result in sanctions to that PASSE under the PASSE Provider Manual and Provider Agreement.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**

◉ **Every twelve months or more frequently when necessary**

○ **Other schedule**

Specify the other schedule:

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

☐ **Medicaid agency**

☐ **Operating agency**

☐ **Case manager**

☑ **Other**

Specify:

The member's PASSE.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The PASSE and its assigned Care Coordinator are responsible for the implementation and monitoring of the PCSP. They must maintain regular contact with the member, making at least one contact with the member or their legal representative each month. During the contact, the care coordinator must discuss issues related to both CES Waiver and non-waiver services and whether or not the member feels that their needs are being met, if they remain satisfied with their provider and express an understanding that they may change providers, and any issues related to the health and safety of the member. If they identify problems, the care coordinator must take action to remediate the issue. The care coordinator is required to maintain documentation of their conversation with the member as evidence that they are fulfilling their obligation to monitor the PCSP.

The PCSP must be reviewed by the care coordinator and the PCSP development team at least annually. The Team must review the member's objectives and determine if they are accomplished, to be continued, or should be modified or discontinued. The team must use the member's input, data collection and provider case notes to make decisions as they review the PCSP.

DMS and DDS staff conduct a random retrospective review of PCSPs. DMS and DDS compare planned services to those actually provided as documented on encounter data from the Medicaid Management Information System (MMIS) and provided by the PASSE's on their quarterly reports.

Annually, DDS and DMS will select a sample of at least 10% of members assigned to each PASSE and conduct interviews, make observations and file reviews to monitor implementation of the PCSP and the health and welfare of the member. If any of the processes reveal a problem with implementation of the PCSP, DMS and DDS cite a deficiency in the report of their review to the PASSE. The PASSE must submit an acceptable plan of correction and implement corrective actions. If a pattern of deficiencies is noted, other sanctions may be implemented according to the PASSE Provider Manual and the PASSE Provider Agreement.

Additionally, the PASSE will be required to submit a PCSP update on their Quarterly Reports to DMS.

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

b. Monitoring Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
SP A1: Percentage of PCSPs developed by PASSE Care Coordinators that were adequate and appropriate to the needs of members as indicated by their assessment (s). Numerator: Number of PCSPs that adequately and appropriately address the member's needs. Denominator: Total number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE PCSP records

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

		95%, with =/-8% margin of error
☑ **Other** Specify: PASSE	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP A2: Percentage of PCSP's that adequately address the member's risk factors.
Numerator: Number of PCSP's that adequately address the member's risk factors;
Denominator: Total number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE PCSP files

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

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, with =/-8% margin of error
☑ **Other** Specify: PASSE	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
SP C1: Percentage of PCSPs that were updated at least annually. Numerator: Number of PCSPs that were updated before the previous PCSP expired; Denominator: Total number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE PCSP files

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, with =/-8% margin of error
☑ **Other** Specify: PASSE	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
SP D1: Number and percentage of providers who delivered services in the type, scope, amount, frequency & duration specified in the PCSP. Numerator: Number of provider agencies reviewed or investigated who delivered services as specified in the PCSP. Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Service Plan Frequency and Duration Deficiencies

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP E2: Number and percentage of participants who were offered choice of PASSE providers. Numerator: Number of participants who were offered choice of a PASSE provider, as indicated by an appropriately completed and signed freedom of choice form that specified choice of providers; Denominator: Number of files reviewed.

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

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

Data Aggregation and Analysis:

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

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

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 member. The system focuses on person-centered service planning and delivery, beneficiary rights and responsibilities, and member outcomes.

DMS and DDS review a random sample of PCSP's developed by PASSE care coordinators for verification of service delivery in the type, scope, amount, frequency and duration specified. They also review to determine if the PCSP address assessed needs, personal goals, risk factors, and were developed according to established procedures. They also review to determine if PCSP are updated annually or when needs change.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If deficiencies are cited based on any of the deficiencies relative to the performance measures stated above as a result of a review of the PASSE or its providers, DMS or DDS gives the PASSE or 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 successfully resolves the compliant or returns for a follow-up onsite review. If the follow-up review reveals that the PASSE or provider has not successfully corrected the deficiencies, DMS or DDS may impose an array of enforcement remedies.

DMS and DDS maintains investigative staff so that, on an ongoing basis, they may investigate any complaints regarding the provider. When it is determined that a PASSE or provider has not met the requirements of the Waiver, the PASSE provider manual, or the PASSE Provider agreement, the PASSE or provider is cited and must submit an acceptable plan of correction. The plan must include an attestation that the deficiency has been corrected for the specific individuals on which the deficiency was written, as well as a description of the processes the provider will put in place to assure the deficiencies do not occur again in the future.

Annually, the PASSE must provide the member with choice 1)between institutional care and CES Waiver services and 2) among qualified PASSE Network providers who serve the county in which the member resides and offers the services that the member needs. The PASSE care coordinator should assist the member or his or her caregiver with making these choices.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

It is initially the responsibility of the DDS Intake and Referral Specialist to inform the person or the legally responsible representative of appeal rights specific to application intake policies and procedures:
1) As CES Waiver services are requested; and
2) When initial choice of home and community based services as an alternative to institutional care is offered.

It is the responsibility of DDS to inform the person or the legally responsible representative of appeal rights specific to the applicant or of program denial of ICF/IDD Level of Care or Medicaid Income Eligibility. It is the responsibility of DDS staff to

inform the person or legally responsible representative of appeal rights specific to closure of an application case for failure of the person or legal representative to comply with requests for required application assessment information. DDS staff sends copies of official letters to the DDS Psychology Team. When the determination is favorable to the applicant the team issues a notice of approval.

When the applicant is determined to meet eligibility criteria DDS staff inform the person or the legally responsible person of appeal rights specific to:
1) Continued choice for institutional or community based services;
2) Provider choice, including the right to change providers;
3) Service denials;
4) When their chosen providers refuse to serve them, and
5) Case closure.

The right to change providers more frequently than annually is specified in the Waiver handbook that is published on the DDS website, the promulgated Medicaid PASSE 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 within the PASSE network at any time I may choose without fear of retaliation." This topic is covered on NCI surveys conducted by the DMS and DDS.

Thereafter, the PASSE care coordinator provides continued education at each annual review regarding the PASSE's appeal process. The member or the legal representative may file an appeal with the PASSE. The member or legal representative may appeal the PASSE's decision to DHS following those processes, which the care coordinator must also inform the member of.

All PASSE appeal processes must meet the requirements of CMS's managed care regulations, as set forth in the PASSE 1915(b) waiver in Section A-IV-E. Additionally, DDS and DMS will use an appeal process in accordance with the Medicaid Provider Manual, Section 191.000 and the Arkansas Administrative Procedures Act, A.C.A. 25-15-201 et seq. Each PASSE must make its members aware of the appeal process and the members' appeal rights.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Members must utilize their PASSE's internal grievance process as described in the PASSE 1915(b) waiver, Section A-IV-E.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Each PASSE must have a grievance process in place. If the member is not satisfied with the results of that grievance process, he or she may appeal to DMS or its agents.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Each PASSE must have a process by which a member can file a complaint or grievance regarding, at a minimum, the type of services available to PASSE members, the denial of a specific service or provider, the quality of service provide, or regarding a provider in the PASSE's network, including a care coordinator.

The PASSE must provide enrolled members with their grievance rights and how to access them in the Member Handbook. All grievances must be filed within 45 days of the event. If the member is unsatisfied with the outcome of the grievance, he or she may appeal to DMS within 30 days of the PASSE's final decision on the grievance.

The PASSE's grievance system must comply with the requirements of CMS's managed care regulations, the PASSE provider Manual, and the PASSE Provider Agreement.

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 the Medicaid PASSE Provider Manual and PASSE Provider Agreement describe the incidents that PASSE Care Coordinators and HCBS providers must report. They must report incidents, using automated form DHS 1910 via secure e-mail, to DMS or DDS 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 DMS or DDS who in turn notifies the DHS Communication Director. Care Coordinators and HCBS 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 DMS or DDS 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 staff will provide training to PASSEs, Care Coordinators, and HCBS Providers regarding the reporting requirements contained. Additionally, PASSEs are required to ensure all credentialed HCBS providers and their staff are trained regarding the prevention of adult and child maltreatment, reporting adult and child maltreatment and DHS and DDS requirements for reporting incidents. This training must be conducted annually. All PASSE members must be informed of their rights. PASSE Care Coordinators must provide support and training to members so that they may recognize attempts to exploit them.

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

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

The DHS Division of Aging and Adult (DAAS), Adult Protective Services, (APS) receives reports of critical events designated as adult abuse or neglect and investigates those allegations. The methods to evaluate the reports and the time-

frames for responding are defined at Ark. Code Ann. § 12-12-1711(b)(1). The law requires that, if the APS staff who receives the report believes that the act described by the reporter constitutes criminal behavior, they must contact the appropriate law enforcement agency. If the APS staff believes the individual to have an immediate need, the staff must treat it as an emergency and report it to 911 services. The APS investigator must see the individual within 24 hours of the report. In non-emergency situations, investigation staff must see the individual who is the subject of concern within three working days and must complete the investigation 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. § 12-18-102. The Arkansas Child Maltreatment Hotline accepts reports of alleged maltreatment and determines if the report constitutes an event defined as abuse or neglect and if the report constitutes a Priority I or Priority II offense. A Priority I offense is sexual abuse, death, broken bones, head injuries, exposure to poison and noxious chemicals and substances and other critical injuries or events. A Priority II offense is one that involves serious issues, but those that are not life threatening.

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

When a HCBS Provider or PASSE Care Coordinator reports an incident to the Adult or Child Hotline, they must also submit an incident report (DHS 1910) to DMS or DDS. The State Staff reviews and evaluates the incident reports to determine if correct procedures and time frames were followed. If the HCBS Provider or Care Coordinator did not report the incident according to proscribed timeframes, the State staff will issue a deficiency and request an Assurance of Adherence of Standards which describes how the PASSE or HCBS Provider will ensure future compliance with the required reporting time frames.

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

If an incident warrants investigation, the State Staff will initiate an investigation according to the PASSE Provider Manual and Provider Agreement. Staff must complete an investigation within 30 days.

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 unit which investigates complaints and concerns, which may or may not constitute a critical concern and proscribes the methods and timeframes for conducting an investigation of a concern or complaint. In brief, the staff member has three working days from the time the complaint is received to make initial contact with the person making the complaint. The staff must begin the fact finding process within one day of initiation of the investigation and must complete the investigation within 30 days. The staff provides a written report to the PASSE and HCBS Provider in question and to the individual making the complaint. If the staff substantiates the complaint, they issue a deficiency to the PASSE or HCBS 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, in conjunction with DMS, is responsible for overseeing the reporting of and response to critical incidents regarding CES Waiver participants. There are three primary facets to the oversight process. One part of the process occurs during the annual onsite readiness review of the PASSE to ensure that the PASSE and its HCBS providers are following applicable policies and procedures and that necessary follow up is conducted on a timely basis. The second occurs as DDS staff reviews and responds as appropriate to reports of incidents that HCBS providers submit to DDS. Third, DDS maintains a database of incidents in order to facilitate the identification of trends and patterns and identify opportunities for improvements and support the development of strategies to reduce the occurrence of incidents in the future.

