

Arkansas Rehabilitation Services, 2020 Rule Revisions – MARK UP

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Summary of Substantive Changes:

These amendments focus on three areas of the Arkansas Rehabilitation Services Policy and Procedure Manual: fee schedules for medical providers, the agency's small-business program, and performance indicators for vocational rehabilitation. The fee-schedule provisions, as amended, will allow for payment using Medicare rates, Arkansas Workers' Compensation rates, a percentage of the provider's bill, or a contract between ARS and the provider.

The small-business program will be amended to clarify that the program administrator reviews business plans for overall feasibility, not for financial contributions by ARS. That decision is left to the vocational-rehabilitation counselor for the person submitting the plan.

There is also a new appendix that addresses the performance indicators used by the federal Rehabilitation Services Administration to assess agencies such as ARS. The appendix describes each indicator and defines the process that ARS follows to track and evaluate the indicators.

SURGICAL AND HOSPITAL INSURANCE

Insurance benefits must be used first in paying for surgical and medical services. ARS will pay the billed amount after comparable services, similar benefits and insurance are applied. The authorized payment will be based on ~~80% of the most current Blue Cross Blue Shield Medicare Fee Schedule.~~ If the service is not covered by Medicare, payment will be based on the current Arkansas Workers' Compensation Fee Schedule (Medical or Laboratory). For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total charges billed for the surgical or medical services. For hospitals or clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount without regard to Medicare or Workers' Compensation-based fee schedules.

[VI-16]

PROCEDURES - ASSISTIVE TECHNOLOGY SERVICES/ REHABILITATION ENGINEERING

- For assistive technology/rehabilitation engineering services associated with a CPT code:
 - ARS will issue payment for assistive technology/rehabilitation engineering services according to the price indicated in the current Blue Cross Blue Shield Medicare or Arkansas Workers' Compensation fee schedule, beginning with Medicare (current as of the date of the invoice) for a given HCPCS line item. ARS will pay 80% of the price indicated in the Blue Cross Blue Shield Medicare Fee Schedule. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total charges billed for the assistive technology or rehabilitation technology.

- ~~For individuals with insurance coverage for assistive technology/rehabilitation engineering services, ARS will issue payment after that insurance coverage for the assistive technology/rehabilitation engineering service has been applied. In no event will ARS pay an amount greater than 80% of the price indicated in the Blue Cross Blue Shield fee schedule for a given HCPCS line item.~~
- For assistive technology/rehabilitation engineering services with no CPT code associated:
 - Access and Accommodations staff will review purchases to ensure the price for the recommended technology is reasonable in the market. A reasonable price will be obtained through competitive bids, following the regulations applicable to ARS as a procurement agency. At least three bids will be solicited.
 - ARS will generally pay 100% of the lowest responsive bid, after accounting for comparable services and benefits, and client participation, as appropriate.

[VI-49 to 50]

Payment for Hearing Aids

- ARS will issue payment for new hearing aids and related devices according to the ~~price indicated in the current Blue Cross Blue Shield Arkansas Workers' Compensation fee schedule (current as of the date of the invoice)~~ for the appropriate L or V code. ~~ARS will pay 80% of the price indicated in the Blue Cross Blue Shield fee schedule for the appropriate L or V code.~~
- For used hearing aids and related devices, ARS will pay 70% of the price indicated for the appropriate L or V code in the Arkansas Workers' Compensation fee schedule.
- For hearing aids and related devices (new or used) not covered by Arkansas Workers' Compensation, ARS will pay up to 50% of the total charges billed.
- For individuals with insurance coverage for hearing aids and related devices, ARS will issue payment after that coverage has been applied. ~~In no event will ARS pay an amount greater than 80% of the price indicated in the Blue Cross Blue Shield fee schedule for a given HCPCS line item.~~

[VI-53]

ARS MEDICAL FEES

~~ARS Fee Schedule is referenced in Section VI. Descriptions~~ The applicable cost of procedures, devices, and other related medical services along with the associated fees are may be found in the

fee schedules maintained by Medicare or the Arkansas Workers' Compensation Commission. Links to these schedules Arkansas Health Information Network's annual Blue Cross/Blue Shield Physician Fee Schedule, Hospital Fee Schedule and Outpatient Fee Schedule to determine the agency's cost for Physical/Mental Restoration or other medical services. This Fee Schedule can be are located on the ARS network. Before applying the fee schedules, ARS counselors must are first to determine if C comparable B benefits are available, including all health insurance plan coverages.