PASSEs are required to develop and implement policy that requires HCBS providers report adult abuse, maltreatment or exploitation, or child maltreatment to the Child Abuse or Adult Maltreatment Hotline. The policy must:
1. Include all incidents described as by DDS,
2. Include any other incidents determined reportable by the program, and
3. Require notification to the parent or guardian of all children age birth to 18 or adults who have a guardian, each time the provider submits an incident report to DDS or according to the Internal Incident Reporting policy.
4. Develop and implement policy regarding follow-up of all incidents.

During the annual onsite review, DDS and DMS staff review the documentation maintained by the PASSE which supports compliance with these requirements. Staff review documentation of incidents to determine if the incident constitutes a reportable incident and confirm that a report was submitted. Staff also PASSE leadership and care coordination staff, as well as HCBS providers in that PASSE's network, to determine if they are familiar with the requirements of incident reporting.

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

DDS maintains a database of incidents that includes the type of incident, the name of the PASSE and HCBS provider involved, the name of the HCBS Waiver participant, and the date of occurrence. Staff review the information on a quarterly basis to determine if there are trends that are relative to specific providers at a system-wide level or within the waiver population. If trends are identified, the information is provided to the Office of Innovation and Delivery System Reform (IDSR) within DMS to determine if any actions are needed.

DDS conducts oversight of CES Waiver investigative activities. Staff maintains a database that includes timeframes regarding initiation and resolution, including notification to the parties involved. Staff generate monthly reports and administrative staff analyzes data on a quarterly basis. Systemic issues, when identified, are presented to the IDSR.

Appendix G: Participant Safeguards

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

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 beneficiary threatens the health or safety of the individual or others. Physical 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.

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 beneficiary 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 PASSE care coordinator must be involved in the development of the behavior management plan. 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 PASSE or HCBS provider report to DDS the use restraints. DDS 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 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.

PASSEs must prohibit maltreatment or corporal punishment of individuals by HCBS providers or their staff. PASSEs must also 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 beneficiary 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 responsible for monitoring the use of restraints by HCBS Providers credentialed by the PASSEs. Therefore, PASSEs and HCBS providers must report the use of restraints to DDS. The DDS 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 staff review records of incident reports and behavior management plans, this review may include interviews of the PASSE care coordinator and/or Provider staff.

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

Appendix G: Participant Safeguards

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

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

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

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

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

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

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, 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 which time, the person is under constant visual and auditory contact and supervision. Time-out interventions include placing a person in a specific time-out room, commonly referred to as exclusionary time-out and removing the positively reinforcing environment from the individual, commonly referred to as non-exclusionary time-out. 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 with the involvement of the PASSE Care Coordinator. The Care Coordinator and/or HCBS 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 care coordinator and/or HCBS 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 care coordinator and/or provider is required to:
1.Develop a simple, efficient and manageable method of collecting data,
2.Collect data regarding the frequency, length of time of each use, the duration of use over time and the impact of restraint and seclusion,
3.Review the data regularly, and
4.Revise the plan as needed if the interventions do not achieve the desired results.

The PASSE care coordinator or the HCBS provider must report to DDS the use of any restrictive intervention. The DDS 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 staff review records of incident reports and behavior management plans and may interview the PASSE care coordinator or HCBS provider staff and individuals.

PASSE's must have policies that prohibit maltreatment or corporal punishment of members and guarantee an array of rights which includes the right to be free from the use of a physical or chemical restraint, medications, or isolation as punishment for the convenience of the provider except when a physical restraint is necessary for the health and safety of the individual.

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

DDS is responsible for monitoring use of restrictive interventions. PASSE care coordinators or HCBS providers must report to DDS the use of any restrictive intervention. The DDS staff review each report to determine why the use of the technique occurred and what corrective action the provider took to prevent the

reoccurrence of the use of the restrictive intervention. Additionally, in an effort to detect the unauthorized use of restrictive intervention, DDS 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 investigates any complaints or concerns regarding the possible use of restrictive interventions.

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

Appendix G: Participant Safeguards

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

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

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

Seclusion is defined as the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving. DDS is responsible for monitoring use of seclusion. PASSE care coordinators or HCBS Providers must report to DDS the use of seclusion. The DDS 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 seclusion. Depending on the circumstances described in the incident report, DDS staff conduct an onsite investigation and cite the PASSE or HCBS provider with deficient practices as necessary.

Additionally, DDS staff review records of incident reports and behavior management plans and interview provider staff and individuals.

Each PASSE must have policies in place that prohibit the use of seclusion.

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

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

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

Appendix G: Participant Safeguards

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

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix

does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

The PASSE Care Coordinator and HCBS service provider has on-going responsibility for first-line monitoring the member's medication regimens. The PASSE Care Coordinator is responsible at all times to assure that the service plan identified and addressed all needs with other supports as necessary to assure the health and welfare of the member.

The Care Coordinator must develop and implement a Medication Management Plan for all members receiving prescription medications. The plan must describe:
1. How direct service staff will, at all times, remain aware of the medications being used by the member,
2. How direct service staff will be made aware of the potential side effect effects of the medications being used by the member,
3. How the care coordinator and service providers will ensure that the member or their guardian will be made aware of the nature and the effect of the medication,
4. How the care coordinator and service providers will ensure that the member or their guardian gives their consent prior to the use of the medication, and
5. How the service providers will ensure that administration of the medication will be performed in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

The HCBS provider providing direct services must maintain medication logs that document at least the following:
1. Name and dosage of the medication given,
2. Route medication was given,
3. Date and time the medication was given,
4. Initials of the person administering or assisting with administration of the medication,
5. Any side effects or adverse reactions, and
6. Any errors in administering the medication.

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

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

Prescription PRN and over-the-counter medications may be appropriate in the use of treating specific symptoms of illnesses. If used, the HCBS Provider must keep data regarding:
1. How often the medication is used,
2. The circumstances in which the medication is used,
3. The symptom for which the medication was used, and
4. The effectiveness of the medication.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful

practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The PASSE is responsible for second-line medication management process to ensure that beneficiaries medications are managed appropriately and in accordance with the medication management plan. DDS and DMS staff review medication management plans and medication logs to ensure compliance with this Waiver, the PASSE Provider Manual, and the PASSE Provider Agreement. If errors are found, State Staff cite the PASSE and the HCBS Provider with a deficient practice and require a plan of correction.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

PASSE HCBS Providers must adhere to the Arkansas Nurse Practice Act, which addresses how medications may be administered and by whom. The Care Coordinator must develop and implement a separate Medication Management plan for all members receiving prescription medications. The plan must describe:
1. How direct service staff will, at all times, remain aware of the medications being used by the member,
2. How direct service staff will be made aware of the potential side effects of the medications being used by the member,
3. How the beneficiary will be made aware of the nature and the effect of the medication,
4. How the beneficiary gives their consent prior to the administration of the medication, and
5. How the administration of the medication will be performed in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

The PASSE must require all HCBS Providers maintain Medication Logs that document at least the following:
1. Name and dosage of the medication given,
2. Route of medication,
3. Date and time the medication was given,
4. Initials of the person administering or assisting with administration of the medication,
5. Any side effects or adverse reactions, and any actions taken as a result, and
6. Any errors in administering the medication.

The Organization providing direct services must ensure that a supervisory level staff documents oversight of the administration of medications at least monthly by reviewing medication logs to determine if:
1. The member consumed the medications accurately as prescribed,
2. The medication is effectively addressing the reason for which it was prescribed, and
3. Any side effects are noted, reported and are being managed appropriately.

The direct service provider must ensure that designated staff report to a supervisor and record the following medication errors missed dose,wrong dose,wrong time of dose,wrong route, and wrong medication.

The direct service provider must ensure that designated staff record any charting omission, loss of medication, unavailability of medications, falsification of records, and any theft of medications.

Additionally, the direct service provider must keep data regarding how often the medication is used, the

circumstances in which the medication is used, the symptom for which the medication was used, and the effectiveness of the medication.

PASSE's must develop and implement policies which describe how HCBS Providers will administer or assist with the administration of medications. The policy must, at least, describe the qualifications of who may administer medications, describe the qualification of who may assist with the administration of medications, specify which class of drugs may be administered by which staff, and require that PRN medications are used only with the consent of the member and according to approval from the prescribing health care professional.

PASSE's are required to provide training to HCBS Providers and staff who provide direct services which details the specifics of the member's service plan including training that provides information related to any medications taken by the person they serve, including possible side effects.

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

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

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

Providers are required to report medication errors to the PASSE. These reports must be made available to DMS upon request and must be reported annually to DMS.

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

The direct services provider must ensure that designated staff report to a supervisor and record medication errors as follows: missed dose, wrong dose,wrong time of dose, wrong route, and wrong medication.

The direct services provider must ensure that designated staff record the following: any charting omission, loss of medication, unavailability of medications, falsification of records, and theft of medications.

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

Providers are required to report medication errors to DDS that cause or have the potential to cause serious injury or illness.

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

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

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

DDS is responsible for monitoring the performance of providers in the administration of medications to persons. As part of quality review of PASSE's, DDS Staff review medication management plans, logs and error reports. They also review internal incident reports as well as those incident reports that the provider submitted to DDS to detect any potentially harmful practices. If they find errors, DDS staff cite the PASSE or HCBS Provider with a deficient practice and require a plan of correction.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
HW1 : Number and percentage of members or legal guardians who received information about how to report abuse, neglect, and exploitation from their PASSE Care Coordinator. Numerator: Number of members who received information about how to report abuse, neglect, and exploitation; Denominator: Number of files reviewed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
HW2: Number and percentage of PASSE Care Coordinators and HCBS Providers who reported critical incidents to DDS within required time frames. Numerator: Number of PASSE Care Coordinators or HCBS Providers who reported critical incidents within required time frames; Denominator: Total number of critical incidents that occurred and were reviewed.

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

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: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

	☑ **Continuously and Ongoing**	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: PASSE	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
HW4: Percentage of PASSE Care Coordinators and HCBS Providers who took corrective actions regarding critical incidents to protect the health and welfare of the member. Numerator: Number of PASSE Care Coordinators and HCBS Providers who took corrective actions; Denominator: Number of PASSE Care Coordinators and HCBS Providers required to take protective actions regarding critical incidents.

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

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

		☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HW5: Number and percentage of complaint investigations that were completed on a timely basis. Numerator: Number of complaint investigations that were completed on a timely basis; Denominator: Number of complaint investigations.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
HW6: Number and percentage of reported deaths which were reviewed by the Mortality Review Committee Numerator: Number of reported deaths which were reviewed timely by the Mortality Review Committee; Denominator: Number of deaths reviewed.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Data Source Report of Timely Mortality Reviews

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

Data Aggregation and Analysis:

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

Performance Measure:

HW7: Percentage of HCBS Providers who adhered to PASSE policies for the use of restrictive interventions. Numerator: Number of HCBS providers who adhered to PASSE policies for the use of restrictive interventions as documented on an incident report; Denominator: Number of individuals for whom the provider utilized restrictive intervention as documented on an incident report.

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HW4: Percentage of PASSE Care Coordinators and HCBS Providers who took corrective actions regarding critical incidents to protect the health and welfare of the member. Numerator: Number of PASSE Care Coordinators and HCBS Providers who took corrective actions; Denominator: Number of PASSE Care Coordinators and HCBS Providers required to take protective actions regarding critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of incident reports.

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: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HW7: Percentage of HCBS Providers who adhered to PASSE policies for the use of restrictive interventions. Numerator: Number of HCBS providers who adhered to PASSE policies for the use of restrictive interventions as documented on an incident report; Denominator: Number of individuals for whom the provider utilized restrictive intervention as documented on an incident report.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of incident reports.

Responsible Party for data		**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW9-Number and percentage of PASSE Care Coordinators who demonstrate responsibility for maintaining overall health care standards. Numerator: Number of provider agencies who met standards and metrics set forth in the PASSE Provider Manual and Provider Agreement. Denominator: Total number of PASSE Care Coordinators reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE Care Coordinator Encounter Data and PASSE Quarterly Reports

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: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
(HW 1) The PASSE must inform all enrolled members of their right to report abuse and the contact information for Child and Adult Hotlines. This form must be included in the Member handbook which is approved by DMS.

(HW4) DDS staff identify critical incident reports that describe incidents which require protective actions, such as behavior management plans, changes in staffing levels, or changes in goals. Staff will determine, through the use of interviews, observations and file reviews, if the provider has taken necessary action to protect the individual in question.

(HW 5) DDS staff must complete the investigations of critical incidents within 30 calendar days of receipt of the concern.

(HW 7) DDS requires that PASSE HCBS Providers submit incident reports each time they utilize a restrictive intervention. DDS staff reviews each report and determines if the methods described in the incident report adhere to the requirements for the use of the type intervention used. DDS staff may contact the PASSE Care Coordinator or the HCBS Provider to obtain additional information, if necessary.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DMS and DDS may take remedial action against the PASSE for any deficiencies noted or for any pattern of non-compliance. These actions are set forth in the PASSE Provider Manual and the PASSE Provider Agreement.

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**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities*

of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

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

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

By using encounter data, the State will have the ability to measure the amount of services provided compared to what is described within the Person Centered Service Plan (PCSP) that is required for individuals receiving CES Waiver services. The state will utilize the encounter data to monitor services provided to determine a baseline, median and any statistical outliers for those service costs.

Additionally, the state will monitor grievance and appeals filed with the PASSE regarding CES Waiver services under the broader Quality Improvement Strategy for the 1915(b) PASSE Waiver.

2. Roles and Responsibilities

The State will work with an External Quality Review Organizations (EQRO) to assist with analyzing the encounter data and data provided by the PASSEs on their quarterly reports.

The State's Beneficiary Support Team will proactively monitor service provision for individuals who are receiving CES Waiver services. Additionally, the team will review PASSE provider credentialing and network adequacy.

3. Frequency

Encounter data will be analyzed quarterly by the State and annually by the EQRO.

Network adequacy will be monitored on an ongoing basis.

4. Method for Evaluating Effectiveness of System Changes

The State will utilize multiple methods to evaluate the effectiveness of system changes. These may include site reviews, contract reviews, encounter data, grievance reports, and any other information that may provide a method for evaluating the effectiveness of system changes.

Any issues with the provision of CES Waiver services that are continually uncovered may lead to sanctions against providers or the PASSE that is responsible for access to those services.

The State will randomly audit PCSPs that are maintained by each PASSE to ensure compliance.

ii. System Improvement Activities

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

b. System Design Changes

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

Arkansas DDS has developed and implemented an HCBS quality improvement strategy that includes a continuous improvement process, measures of program performance, and measures of experience of care.
Components:
Continuous improvement process: DDS convened in November of 2011 a Quality Assurance Committee, made up of state agency staff, providers, and other stakeholders. This Committee meets at least quarterly. Measures of program performance: DDS has developed robust measures of program performance though Performance Measures related to the subassurances.
Experience of care: DDS has conducted the National Core Indicator Adult Consumer Survey since July of 2006. During these seven survey cycles, DDS has improved its process and the transparency of its results. NCI survey data is on the DDS webpage.
Beginning in 2019, an External Quality Review Organization will be conducting quality reviews on all PASSE activities and service delivery.

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

PASSE encounter claims data will be audited quarterly for program policy alignment. 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 PASSEs will be responsible for maintaining a claims payment system that can interface with the Medicaid Management Information System (MMIS) used by DHS. All HCBS Providers who bill for the PASSE's enrolled members must utilize the PASSE's claims system. DMS will pay a per member, per month (PMPM) prospective payment for each enrolled member to cover all services for that month. DMS, in conjunction with DDS, will conduct utilization reviews of the encounter data to ensure adequate services are delivered to the enrolled member based on his or her PCSP.

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

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 set forth by the PASSE and in the Medicaid PASSE Provider Manual.

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. 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.

OMIG performs regular reviews of Waiver services delivered. During the last two state fiscal years, 21% of our audits were devoted to Waiver providers.
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 members 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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability 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 only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
FA1: Number and percent of reviewed encounter claims that align with services specified in the member's PCSP. Numerator: Number of encounter claims that align with services in the member's PCSP; Denominator: Number of encounter claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient PCSPs and PASSE encounter claims

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE Quarterly 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: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix I: Financial Accountability

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

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

Care coordination- Until December 31, 2018, the monthly rate for care coordination is $173.33. This rate is consistent with the rate paid for care coordination under the Provider-Led Care Coordination Program, 1915(b) Waiver AR07.00.00. Person-Centered Service Plan Development component-This service component can be billed once per year without documentation of a change in circumstances. The rate is $90.00 per plan development. The rate is based on the current rate paid to behavioral health providers for the development of a treatment plan. These rates will cease on January 1, 2019, when the PASSE's take over full responsibility for care coordination.

Supportive Living - The maximum daily rate for supportive living is $391.95 (Tier 3) and $184.80 (Tier 2). 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. 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 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.

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.

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 (PERS) - 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.

In 2018, DMS and DDS worked with an actuarial firm to develop updated rates for CES Waiver services before the PASSE 1915(b) waiver global payments (PMPMs) were developed. These new rates will be part of the capitated rate beginning on January 1, 2019. Each Waiver participant's PASSE will receive a PMPM for that client that must be used to provide all CES Waiver services, care coordination under the 1915(b) waiver, and Medicaid State Plan services that are not excluded. The new rates are described below.

Supportive Living and Respite Services rates were converted from a maximum daily allowance to an hourly rate to allow for more flexibility in the PCSP development for beneficiaries. The cost-based method was used to develop the hourly rates and considered the following variables:
-direct service provide salaries and benefits
-transportation costs
-direct service-related expense and overhead costs
-annual number of hours practitioners are at work
-percentage of time an at-work practitioner is able to convert to billable units (productivity)
-adjustment for overtime costs

Supported employment rates were developed using a cost-based method developed from the following variables:
-direct service provide salaries and benefits
-transportation costs
-direct service-related expense and overhead costs
-annual number of hours practitioners are at work
-percentage of time an at-work practitioner is able to convert to billable units (productivity)
The supportive employment rate is paid in 15 minute units.

The services subject to annual limits remained the same. This includes: adaptive equipment, environmental modifications, specialized medical supplies, supplemental support services, and community transition services. The actuary examined these rates to determine reasonableness of the annual limits by summarizing the annual expenditures per beneficiary between January 1, 2015 and December 31, 2017 to determine how often beneficiaries' aggregate expenditures for those services were within 5% of the annual limit. This examination showed that
(1) for the adaptive equipment and environmental modification grouped services, only 0.6% came within 5% of the limit; and
(2) for the specialized medical supplies, supplemental support services, and community transition services, only 2.6% of claims came within 5% of the limit.

The rates for consultation and crisis intervention remained the same.

Rate Determination Responsibility: DDS is responsible to develop and present all proposed rates to 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 documents 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 CES Waiver budget for each member is determined by the PASSE through the Person Centered Service Plan (PCSP) development process, after completion of the Independent Assessment. The PCSP development team includes the PASSE care coordinator and the individual or their legal representative. All other persons attending are at the

discretion of the individual or their legal representative, and may include other professionals, as appropriate. The members of the team will determine treatment objectives and goals, as well as services to be provided and frequency of service provision to ensure the member's desired outcomes, needs and preferences are addressed. A PCSP revision can be requested at any time that the member's needs change. The services included in the PCSP must be approved by the member's PASSE. There is an appeal process with both the PASSE and DMS if the member disagrees with the PASSE's approval determination.

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

HCBS Providers will bill directly to the PASSE's for CES Waiver services provided to enrolled members. The PASSE's must establish rates with the HCBS Waiver providers that ensure services are provided to all enrolled members across the state.

The PASSE's will receive a prospective PMPM for each enrolled member and DMS, in conjunction with DDS, will review all encounter claims quarterly.

Appendix I: Financial Accountability

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

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

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

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

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

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

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

Appendix I: Financial Accountability

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

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

The assessed needs of each person are identified through a functional Independent Assessment. The PASSE's care coordinator must use that Independent Assessment, the health questionnaire, and other evaluations and assessments to create a PCSP for each member. The services provided to that member must be based upon the objectives and goals set forth in the PCSP.

Providers maintain case notes of each service day with the person served. Providers maintain administrative records such as timesheets and payroll records for provider staff. DMS staff, in conjunction with DDS, reviews the provider records against the encounter claims to ensure services were provided in accordance with the PCSP.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

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

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

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

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

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

  Payments are made to the PASSEs through the MMIS system. These payments are a PMPM to cover all the member's services.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

HCBS providers of CES Waiver services are only provided and paid by the PASSE's.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

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

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

No, the capitated payment is not reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

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

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

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

○ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

◉ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

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

DDS has established an Organized Health Care Delivery System (OHCDS) option as per 42 CFR 447.10 (b) for HCBS Waiver providers credentialed by a PASSE. The PASSE Provider Agreement requires that the services of a subcontractor will comply with Medicaid regulations. The OHCDS provider assumes all liability for contract non-compliance. The OHCDS provider must provide at least one HCBS Waiver service directly utilizing its own employees. The OHCDS provider must also have a written contract that specifies the services and assures that work will be completed in a timely manner and be satisfactory to the person served. OHCDS is optional.