[Appendix I-1]

3. RATES OF PAYMENT

When determining ~~model~~ rates for of payment to third party vendors, reimbursement, ARS first requires that the vendors be properly licensed or accredited. utilizes approved standards of compensation that are recognized authorities or accrediting bodies in the applicable field and establishes that rate for its certified vendors providing goods or services. For example, licensure by the state is recognized by ARS as a criterion for approval of all health care providers. medical providers must be in good standing with the applicable State of Arkansas licensing board or agency. Rates of payment for licensed physician or other authorized health care professionals are set at 80% of the Arkansas Blue Cross Blue Shield rate of pay If properly licensed, medical providers will be paid using the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the medical provider. Similarly, ARS recognizes national accreditation for the approval of colleges and universities as providers. For hospitals or clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount without regard to Medicare or Workers' Compensation-based fee schedules.

[Appendix I-4]

5. MEDICAL REHABILITATION SERVICES

The rate of payment for physician services, dental treatment, glasses, optical aids, and artificial eyes, hearing aids, hospitalization, nursing services, orthotic devices, physical and occupational therapy, prosthetic devices, psychotherapy, speech and hearing therapy, and surgical implants/appliances are based on at 80% of the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider. the Arkansas Blue Cross and Blue Shield fee schedule. Arkansas Blue Cross and Blue Shield uses the Resource Based Relative Value System (RBRVS) as a guide for establishing fees. The RBRVS was developed with input from thousands of providers, and has become industry standard for establishing physician payments. ARS utilizes health care professionals and facilities that have agreed to accept the Arkansas Blue Cross and Blue Shield fee schedule as their maximum payment, and cannot collect amounts greater than the schedule for covered services to those insured by Arkansas Blue Cross and Blue Shield. With hospitals, Arkansas Blue Cross and Blue Shield determines hospital payment rates using the Diagnosis Related Groups (DRGs) classification

~~system which groups hospital patients according to similar diagnostic criteria and other characteristics.~~

5.01 Physician Services

~~Rates of payment for medical services provided by physicians are based on set at 80% of the Arkansas Blue Cross/ Blue Shield rate fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission, as of July 1st of each year, updated annually. Services are identified by CPT code and reimbursed using the fee schedule set by Arkansas Blue Cross/ Blue Shield where possible. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.~~

5.02 Dental Treatment

~~Rates of payment for dental services are based on set at 80% of the Arkansas Blue Cross/ Blue Shield rate fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission, as of July 1st of each year, updated annually. Services are identified by CPT code and reimbursed using the fee schedule set by Arkansas Blue Cross/ Blue Shield where possible. For services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider. If no qualified vendor agrees to accept the rate established for dental services, the counselor may, with the written permission of the district manager that is entered into the client case file, negotiate a reasonable fee based on the lowest of three competitive estimates from vendors in the local area.~~

Insurance benefits must be used first in paying for surgical and medical services. The amount allowed authorized by the ARS Fee Schedule will be authorized followed by the statement "Rehabilitation Services will pay only that part of the authorized amount not covered by the insurance policy up to the maximum amount allowed by the ARS Fee Schedule." (See Appendix I-1.)

The file must document the rational use in price decision: previously proposed prices, contracted prices, market research for the same items.

5.03 Glasses, Optical Aids, and Artificial Eyes

~~Rates of payment are based on set at 80% of the Arkansas Blue Cross/ Blue Shield rate fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission for prescription glasses, optical aids, and artificial eyes. For devices covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.~~

~~Rates of payment are set at the published list price for a non-prescription item, e.g., closed circuit television, magnifiers, etc. The ARS assistive technology team, here and after referred to as Access and Accommodations, reviews purchases to ensure the price is reasonable in the market. If no qualified vendor agrees to accept the published rate of payment, the counselor may, with the written permission of the district manager that is entered into the client case file, negotiate a reasonable fee based on the lowest of three competitive estimates from vendors in the local area.~~

5.04 Hearing Aids

Invoices for hearing aids must be itemized. Each line item must correspond to the recommendations for the individual in the audiology/hearing aid evaluation.

Line items for devices not recommended for the individual in the audiology/hearing aid evaluation may be rejected if inconsistent with the individual's Employment Plan. Non-itemized or bundled invoices will be rejected and returned to the vendor.

Each line item for a hearing aid or related device must include the appropriate billing code from the "L" or "V" sections of the Health Care Common Procedures Coding System (HCPCS). ARS may request further documentation to support a given L or V code, and may refuse payment if the vendor cannot provide the documentation requested.

Used devices, if provided, must be disclosed on the invoice as "refurbished," "used," or "rebuilt." Failure to disclose a refurbished device or to follow the FDA procedures may result in removal of the vendor from the ARS Approved Vendor List.

Counselor will verify that the individual received the device and is able to use it. Document in the ECF. Counselor will key required information into the case management system for ARS Purchase Authorization.