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

○ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

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

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

○ **This waiver is a part of a concurrent ◆1115/◆1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ◆1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

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

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

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching

arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

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

☐ **Other State Level Source(s) of Funds.**

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

Appendix I: Financial Accountability

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

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

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

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

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

☐ **Other Local Government Level Source(s) of Funds.**

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

Appendix I: Financial Accountability

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

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

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

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

Appendix I: Financial Accountability

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

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

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

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

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

Appendix I: Financial Accountability

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

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

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

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

Appendix I: Financial Accountability

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

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

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

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

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

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

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

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

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

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	48237.50	15678.00	63915.50	115475.00	15811.00	131286.00	67370.50
2	43663.49	16148.00	59811.49	118939.00	5986.00	124925.00	65113.51
3	43349.20	16632.00	59981.20	122507.00	6165.00	128672.00	68690.80
4	822.76	17131.00	17953.76	126182.00	6350.00	132532.00	114578.24
5	768.09	17645.00	18413.09	129968.00	6541.00	136509.00	118095.91

Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	4303	4303
Year 2	4803	4803
Year 3	4863	4863
Year 4	4883	4883
Year 5	4903	4903

Appendix J: Cost Neutrality Demonstration

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

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

The average is based on the actual prior experience from FY 2014 372 report. The average length of stay is 354.6 days.

Appendix J: Cost Neutrality Demonstration

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

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

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

The basis for estimates of all services was based on FY 2015 Expenditures derived from AR MMIS system pending acceptance of 372 Report for time period.

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

Utilization of Medicaid services provided outside of the scope of the waiver have been carried forward to represent anticipated costs.

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

Historic cost trends have been carried forward to represent anticipated institutional costs.

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

Historic cost trends have been carried forward to represent anticipated costs residents may incur outside of the institution.

Appendix J: Cost Neutrality Demonstration

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

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

Waiver Services	
Respite	
Supported Employment	
Supportive Living	
Specialized Medical Supplies	
Adaptive Equipment	
Community Transition Services	
Consultation	
Crisis Intervention	
Environmental Modifications	
Supplemental Support	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932 (a), Section 1937). 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. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**305942.79**
Respite	☐	day	151	18.16	111.57	**305942.79**	
Supported Employment Total:							**666444.05**
Supported Employment	☐	15 minutes	101	1838.01	3.59	**666444.05**	
Supportive Living Total:							**204064441.56**
Supportive Living	☐	day	4162	294.00	166.77	**204064441.56**	
Specialized Medical Supplies Total:							**593950.50**
Specialized Medical Supplies	☐	monthly	923	11.00	58.50	**593950.50**	
Adaptive Equipment Total:							**681224.67**
Personal Emergency System Service Fee	☐	monthly	24	12.00	29.25	**8424.00**	
Adaptive Equipment	☐	package	286	1.39	1692.41	**672800.67**	
Community Transition Services Total:							**369009.27**
Community Transition Services	☐	package	108	1.05	3254.05	**369009.27**	
Consultation Total:							**113899.50**
Consultation	☐	hour	177	6.25	102.96	**113899.50**	
Crisis Intervention Total:							**5084.00**
Crisis Intervention	☐	hour	25	1.60	127.10	**5084.00**	
Environmental Modifications Total:							**685201.32**
Environmental Modifications	☐	package	147	1.05	4439.27	**685201.32**	
Supplemental Support Total:							**80759.69**
Supplemental Support	☐	monthly	64	3.33	378.94	**80759.69**	

GRAND TOTAL:	**207565957.36**
Total: Services included in capitation:	
Total: Services not included in capitation:	207565957.36
Total Estimated Unduplicated Participants:	**4303**
Factor D (Divide total by number of participants):	**48237.50**
Services included in capitation:	
Services not included in capitation:	48237.50
Average Length of Stay on the Waiver:	355

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932 (a), Section 1937). 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. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**326203.90**
Respite	☐	day	161	18.16	111.57	**326203.90**	
Supported Employment Total:							**699436.33**
Supported Employment	☐	15 minutes	106	1838.01	3.59	**699436.33**	
Supportive Living Total:							**206025656.76**
Supportive Living	☐	day	4202	294.00	166.77	**206025656.76**	
Specialized Medical Supplies Total:							**600385.50**
Specialized Medical Supplies	☐	monthly	933	11.00	58.50	**600385.50**	
Adaptive Equipment Total:							**708259.17**
Personal Emergency System Service Fee	☐	monthly	34	12.00	29.25	**11934.00**	
Adaptive Equipment	☐	package	296	1.39	1692.41	**696325.17**	
Community Transition Services Total:							**403176.79**
Community Transition Services	☐	package	118	1.05	3254.05	**403176.80**	
Consultation Total:							**120334.50**
Consultation	☐	hour	187	6.25	102.96	**120334.50**	
Crisis Intervention Total:							**7117.60**
Crisis Intervention	☐	hour	35	1.60	127.10	**7117.60**	
Environmental Modifications Total:							**731813.66**
Environmental Modifications	☐	package	157	1.05	4439.27	**731813.66**	
Supplemental Support Total:							**93378.39**
Supplemental Support	☐					**93378.39**	

GRAND TOTAL:	**209715762.61**
Total: Services included in capitation:	
Total: Services not included in capitation:	209715762.61
Total Estimated Unduplicated Participants:	**4803**
Factor D (Divide total by number of participants):	**43663.49**
Services included in capitation:	
Services not included in capitation:	43663.49
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		monthly	74	3.33	378.94		
					GRAND TOTAL:		**209715762.61**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		209715762.61
					Total Estimated Unduplicated Participants:		**4803**
					Factor D (Divide total by number of participants):		**43663.49**
					Services included in capitation:		
					Services not included in capitation:		43663.49
					Average Length of Stay on the Waiver:		355

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932 (a), Section 1937). 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. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**336334.46**
Respite	☐	day	166	18.16	111.57	**336334.46**	
Supported Employment Total:							**732428.60**
Supported Employment	☐	15 minutes	111	1838.01	3.59	**732428.60**	
Supportive Living Total:							**207006264.36**
Supportive Living	☐	day	4222	294.00	166.77	**207006264.36**	
Specialized Medical Supplies Total:							**603603.00**
Specialized Medical Supplies	☐	monthly	938	11.00	58.50	**603603.00**	
Adaptive Equipment Total:							**721776.42**
Personal Emergency System Service Fee	☐	monthly	39	12.00	29.25	**13689.00**	
Adaptive Equipment	☐	package	301	1.39	1692.41	**708087.42**	
Community Transition Services Total:							**420260.56**
					GRAND TOTAL:		**210807161.37**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		210807161.37
					Total Estimated Unduplicated Participants:		**4863**
					Factor D (Divide total by number of participants):		**43349.20**
					Services included in capitation:		
					Services not included in capitation:		43349.20
					Average Length of Stay on the Waiver:		355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition Services	☐	package	123	1.05	3254.05	**420260.56**	
Consultation Total:							**123552.00**
Consultation	☐	hour	192	6.25	102.96	**123552.00**	
Crisis Intervention Total:							**8134.40**
Crisis Intervention	☐	hour	40	1.60	127.10	**8134.40**	
Environmental Modifications Total:							**755119.83**
Environmental Modifications	☐	package	162	1.05	4439.27	**755119.83**	
Supplemental Support Total:							**99687.75**
Supplemental Support	☐	monthly	79	3.33	378.94	**99687.75**	

GRAND TOTAL:	**210807161.37**
Total: Services included in capitation:	
Total: Services not included in capitation:	210807161.37
Total Estimated Unduplicated Participants:	**4863**
Factor D (Divide total by number of participants):	**43349.20**
Services included in capitation:	
Services not included in capitation:	43349.20
Average Length of Stay on the Waiver:	355

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932 (a), Section 1937). 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. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**356373.25**
Respite	☐	hour	176	125.30	16.16	**356373.25**	
Supported Employment Total:							**861365.01**
Supported Employment	☐	15 minutes	116	1838.01	4.04	**861365.01**	

GRAND TOTAL:	**4017540.54**
Total: Services included in capitation:	
Total: Services not included in capitation:	4017540.54
Total Estimated Unduplicated Participants:	**4883**
Factor D (Divide total by number of participants):	**822.76**
Services included in capitation:	
Services not included in capitation:	822.76
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Living Total:							**0.00**
Supportive Living	☐	hour	4242	0.00	17.07	**0.00**	
Specialized Medical Supplies Total:							**606820.50**
Specialized Medical Supplies	☐	monthly	943	11.00	58.50	**606820.50**	
Adaptive Equipment Total:							**735293.67**
Personal Emergency System Service Fee	☐	monthly	44	12.00	29.25	**15444.00**	
Adaptive Equipment	☐	package	306	1.39	1692.41	**719849.67**	
Community Transition Services Total:							**437344.32**
Community Transition Services	☐	package	128	1.05	3254.05	**437344.32**	
Consultation Total:							**126769.50**
Consultation	☐	hour	197	6.25	102.96	**126769.50**	
Crisis Intervention Total:							**9151.20**
Crisis Intervention	☐	hour	45	1.60	127.10	**9151.20**	
Environmental Modifications Total:							**778425.99**
Environmental Modifications	☐	package	167	1.05	4439.27	**778425.99**	
Supplemental Support Total:							**105997.10**
Supplemental Support	☐	monthly	84	3.33	378.94	**105997.10**	

GRAND TOTAL:	**4017540.54**
Total: Services included in capitation:	
Total: Services not included in capitation:	4017540.54
Total Estimated Unduplicated Participants:	**4883**
Factor D (Divide total by number of participants):	**822.76**
Services included in capitation:	
Services not included in capitation:	822.76
Average Length of Stay on the Waiver:	355

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932 (a), Section 1937). 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. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							**0.00**
Respite	☐	hour	176	0.00	16.16	**0.00**	
Supported Employment Total:							**898492.81**
Supported Employment	☐	15 minutes	121	1838.01	4.04	**898492.81**	
Supportive Living Total:							**0.00**
Supportive Living	☐	hour	4262	0.00	17.07	**0.00**	
Specialized Medical Supplies Total:							**610038.00**
Specialized Medical Supplies	☐	monthly	948	11.00	58.50	**610038.00**	
Adaptive Equipment Total:							**748810.92**
Personal Emergency System Service Fee	☐	monthly	49	12.00	29.25	**17199.00**	
Adaptive Equipment	☐	package	311	1.39	1692.41	**731611.92**	
Community Transition Services Total:							**454428.08**
Community Transition Services	☐	package	133	1.05	3254.05	**454428.08**	
Consultation Total:							**129987.00**
Consultation	☐	hour	202	6.25	102.96	**129987.00**	
Crisis Intervention Total:							**10168.00**
Crisis Intervention	☐	hour	50	1.60	127.10	**10168.00**	
Environmental Modifications Total:							**801732.16**
Environmental Modifications	☐	package	172	1.05	4439.27	**801732.16**	
Supplemental Support Total:							**112306.45**
Supplemental Support	☐	monthly	89	3.33	378.94	**112306.45**	

GRAND TOTAL:		**3765963.42**
Total: Services included in capitation:		
Total: Services not included in capitation:		3765963.42
Total Estimated Unduplicated Participants:		**4903**
Factor D (Divide total by number of participants):		**768.09**
Services included in capitation:		
Services not included in capitation:		768.09
Average Length of Stay on the Waiver:	355	

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1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. **Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Supported Employment; Behavior Assistance; Adult Rehabilitation Day Treatment; Peer Support; Family Support Partners; Residential Community Reintegration; Outpatient Substance Abuse Treatment; Crisis Intervention; Planned Respite; Emergency Respite; Mobile Crisis Intervention; Therapeutic Host Home; Recovery Support Partners (for Substance Abuse); Substance Abuse Detox (Observational).

2. **Concurrent Operation with Other Programs.** *(Indicate whether this benefit will operate concurrently with another Medicaid authority):*

***Select one*:**

	Not applicable		
X	**Applicable**		
Check the applicable authority or authorities:			
	Services furnished under the provisions of §1915(a)(1)(a) of the Act. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*		
X	**Waiver(s) authorized under §1915(b) of the Act** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:* *Provider-Led Arkansas Shared Savings Entity (PASSE) Program*		
Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
X	§1915(b)(1) (mandated enrollment to managed care)		§1915(b)(3) (employ cost savings to furnish additional services)
	§1915(b)(2) (central broker)	X	§1915(b)(4) (selective contracting/limit number of providers)
	A program operated under §1932(a) of the Act. *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*		
	A program authorized under §1115 of the Act. *Specify the program*:		

3. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS. Benefit-***(Select one):*

X	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	X	The Medical Assistance Unit *(name of unit)*:	The Division of Medical Services (DMS)
		Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative 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. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non- State Entity
1. Individual State plan HCBS enrollment	☑			
2. Eligibility evaluation	☑			
3. Review of participant service plans	☑		☑	
4. Prior authorization of State plan HCBS	☑		☑	
5. Utilization management	☑		☑	
6. Qualified provider enrollment	☑		☑	

7. Execution of Medicaid provider agreement	☑			
8. Establishment of a consistent rate methodology for each State plan HCBS	☑		☑	
9. Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑			
10. Quality assurance and quality improvement activities	☑		☑	

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The Provider-led Arkansas Shared Savings Entity (PASSE) is a risk-based entity that provides all services to members, will contract with providers and negotiate rates for services. They will also develop and review service plans for members and authorize services, as well as conduct internal quality review. The PASSE is responsible for complying with conflict-free case management requirements as described in the 1915(b) PASSE Waiver Section A, Part I.F.8.

The External Quality Review Organization (EQRO) that contracts with DMS will assist with quality assurance and quality improvement for all 1915(i) service activities.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	Jan. 1, 2019	Dec. 31, 2019	30,000
Year 2	Jan. 1, 2020	Dec. 31, 2020	
Year 3	Jan. 1, 2021	Dec. 31, 2021	
Year 4	Jan. 1, 2022	Dec. 31, 2022	
Year 5	Jan. 1, 2023	Dec. 31, 2023	

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☑ The State does not provide State plan HCBS to the medically needy.

☐ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

	Directly by the Medicaid agency
X	By Other (*specify State agency or entity under contract with the State Medicaid agency*): For the dually diagnosed population, eligibility evaluations are completed by an eligibility committee made up of representatives from the Department of Human Services, Division of Behavioral Health Services (DBHS) and the Division of Developmental Disabilities Services (DDS). Before an application is reviewed by this committee the individual must have a documented behavioral health diagnosis and a documented developmental disability. Each individual must be determined to meet the eligibility criteria for ICF/IID, and be assessed by the DHS third party contractor and determined to be a Tier 2 or Tier 3 on the functional assessment for HCBS services. The dual diagnosis committee must review these determinations and find that the services offered by the 1915(i) will address the individual's functional deficits better than other HCBS service options. For the behavioral health population, the individual must have a behavioral health diagnosis and have received a Tier 2 or Tier 3 on the functional assessment for HCBS behavioral health services conducted by DHS's third party contractor and be enrolled in a Provider-Led Arkansas Shared Savings Entity (PASSE). DHS will use at least fifty percent (50%) of the premium tax that will be collected from the PASSEs to fund additional 1915(c) CES Waiver slots, and the premium tax will also be used to fund the cost of 1915(i) Services for Community Independence for individuals with developmental disabilities that meet the following criteria: the individual must have a developmental disability diagnosis, have received a Tier 2 or Tier 3 determination on the functional assessment for HCBS developmental disability services conducted by DHS's third party contractor, and be enrolled in a PASSE. We expect to begin the 1915(i) services for these individuals on July 1, 2019. For beneficiaries with BH service needs: a. Tier II – At this level of need, services are provided in a counseling services setting but the level of need requires a broader array of services. b. Tier III – Eligibility for this level of need will be identified by additional criteria, which could lead to inpatient admission or residential placement. For beneficiaries with Developmental Disabilities (DD) service needs: a. Tier II – The individual meets the institutional level of care criteria and is eligible to receive paid services and supports. b. Tier III – The individual meets the institutional level of care criteria and is eligible for the most intensive level of services, including 24 hours-a-day/7 days a week paid services and supports. For beneficiaries who are dually-diagnosed (Behavioral Health and Developmental Disabilities

services needs):

a. The member meets the institutional level of care criteria by the Division of Developmental Disabilities (DDS) and has received an Independent Assessment and been determined to meet Tier II or Tier III Level of Care.

i. Individuals who have a primary diagnosis that is a behavioral health or intellectual/developmental disability and a secondary diagnosis that is a behavioral health or intellectual/developmental disability (both diagnoses cannot be behavioral health or developmental disability); and

ii. Have met the institutional level of care for ICF/IID; and

iii. Have received an IA and are eligible for Tier II or Tier III behavioral health services.

iv. The DHS Dual Diagnosis Evaluation Committee must review and approve all members that will be placed into the dually-diagnosed category.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

For the behavioral health population, the assessor must have a Bachelor's Degree or be a registered nurse with one (1) year of experience with mental health populations.

For the developmental disability population, the assessor must have at least two (2) years' experience working with the intellectually or developmentally disabled population and meet the qualifications of a Qualified Developmental Disability Professional (QDDP). The QDDP qualifications are the same as the qualifications of a care coordinator, set out in the Section on Person Centered Plan and Service Delivery, pg. 13, #5.

For the dually diagnosed, the assessor may either of the qualifications above.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Dually diagnosed clients:

1) must have a documented behavioral health diagnosis and a documented developmental disability. These diagnoses must be made a physician and be contained in the individual's existing medical record;
2) Must meet the institutional level of care criteria set forth by the Division of Developmental Disabilities Services for admission into an ICF/IID or CES Waiver;
3) Must have been deemed a Tier 2 or Tier 3 by the independent assessment of functional need related to diagnosis; and
4) Must be determined appropriate for HCBS State Plan services by the DHS Dual Diagnosis Evaluation Committee. The DHS Dual Diagnosis Evaluation Committee will be made up of clinicians and programmatic experts that work for or contract with the Division of Developmental Disabilities Services, the Division of Aging, Adult, and Behavioral Health Services, and the Division of Medical Services within the Arkansas Department of Human Services. This committee will be responsible for reviewing any cases presented for consideration to place the individual into a dual-diagnosed rate cell within the PASSE program and deemed eligible for the 1915(i) HCBS services.

Behavioral Health clients:

1) Must have a documented behavioral health diagnosis, made by a physician and contained in the individual's medical record; and
2) Must have been deemed a Tier 2 or Tier 3 by the independent assessment of functional need related to diagnosis.

Developmentally disabled clients:
1) Must have a documented developmental disability diagnosis, made by a physician and contained in the individual's medical record; and
2) Must have been deemed a Tier 1, Tier 2, or Tier 3 by the independent assessment of functional need related to diagnosis.

The dually diagnosed must undergo the Independent Assessment annually and be deemed appropriate for HCBS State Plan Services by the DHS Dual Diagnosis Evaluation Committee annually.

Behavioral health clients must undergo the Independent Assessment and be deemed a Tier 2 or Tier 2 annually.

The Developmentally Disabled clients must be deemed appropriate and eligible for HCBS State Plan Services by the Division of Developmental Disability Services annually. They must undergo the Independent Assessment at least every three (3) years. The independent assessment determines the Tier level of the client and the corresponding PMPM.

4. ☑ **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

For the dual diagnosed population, each individual must be determined to meet the eligibility criteria for ICF/IID, and be assessed by the DHS third party contractor and determined to be a Tier 2 or Tier 3 on the functional assessment for HCBS services. The dual diagnosis committee must review these determinations and find that the services offered by the 1915(i) will address the individual's functional deficits better than other HCBS service options.

For the behavioral health population, the individual must have a behavioral health diagnosis and have received a Tier 2 or Tier 3 on the functional assessment for HCBS behavioral health services conducted by DHS's third party contractor.

For the developmental disabilities population, the individual must have developmental disabilities diagnosis and have received a Tier 1, Tier 2, or Tier 3 on the functional assessment for HCBS developmental disabilities services conducted by DHS's third party contractor.

The functional assessment takes into account the individuals' ability to provide his or her own support, as well as other natural support systems, as well as the level of need to accomplish ADLs and IADLs.

For the dually diagnosed, the DHS Dual Diagnosis Evaluation Committee then looks at the individual's level of need and whether or not the HCBS state plan services can address those needs better than other services.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised

institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Dual Diagnosed: 1) Meet ICF/IID level of care; 2) Assessed as Tier 2 or 3 on the independent assessment; 3) Have a documented behavioral health diagnosis and developmental disability; and 4) Determined that services on the 1915(i) are more appropriate than CES Waiver services. Behavioral Health: 1) Have a documented behavioral health diagnosis; and 2) Assessed as a Tier 2 or 3 on the independent assessment. Developmental Disability: 1) Have a documented developmental disability diagnosis; and 2) Assessed as a Tier 1, Tier 2 or Tier 3 on the independent assessment; and 3) Enrolled in a PASSE. For the dual diagnosed population, each individual must be determined to meet the eligibility criteria for ICF/IID, and be assessed by the DHS third party contractor and determined to be a Tier 2 or Tier 3 on the functional assessment for HCBS services. The dual diagnosis committee	Must meet at least one of the following three criteria as determined by a licensed medical professional: 1. The individual is unable to perform either of the following: A. At least one (1) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or, B. At least two (2) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without limited assistance from another person; or, 2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or, 3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening. 4. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied	1) Diagnosis of developmental disability that originated prior to age of 22; 2) The disability has continued or is expected to continue indefinitely; and 3) The disability constitutes a substantial handicap to the person's ability to function without appropriate support services, including but not limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment. Must also be in need of and able to benefit from active treatment and unable to access appropriate services in a less restrictive setting.	There must be a written certification of need (CON) that states that an individual is or was in need of inpatient psychiatric services. The certification must be made at the time of admission, or if an individual applies for Medicaid while in the facility, the certification must be made before Medicaid authorizes payment. Tests and evaluations used to certify need cannot be more than one (1) year old. All histories and information used to certify need must have been compiled within the year prior to the CON. In compliance with 42 CFR 441.152, the facility-based and independent CON teams must certify that: A. Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary; B. Proper treatment of the beneficiary's psychiatric condition requires inpatient services under the direction of a physician and C. The services can be reasonably expected to prevent further regression or to improve the beneficiary's condition so that the services will no longer be needed.

must review these determinations and find that the services offered by the 1915(i) will address the individual's functional deficits better than other HCBS service options. For the behavioral health population, the individual must have a behavioral health diagnosis and have received a Tier 2 or Tier 3 on the functional assessment for HCBS behavioral health services conducted by DHS's third party contractor. For the developmental disabilities population, the individual must have developmental disabilities diagnosis and have received a Tier 1, Tier 2, or Tier 3 on the functional assessment for HCBS developmental disabilities services conducted by DHS's third party contractor. The functional assessment takes into account the individuals' ability to provide his or her own support, as well as other natural support systems, as well as the level of need to accomplish ADLs and IADLs. For the dually diagnosed, the DHS Dual Diagnosis Evaluation Committee then looks at the individual's level of need and whether or not the HCBS state plan services can address those needs better than other services.	or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition which is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition which would render the individual ineligible if expected to last more than twenty-one (21) days.		