ARS will issue payment for new hearing aids and related devices according to the price indicated for the appropriate L or V code in the Blue Cross Blue Shield fee schedule established by the Arkansas Workers' Compensation Commission (current as of the date of the invoice) for the appropriate L or V code. ARS will pay 80% of the price indicated in the Blue Cross Blue Shield Medicare fee schedule for the appropriate L or V code. For used hearing aids and related devices, ARS will pay 70% of the price indicated for the appropriate L or V code, using the Arkansas Workers' Compensation Fee Schedule.

For hearing aids and related devices (new or used) not covered by Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.05 Hospitalization

Rates of payment for the first day of inpatient hospital services are based on the set at 80% of the Arkansas Blue Cross Blue Shield Hospitalization per diem fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For first-day hospital services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

For hospital services beyond one day, ARS will pay up to 50% of the total amount billed by the provider.

For hospitals with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount. for that facility. The rate of payment for surgery is set at the Medicaid rate.

5.06 Nursing Services

Rates of payment for nursing services are based on the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For nursing services covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider. For hospitals or outpatient clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount.

~~provided in in-home or outpatient settings are included in the Arkansas Blue Cross Blue Shield physician fee schedule or the outpatient fee schedule.~~

5.07 Orthotic Devices

Rates of payment for orthotic devices are based on set at 80% of the Arkansas Blue Cross/ Blue Shield rate fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For orthotics covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.08 Physical and Occupational Therapy

Rates of payment for physical and occupational therapy services are based on set at 80% of the Arkansas Blue Cross Blue Shield Physician Fee Schedule as of July 1st of each year, updated annually fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For physical and occupational therapies covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

[Appendix I-5 to 8]

5.10 Prosthetic Devices

Rates of payment for prosthetics are based on set at 80% of the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. All prosthetic requests are reviewed by the Access and Accommodations physical therapist to ensure the prosthesis and its components are consistent with the client's expressed vocational goal. As part of the report, the physical therapist will document 80% of the allowable Arkansas Blue Cross Blue Shield rate for the device. For prosthetics covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider.

5.13 Surgical Implants/Appliances

Rates of payment for surgical implants/appliances are based on the fee schedules established by (1) Medicare or (2) the Arkansas Workers' Compensation Commission. For implants or appliances covered by neither Medicare nor Arkansas Workers' Compensation, ARS will pay up to 50% of the total amount billed by the provider. For hospitals or outpatient clinics with which ARS has a contract establishing an all-inclusive amount for services, ARS will pay the contract amount. reimbursed 80% of the Arkansas Blue Cross Blue Shield rate as of July 1st of each year, updated annually. Services are identified and reimbursed by CPT code. If no qualified vendor agrees to accept the rate established for surgical implants/appliances, the counselor may, with the written permission of the district manager that is entered into the client case file, negotiate a reasonable fee based on the lowest of three competitive estimates from vendors in the local area.

[Appendix I-10]

Small Business Program

The role of the Consultant includes, but is not limited to, providing the following assistance to the client as follows:

1. Recommendation of training and technical assistance from appropriate organizations consisting of subjects such as exploring entrepreneurship, small business development, business plan development, small business management, accounting for business, and business financing.
2. Referral of the client to an appropriate resource as it relates to the development of a business plan defining the concept of the business and the business market and competition analysis.
3. Assistance in identifying resources for the capitalization of the business.
4. ~~The Consultant will d~~ Development of a report upon completion of these activities. The report will that summarizes the Consultant's findings and provides recommendations as it relates to the operation of a new or existing business. The Consultant's report will be written prior to development of an approved IPE by the VR counselor and the client developing an approved IPE.
5. Determination of whether the client's business plan is feasible. The Small Business Consultant only approves the plan. He/she The Consultant does not approve funding assistance amounts or allotments for a client's small business. The VR Counselor will review proposed the Consultant's report, together with the funding assistance requested in the client's business plan. The VR Counselor will then recommend an amount of funding to be authorized in the IPE. If funding for a small business is approved, comparable benefits and services will be taken into consideration, as well as the client's ability to contribute. and approve amount ARS can assistance with along with client participation and/or comparable benefits."