*Long Term Care/Chronic Care Hospital **LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Targeted to individuals with a behavioral health diagnosis, a developmental disability diagnosis, or those dually diagnosed with a behavioral health and developmental disability diagnosis.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. *(Specify the phase-in plan):*

(By checking the following box the State assures that):

8. ☑**Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. ☑ **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) 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 person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: One.
ii.	**Frequency of services.** The state requires (select one):
X	**The provision of 1915(i) 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 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

This Waiver, along with the concurrent 1915(b) PASSE Waiver and 1915(c) Community and Employment Supports Waiver, will be subject to the HCBS Settings requirements and therefore must be included in the State Wide Transition Plan.

The Division of Medical Services (DMS) is the State Medicaid Agency (SMA) responsible for operating this 1915(i) Waiver impacted by the HCBS Settings Rule. The purpose of this waiver is to support individuals of all ages who have a behavioral health diagnosis, a developmental disability diagnosis, or a dual diagnosis of behavioral health and developmental disability, and who choose to receive services within their community. The person-centered service plan offers an array of services that allow flexibility and choice for the participant. Services are provided in the member's home and community with coordination and oversight from the member's PASSE.

Individuals served by the 1915(i) Waiver choose to reside in the community and receive HCBS services in their home. The home may be the person's home, the home of a family member or friend, a group home, a provider owned or controlled apartment, or the home of a staff person who is employed by the HCBS provider. It is assumed that people who live in their own home or the home of a family member or friend who is not paid staff receive services in a setting that complies with requirements found at 42 CFR 441.301(c)(4).

The Provider-Led Arkansas Shared Savings Entity (PASSE) to which the member is attributed provides care coordination and develops the Person-Centered Service Plan (PCSP). The PASSE's care coordinator assesses the

person's needs and wants and facilitates the development of the person-centered plan, including the selection of services providers in the PASSE's network. DMS and its agent (including DDS) will monitor the development of the PCSP and the provision of services by the PASSE. Information on the HCBS Settings rule will be included in annual training opportunities for PASSE care coordinators and DMS's monitoring staff.

The PASSE is responsible for credentialing their HCBS providers; as such, they must ensure that homes where those provides serve members comply with the HCBS settings rule. As the oversight agency, DMS has set up an inter-divisional work group who has met since 2014, and will continue to meet. The work group has reviewed the regulations

Assessment of Compliance with Residential and Non-Residential Settings Requirements

An inter-divisional HCBS Settings working group has met regularly since 2014 and will continue to meet during the implementation of the Statewide Transition Plan (STP). The working group consists of representatives from DAAS, DDS, and Division of Medical Services (DMS) within the Arkansas Department of Human Services. The working group initially met to review the new regulations and develop the initial STP and corresponding timeline. DMS will convene this working group to set applicable standards for PASSE HCBS settings. It will be expected that PASSE organizations implement these standards, and the federal HCBS Settings Rule into their provider agreements and credentialing standards.

Agents of DMS will be assigned to review teams. The review teams will conduct reviews of randomly selected provider owned or controlled apartments and group homes.

Upon completion of the review, notes from the review team member will be summarized in a standard report and sent to the Provider and the PASSE. The report will summarize the visit, noted areas needing improvement that were observed and documented, requested clarification of provider policies and procedures and/or a corrective action plan. A deadline will be given to the provider and the PASSE to provide this information and technical assistance for DMS and the Settings working group will be provided.

Ongoing Training

DMS and the HCBS Settings working group will develop and conduct PASSE and provider trainings, as well as provided tailored technical assistance to partially compliant and non-compliant providers.

Heightened Scrutiny

DMS recognizes that certain settings are presumed non-compliant with the HCBS Settings requirements. Specifically, some home and community based settings have institutional qualities – those settings that are publicly or privately owned facilities that provide inpatient treatment, those settings that are located on the grounds of, or immediately adjacent to, a public institution, or those settings that have the effect of isolating individuals from the broader community. These settings include those that are located on or near the grounds of an institution and settings which may isolate individuals from the community. These settings include group homes located on the grounds of or adjacent to a public institution, numerous group homes co-located on a single site, a disability-specific farm-like service setting and apartments located in apartment complexes also occupied by persons who do not receive HCBS services. DMS will identify these settings and require the PASSE implement heightened scrutiny for those settings presumed not to be home and community based.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

For the behavioral health population, the assessor must have a Bachelor's Degree or be a registered nurse with one (1) year of experience with mental health populations.

For the developmental disabilities population, the assessor must have at least two (2) years' experience with the intellectually or developmentally disabled populations and meet the requirements of a QDDP.

For the dually diagnosed, the assessor may meet either of the above qualifications.

5. **Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The Provider Led Arkansas Shared Savings Entity (PASSE) Care coordinator is responsible for providing care coordination to all clients receiving State plan HCBS services, including development of the PCSP. The care coordination service is offered through the 1915(b) Waiver and is described in detail in Section A, Part I-F(8). These care coordinators must meet the following qualifications:

1. Be a registered nurse, a physician or have a bachelor's degree in a social science or a health-related field; or
2. Have at least one (1) year experience working with developmentally or intellectually disabled clients or behavioral health clients.

6. **Supporting the Participant in Development of Person-Centered Service Plan.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

From the time an individual makes contact with DHS Beneficiary Support regarding receiving HCBS state plan services, DHS informs the individual and their caregivers of their right to make choices about many aspects of the services available to them and their right to advocate for themselves or have a representative advocate on their behalf. It is the responsibility of everyone at DHS, the PASSE who

receives attribution and provides care coordination, and the services providers to make sure that the PASSE member is aware of and is able to exercise their rights and to ensure that the member and their caregivers are able to make choices regarding their services.

The PASSE's care coordinator is responsible for scheduling and coordinating the PCSP development meeting. As part of this responsibility the care coordinator must ensure that anyone the member wishes to be present is invited. Typically, the development team will consist of the member and their caregivers, the care coordinator, service providers, professionals who have conducted assessments or evaluations, and friends and persons who support the member. The care coordinator must ensure that the member does not object to the presence of any participants to the PCSP development meeting. If the member or the caregiver would like a party to be present, the care coordinator is responsible for inviting that individual to attend.

During the PCSP development meeting, everyone in attendance is responsible for supporting and encouraging the member to express their wants and desires and to incorporate them into the PCSP when possible. The care coordinator is responsible for managing and resolving any disagreements which arise during the PCSP development meeting.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Before a PASSE member can access HCBS state plan services, they must be enrolled in a PASSE under the 1915(b) Provider Led Shared Savings Entities Waiver. The PASSE is responsible for providing all needed services to all enrolled members and may limit a member's choice of providers based on its provider network. The provider network must meet minimum adequacy standards set forth in the 1915(b) Waiver, the PASSE Provider Manual, and the PASSE provider agreement.

The member has 90 days after initial enrollment to change their assigned PASSE. Once a year, there is a 30-day open enrollment period, in which the member may change their PASSE for any reason. At any time during the year, a member may change their PASSE for cause, as defined in 42 CFR 438.56.

The State has a Beneficiary Support Office to assist the member in changing PASSE's, including informing the member of their rights regarding choosing another PASSE and how to access information on each PASSE's provider network. The Beneficiary Support Office will begin reaching out to a beneficiary once it is determined he or she meets the qualifications to be enrolled in a PASSE.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

Immediately following enrollment in a PASSE, the PASSE care coordinator must develop an interim service plan (ISP) for member. If the member was already enrolled in a program that required PCSPs, then that PCSP may be the ISP for the member. The ISP may be effective for up to 60 days, pending completion of the full PCSP.

After enrollment, and prior to the PCSP development meeting, the care coordinator must conduct a health questionnaire with the member. The care coordinator must also secure any other information that may be needed to develop the PCSP, including, but not limited to:

a) Results of any evaluations that are specific to the needs of the member;

b) The results of any psychological testing;

c) The results of any adaptive behavior assessments;

d) Any social, medical, physical, and mental health histories; and

e) A risk assessment.

The PCSP development team must utilize the results of the independent assessment, the health questionnaire, and any other assessment information gathered. The PCSP must include the member's goals, needs (behavioral, developmental, and health needs), and preferences. All needed services must be noted in the PCSP and the care coordinator is responsible for coordinating and monitoring the implementation of the PCSP.

The PCSP must be developed within 60 days of enrollment into the PASSE. At a minimum, the PCSP must be updated annually.

DMS, or its designated agent, arranges for a specified number of service plans to be reviewed annually, using the sampling guide, "A Practical Guide for Quality Management in Home and Community-Based Waiver Programs," developed by Human Services Research Institute and the Medstat Group for CMS in 2006. A systematic random sampling of the active case population is drawn whereby every "nth" name in the population is selected for inclusion in the sample. The sample size is based on a 95% confidence interval with a margin of error of +/- 8%. 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.

DMS, or its agent, then requires the PASSE to submit the PCSP for all individuals in the sample. DMS or its agent conducts a retrospective review of provided PCSPs based on identified program, financial, and administrative elements critical to quality assurance. DMS or its agent reviews the plans to ensure they have been developed in accordance with applicable policies and procedures, that plans ensure the health and welfare of the member, and for financial and utilization components. DMS or its agent communicates findings from the review to the PASSE for remediation. Systemic findings may necessitate a change in policy or procedures. A pattern of non-compliance from one PASSE may result in sanctions to that PASSE under the PASSE Provider Manual and Provider Agreement.

9. **Maintenance of Person-Centered Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

	Medicaid Agency		Operating Agency		Case Manager
X	Other *(Specify)*: The PASSE				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Supported Employment
Service Definition (Scope):	
Helps members acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany members on interviews and providing ongoing support and/or on-the-job training once the member is employed. This service replaces traditional vocational approaches that provide immediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries from mainstream society. Service settings may vary depending on individual need and level of community integration, and may include the member's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Must be listed in the Member's PCSP.	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Behavior Assistance

Service Definition (Scope)*:*

A specific outcome oriented intervention provided individually or in a group setting with the member and/or their caregivers that will provide the necessary support to attain the goals of the PCSP and the behavioral health treatment plan. Service activities include applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The service activity should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life and strengthen skills in a variety of life domains.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be documented in the PCSP.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver

Disabilities and Behavioral Health Diagnoses			program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Adult Rehabilitation Day Treatment

Service Definition (Scope)*:*

A continuum of care provided to recovering members living in the community based on their level of need. This service includes educating and assisting the members with accessing supports and services needed. The service assists recovering members to direct their resources and support systems. Activities include training to assist the member to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular environment. Adult rehabilitation day treatment includes training and assistance to live in and maintain a household of their choosing in the community. In addition, activities can include transitional services to assist members after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

Adult rehabilitative day treatment is an array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified members that are aimed at long-term recovery and maximization of self-sufficiency. These rehabilitative day activities are person and family centered, recovery based, culturally competent, and provided needed accommodation for any disability. These activities must also have measurable outcomes directly related to the member's PCSP. Day treatment activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his or her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing;

community integration skills and any similar skills required to implement the member's behavioral health treatment plan or PCSP.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Must be listed in the PCSP.
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☑	Categorically needy *(specify limits):*
	Staff to member ratio: 1:15 maximum
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Peer Support

Service Definition (Scope):
A person-centered service provided by individuals, 18 and older, who self-identify as someone who has received or is receiving behavioral health services and, thus, is able to provide expertise not replicated by professional training. Peer support providers are trained peer specialists who work with members to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Peer support specialists may assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which improve the member's functional ability. Services are provided on an individual or group basis, and may be provided in the home or the community.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Must be in the member's PCSP.
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*
☑ Categorically needy *(specify limits):*
None
☐ Medically needy *(specify limits):*
N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:			
	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Family Support Partners
Service Definition (Scope)*:*	
A service provided by peer counselors, of Family Support Partners (FSP), who model recovery and resiliency for caregivers of children and youth with behavioral health care needs. FSP come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency. A FSP may assist, teach and model appropriate child-rearing strategies, techniques and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations, and childcare activities. It may also assist the member's family in securing resources and developing natural supports.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Must be in the PCSP.	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based	DMS	Annually. Proof of credentialing must be

Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses		submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Pharmaceutical Counseling

Service Definition (Scope)*:*

A one-to-one or group intervention by a nurse with member(s) and/or their caregivers, related to their psychopharmalogical treatment. Pharmaceutical Counseling involves providing medication information orally or in written form to the member and/or their caregivers. The service should encompass all the parameters to make the member and/or family understand the diagnosis prompting the need for medication and any lifestyle modifications required.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be on the PCSP.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses.	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Supportive Life Skills Development

Service Definition (Scope)*:*

A service that provides support and training for youth and adults on a one-on-one or group basis. This service should be a strength-based, culturally appropriate process that integrates the member into their community as they develop their recovery plan or habilitation plan. This service is designed to assist members in acquiring the skills needed to support as independent a lifestyle as possible, enable them to reside in their community (in their own home, with family, or in an alternative living setting), and promote a strong sense of self-worth. In addition, it aims to assist members in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living.

Topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, socialization, community integration, wellness, and nutrition. For clients with developmental or intellectual disability, life skills development may focus on acquiring skills to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as communication, bathing, grooming, cooking, shopping, or budgeting.

The PCSP should address the recovery or habilitation objective of each activity performed under Life Skills Development and Support.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be listed in PCSP. In group setting, a client to staff ratio of 10:1.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*

	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Child and Youth Support

Service Definition (Scope)*:*

Clinical services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home; working with teachers/schools to modify classroom environment to increase positive behaviors in the classroom; and increase a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of illness and training the parents in effective interventions and techniques for working with the schools.

Service activities may include an In-Home Case Aide, which is an intensive therapy in the member's home or a community-based setting. Youth served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out-of-home placement. Services may deal with family issues related to the promotion of healthy family interactions, behavior training, and feedback to the family.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be on the PCSP.
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☑	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Therapeutic Communities
Service Definition (Scope):	
A non-facility based setting that emphasizes the integration of the member within his or her community; progress is measured within the context of that community's expectation. Therapeutic Communities are	

highly structured environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the member on their PCSP. Therapeutic Communities employ community imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the community setting. Participants and staff members act s facilitators, emphasizing self-improvement.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be in the PCSP.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Residential Community Reintegration

Service Definition (Scope)*:*

Serves as an intermediate level of care between Inpatient Psychiatric facilities and outpatient behavioral health services. The program provides 24 hours per day intensive therapeutic care in a small group home setting for children and youth with emotional and/or behavior problems which cannot be remedied with less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. Community reintegration may be offered as a step-down or transitional level of care to prepare a youth for less intensive treatment.

Residential Community Reintegration programs must ensure (1) there are a minimum of two direct care staff available at all times; and (2) educational services are provided to all beneficiaries enrolled in the program.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be in the PCSP.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental	DMS	Annually. Proof of credentialing must be submitted to DMS.

Disabilities and Behavioral Health Diagnoses		

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Outpatient Substance Abuse Treatment

Service Definition (Scope)*:*

Group based, non-residential, intensive and structured interventions to improve symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). These interventions consist of primarily counseling and education

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and	DMS	Annually. Proof of

Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses		credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Crisis Intervention

Service Definition (Scope)*:*

Crisis intervention is an unscheduled, immediate, short-term treatment activity(ies) provided to a member who is experiencing a psychiatric or behavioral crisis. Crisis Intervention is delivered in the member'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 who are in need of non-physical intervention to maintain or re-establish a behavior management or positive programming plan.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as

for Persons with Developmental Disabilities and Behavioral Health Diagnoses			defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Planned Respite

Service Definition (Scope)*:*

Temporary direct care and supervision for a beneficiary due to the absence or need for relief of the non-paid primary caregiver. Planned respite can occur at medical or specialized camps, day-care programs, the member's home or place of residence, the respite care provider's home or place of residence, foster homes, or a licensed respite facility.

The primary purpose of Planned Respite is to relieve the principal care giver of the member with a behavioral health need so that stressful situations are de-escalated and the care giver and member have a therapeutic and safe outlet.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be in the PCSP.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:			
	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Emergency Respite
Service Definition (Scope)*:*	
Temporary direct care and supervision for a member who is experiencing an acute behavioral crisis. Emergency respite can occur in a facility setting. The primary purpose of Emergency Respite is to de-escalate stressful situations and return the member back into the community.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
None.	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*

	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Mobile Crisis Intervention

Service Definition (Scope):

A short-term, on-site, face-to-face therapeutic response to a member experiencing a behavioral health crisis for the purpose of identifying, assessing, treating and stabilizing the situation and reducing immediate risk of danger to the member or others consistent with the member's risk management/safety plan, if available. This service is available 24 hours per day, seven days per week, and 365 days per year; and is available after hours and on weekends when access to immediate response is not available through appropriate agencies.

The service includes a crisis assessment, engagement in a crisis planning process, which may result in the development /update of one or more Crisis Planning Tools (Safety Plan, Advanced Psychiatric Directive, etc.) that contain information relevant to and chosen by the beneficiary and family, crisis intervention and/or stabilization services including on-site face-to-face therapeutic response, psychiatric

consultation, and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services and supports, including access to appropriate services along the behavioral health continuum of care.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Therapeutic Host Homes

Service Definition (Scope)*:*

A home or family setting that that consists of high intensive, individualized treatment for the member whose behavioral health or developmental disability needs are severe enough that they would be at risk of placement in a restrictive residential setting.

A therapeutic host parent is trained to implement the key elements of the member's PCSP in the context of family and community life, while promoting the PCSP's overall objectives and goals. The host parent should be present at the PCSP development meetings and should act as an advocate for the member.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be in the PCSP.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses		N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and	DMS	Annually. Proof of credentialing must be submitted to DMS.

Behavioral Health Diagnoses		

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Recovery Support Partners (for Substance Abuse)

Service Definition (Scope)*:*

A continuum of care provided to recovering members living in the community. Recovery Support partners may educate and assist the individual with accessing supports and needed services, including linkages to housing and employment services. Additionally, the Recovery Support Partner assists the recovering member with directing their resources and building support systems. The goal of the Recovery Support Partner is to help the member integrate into the community and remain there.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Must be in the PCSP.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and	DMS	Annually. Proof of credentialing must be submitted to DMS.

Behavioral Health Diagnoses		

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Substance Abuse Detoxification (Observational)

Service Definition (Scope)*:*

A set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize the member by clearing toxins from his or her body. Detoxification (detox) services are short term and may be provided in a crisis unit, inpatient, or outpatient setting. Detox services may include evaluation, observation, medical monitoring, and addiction treatment. The goal of detox is to minimize the physical harm caused by the abuse of substances and prepare the member for ongoing substance abuse treatment.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

2. ☑**Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

a) Relatives may be paid to provide HCBS services, provided they are no the parent, legally responsible individual, or legal guardian of the member.
b) The HCBS services that relatives may provide are: supported employment, peer support, family support partners, therapeutic host home, life skills development, and planned respite.
c) All relatives who are paid to provide the services must meet the minimum qualifications set forth in this Waiver and may not be involved in the development of the Person Centered Service Plan (PCSP).
d) These individuals must be monitored by the PASSE to ensure the delivery of services in accordance with the PCSP. Each month, the care coordinator will monitor the delivery of services and check on the welfare of the member.
e) Payments are not made directly from the Medicaid agency to the relative. Instead, the State pays the PASSE a per member per month (PMPM) prospective payment for each attributed member. The PASSE may then utilize qualified relatives to provide the service.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

Election of Participant-Direction. (Select one):

⊙	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

1. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

2. **Limited Implementation of Participant-Direction.** *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

3. **Participant-Directed Services.** *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

4. Financial Management. (*Select one)* :

	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

5. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and Specifies the financial management supports to be provided.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. **Participant–Employer Authority** *(individual can select, manage, and dismiss State plan HCBS providers). (Select one):*

	The state does not offer opportunity for participant-employer authority.	
	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. **Participant–Budget Authority** *(individual directs a budget that does not result in payment for medical assistance to the individual). (Select one):*

	The state does not offer opportunity for participants to direct a budget.
	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*

	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

3. Providers meet required qualifications.

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

5. The SMA retains authority and responsibility for program operations and oversight.

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	Requirement 1: Service Plans Address Needs of Participants, are reviewed annually and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	The percentage of PCSPs developed by PASSE Care Coordinators that Meet the requirements of 42 CFR §441.725. Numerator: Number of PCSPs that adequately and appropriately address the beneficiary's needs. Denominator: Total Number of PCSPs reviewed.
Discovery Activity *(Source of Data & sample size)*	A representative sample will be used based on the sample size selected for PCSP review by DMS. The sample size will be determined using a confidence interval of 95% with a margin of error of +/-8%. The data will be derived from the PASSE and must include copies of the PCSP and all updates, the Independent Assessment, the health questionnaire and other documentation used at the PCSP development meeting.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or its agents

Requirement	Requirement 1: Service Plans
Frequency	Sample will be selected and reviewed annually.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PASSE will be responsible for remediating deficiencies in PCSPs of their attributed beneficiaries. If there is a pattern of deficiencies noticed, action will be taken against the PASSE, up to and including, instituting a corrective action plan or sanctions pursuant to the PASSE Provider Agreement.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and findings will be reported to the PASSE annually. If a pattern of deficiency is noted, this may be made public.

Requirement	Requirement 2: Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence One *(Performance Measure)*	The percentage of beneficiaries who are evaluated to meet the Level of Care for ICF/IID by the DDS psychology unit, receive the independent functional assessment, and are determined appropriate for 1915(i) HCBS State Plan Services by the DHS Dual Diagnosis Evaluation Committee in a timely manner and without undue delay. Numerator: The number of beneficiaries who are evaluated and assessed for eligibility in a timely manner. Denominator: The total number of beneficiaries who are identified for the 1915(i) HCBS State Plan Services eligibility process.
Discovery Activity One *(Source of Data & sample size)*	A 100% sample of the application packets for beneficiaries who undergo the eligibility process will be reviewed for compliance with the timeliness standards. The data will be collected from the Independent Assessment Vendor, the DDS Psychology Unit, and the DHS Dual Diagnosis Evaluation Committee.
Monitoring Responsibilities *(Agency or entity that conducts*	DMS or its agents

discovery activities)	
Discovery Evidence Two	The Percentage of beneficiaries for whom the appropriate eligibility process and instruments were used to determine initial eligibility for HCBS State Plan Services. Numerator: Number of beneficiaries' application packets that reflect appropriate processes and instruments were used. Denominator: Total Number of application packets reviewed.
Discovery Activity Two	A 100% sample of the application packets for beneficiaries who went through the eligibility determination process will be reviewed. The data will be collected from the Independent Assessment Vendor, the DDS Psychology Unit, and the DHS Dual Diagnosis Evaluation Committee.
Monitoring Responsibility	DMS or its agents.
Discovery Evidence Three	The percentage of beneficiaries who are re-determined eligible for HCBS State Plan Services before their annual PCSP expiration date. Numerator: The number of beneficiaries who are re-determined eligible timely (before expiration of PCSP). Denominator: The total number of beneficiaries re-determined eligible for HCBS State Plan Services.
Discovery Activity Three	A 100% sample of the application packets for beneficiaries who went through the eligibility re-determination process will be reviewed. The data will be collected from the Independent Assessment Vendor, the DDS Psychology Unit, and the DHS Dual Diagnosis Evaluation Committee.
Monitoring Responsibilities	DMS or its agents.

Requirement	Requirement 2: Eligibility Requirements
Frequency	Sample will be selected and reviewed quarterly.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	For DDS ICF/IID Level of Care Determinations: The Psychology Unit Manager reviews 100% of all applications submitted within the previous quarter for process and instrumentation review. If a pattern of deficiency is found, the Psychology Unit Manager works with the Psychology Staff to develop a corrective action plan, to be implemented within 10 days. Results are tracked and submitted to the appropriate DMS office quarterly, along with any corrective action plans. For Independent Functional Assessments: The Independent Assessment Vendor

timeframes for remediation)	is responsible for developing and implementing a quality assurance process, which includes monitoring for accuracy, data consistency, integrity, and completeness of assessments, and the performance of staff. This must include a desk review of assessments with a statistically significant sample size. Of the reviewed assessments, 95% must be accurate. The Independent Assessment Vendor submits monthly reports to DHS's contract monitor. When deficiencies are noted, a corrective action plan will be implemented with the Vendor. For the DHS Dual Diagnosis Evaluation Committee: The Committee will examine all application packets reviewed to ensure review was timely and accurate. The Committee will submit quarterly reports to the appropriate DMS staff; these reports will identify any systemic deficiencies and corrective action that will be taken. If corrective action was taken in the previous quarter, the quarterly report will update DMS on the implementation of that corrective action plan.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported quarterly.

Requirement	Requirement 3: Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percentage of providers certified and credentialed by the PASSE. Numerator: Number of provider agencies that obtained annual certification in accordance with PASSE's standards. Denominator: Number of HCBS provider agencies reviewed.
Discovery Activity *(Source of Data & sample size)*	100% of HCBS providers credentialed by the PASSEs will be reviewed by DMS or its agents during the annual readiness review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or its agents

Requirement	Requirement 3: Providers meet required qualifications.
Frequency	Annually, during readiness review.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for*	Remediation associated with provider credential and certification that is not current would include additional training for the PASSE, as well as remedial or corrective action, including possible recoupment of PMPM payments. Additionally, if a PASSE does not pass the annual readiness review, enrollment in the PASSE may potentially be suspended.

remediation)	
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported annually.

Requirement	Requirement 4: Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of provider owned apartments or homes that meet the home and community-based settings requirements. Denominator: Number of provider owned apartments and homes that meet the HCBS Settings requirements in 42 CFR 441.710(a)(1) & (2). Numerator: Number of provider owned apartments and homes that are reviewed by the DMS Settings review teams.
Discovery Activity *(Source of Data & sample size)*	Review of the Settings Review Report sent to PASSEs. The reviewed apartments or homes will be randomly selected. A typical review will consist of at least 10% of each PASSE providers' apartments and homes each year.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or its agents.

Requirement	Requirement 4: Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Frequency	Provider owned homes and apartments will be reviewed and the report compiled annually.
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PASSE will be responsible for ensuring compliance with HCBS Settings requirements. If there is a pattern of deficiencies noticed by DMS or its agents, action will be taken against the PASSE, up to and including, instituting a corrective action plan or sanctions pursuant to the PASSE Provider Agreement.
Frequency *(of Analysis and Aggregation)*	Annually.

Requirement	Requirement 5: The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percentage of policies developed must be promulgated in accordance with the DHS agency review process and the Arkansas Administrative Procedures Act (APA). Numerator: Number of policies and procedures appropriately promulgated in accordance with agency policy and the APA; Denominator: Number of policies and procedures promulgated.
Discovery Activity *(Source of Data & sample size)*	100% of policies developed must be reviewed for compliance with the agency policy and the APA.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or its agents

Requirement	Requirement 5: The SMA retains authority and responsibility for program authority and oversight.
Frequency	Continuously, and as needed, as each policy is developed and promulgated.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	DHS's policy unit is responsible for compliance with Agency policy and with the APA. In cases where policy or procedures were not reviewed and approved according to DHS policy, remediation includes DHS review of the policy upon discovery, and approving or removing the policy.

timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Each policy will be reviewed for compliance with applicable DHS policy and the APA.

Requirement	Requirement 6: The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery Evidence One *(Performance Measure)*	Number and percentage of services delivered and paid for with the PMPM as specified by the member's PCSP. Numerator: Number of provider agencies reviewed or investigated who delivered and paid for services as specified in the PCSP. Denominator: Total number of provider agencies reviewed or investigated.
Discovery Activity One *(Source of Data & sample size)*	Utilization review of a random sampling of member's services will be conducted to compare services delivered to the member's PCSP.
Discovery Evidence Two	Each PASSE meets its own established Medical Loss Ratio (MLR). Numerator: Number of PASSE's that meet the MLR; Denominator: Total number of PASSE's
Discovery Activity Two	The PASSE must report its MLR on the Benefits Expenditure Report, required to be submitted to DMS on a quarterly basis.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or its agents

Requirement	Requirement 6: The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Frequency	Quarterly.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMS's IDSR Office and its agents are responsible for oversight of the PASSE's including review of the quarterly Beneficiary Expenditure Report and the utilization review.
Frequency *(of Analysis and Aggregation)*	Data will be gathered quarterly.

Requirement	Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percentage of HCBS Provider entities that meet criteria for abuse and neglect reporting training for staff. Numerator: Number of provider agencies investigated who complied with required Abuse and neglect training set out in the Waiver and the PASSE provider agreement; Denominator: Total number of provider agencies reviewed or investigated.
Discovery Activity *(Source of Data & sample size)*	100% of PASSE training records will be reviewed at the annual readiness review; additionally, training records for individual HCBS providers or employees may be reviewed when there is a compliant of abuse or neglect.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or its agents

Requirement	Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Frequency	Annually, and continuously, as needed, when a compliant is received.
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMS's IDSR Office and its agents are responsible for oversight of the PASSE's including readiness review. This review will include an audit of all training records.
Frequency *(of Analysis and Aggregation)*	Data will be gathered annually at readiness review. Individual Provider training records will be reviewed at the time of any complaint investigation.

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

By using encounter data, the State will have the ability to measure the amount of services provided compared to what is described within the Person Centered Service Plan (PCSP) that is required for individuals receiving HCBS State Plan services. The state will utilize the encounter data to monitor services provided to determine a baseline, median and any statistical outliers for those service costs.

Additionally, the state will monitor grievance and appeals filed with the PASSE regarding HCBS State Plan services under the broader Quality Improvement Strategy for the 1915(b) PASSE Waiver.

2. Roles and Responsibilities

The State will work with an External Quality Review Organizations (EQRO) to assist with analyzing the encounter data and data provided by the PASSEs on their quarterly reports.

The State's Beneficiary Support Team will proactively monitor service provision for individuals who are receiving 1915(i) services. Additionally, the team will review PASSE provider credentialing and network adequacy.

3. Frequency

Encounter data will be analyzed quarterly by the State and annually by the EQRO.

Network adequacy will be monitored on an ongoing basis.

4. Method for Evaluating Effectiveness of System Changes

The State will utilize multiple methods to evaluate the effectiveness of system changes. These may include site reviews, contract reviews, encounter data, grievance reports, and any other information that may provide a method for evaluating the effectiveness of system changes.

Any issues with the provision of 1915(i) services that are continually uncovered may lead to sanctions against providers or the PASSE that is responsible for access to 1915(i) services.

The State will randomly audit each PCSP that is maintained by each PASSE to ensure compliance.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

	HCBS Case Management
	HCBS Homemaker
	HCBS Home Health Aide
	HCBS Personal Care
	HCBS Adult Day Health
	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
	HCBS Psychosocial Rehabilitation
	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (Specify below): All HCBS Services provided under the 1915(i): Payment for these services will be made by the PASSE Organized Care entity who will receive a PMPM for each member enrolled in the PASSE. The PMPM was developed based on historical utilization of services by the population being enrolled in the PASSEs. Please see the 1915(b) PASSE Waiver, Appendix D, for more information.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):*_____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26- 05, and Baltimore, Maryland 21244-1850.