[Appendix A-2]

WIOA Common Performance Measures

Section 116 of Workforce Investment and Opportunity Act (WIOA) requires Arkansas Rehabilitation Services to assess how well the Vocational Rehabilitation program performs each quarter, and annually, based on the following 6 indicators:

1. <u>Employment Rate - 2nd Quarter After Exit</u>	<u>The percentage of participants who are working in the community during the second quarter after exit from the program. A VR client must work 90 days before their case can be closed. Once the 90- day</u>
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	<p><u>timeframe is complete and the case is closed, the client has “exited” the program.</u></p> <p><u>The client’s work record will be validated 6 months (2 quarters) after they exit the program. In order to verify that the client is employed at that time, ARS staff will obtain supporting documents such as:</u></p> <ul style="list-style-type: none"> • <u>Direct Unemployment Insurance (UI) wage match - I Wage (applies to status 26 and status 28 closures)</u> • <u>Federal or military employment records</u> • <u>Paystub</u> • <u>W2 or tax record</u> • <u>Verification from the client in writing using an agency form or a letter from the client, signed and dated from the client and counselor</u> • <u>Verification using an agency out-of-state wage form</u> • <u>Verification from the Employer on letterhead with employment start date and justification</u> • <u>Verification Form for Self-Employment Income and Expenses</u> <p><u>The “employment rate” for this indicator is essentially the number of clients who are employed 2 quarters after exiting the program, divided by the total number of clients who exited during the same reporting period.</u></p> <p><u>Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.</u></p>
<p>2. <u>Employment Rate - 4th Quarter After Exit</u></p>	<p><u>The percentage of participants who are working in the community during the fourth quarter after exit from the program. A VR client must work 90 days before their case can be closed. Once the 90- day timeframe is complete and the case is closed, the client has “exited” the program.</u></p> <p><u>The client’s work record will be validated 12 months (4 quarters) after they exit the program. In order to verify that the client is employed at that time, ARS staff will obtain supporting documents such as:</u></p> <ul style="list-style-type: none"> • <u>Direct Unemployment Insurance (UI) wage match - I Wage (applies to status 26 and status 28 closures)</u> • <u>Federal or military employment records</u> • <u>Paystub</u> • <u>W2 or tax record</u>

	<ul style="list-style-type: none"> • <u>Verification from the client in writing using an agency form or a letter from the client, signed and dated from the client and counselor</u> • <u>Verification using an agency out-of-state wage form</u> • <u>Verification from the Employer on letterhead with employment start date and justification</u> • <u>Verification Form for Self-Employment Income and Expenses</u> <p>The “employment rate” for this indicator is essentially the number of clients who are employed 4 quarters after exiting the program, divided by the total number of clients who exited during the same the reporting period.</p> <p>Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.</p>
3. <u>Median Earnings 2nd Quarter After Exit</u>	<p>The median quarterly earnings for participants who are working in the community 6 months after they exit the program, as validated through direct UI wage match, federal or military employment records, or supplemental wage information like the Verification Form for Self-Employment Income and Expenses.</p> <p>The median wage is determined by listing participants’ quarterly wages from the lowest to the highest value. The wage in the middle of the list is the median quarterly wage. If there are an even number of participants in the list, the median is the average of the middle two wages.</p> <p>Generally, participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.</p> <p><u>However, the following clients are not included:</u></p> <ul style="list-style-type: none"> • <u>Clients who have exited but are not employed in the 2nd quarter after exit.</u> • <u>Clients who have exited and are employed, but for whom earnings are not yet available.</u> • <u>Clients who have exited and are working, but have no income (e.g., unpaid family workers)</u> • <u>Clients who have exited but are in subsidized employment.</u>

	<ul style="list-style-type: none"> • <u>Clients who have exited, but one or more of the “Exclusions” apply. See section on Exclusions, below.</u> <p><u>Note that there is a two-quarter lag in reporting wages. If a participant’s wages are not available after two quarters, the wage must be reported as \$0, and the person is not considered employed for purposes of Median Earnings – 2nd Quarter. A median wage reported as \$0 will negatively impacts Employment Rate – 2nd Quarter.</u></p>
4. <u>Credential Attainment</u>	<p><u>The percentage of program participants enrolled in an education or training program (excluding on-the-job training and customized training) who attain a recognized postsecondary credential or a secondary school diploma, or its recognized equivalent, during participation in, or within one year after exit from, the program.</u></p> <p><u>A high-school school diploma or GED can count for purposes of credential attainment, but only if the client becomes employed within one year after exit, or enrolls in an education or training program leading to a recognized postsecondary credential within one year after exit.</u></p> <p><u>Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.</u></p>
5. <u>Measurable Skill Gains</u>	<p><u>The percentage of program participants who, during a program year, are enrolled in an education or training program that leads to a recognized postsecondary credential or employment and gain a skill that counts as “documented progress” towards the credential or employment.</u></p> <p><u>Progress can be academic, technical, occupational, or other, depending on the type of education or training program:</u></p> <ol style="list-style-type: none"> 1. <u>Documented achievement of at least one educational functioning level of a participant who is receiving instruction below the postsecondary education level;</u> 2. <u>Documented attainment of a secondary school diploma or its recognized equivalent;</u> 3. <u>Secondary: Transcript or report card showing passing grades for 1 semester;</u> 4. <u>Postsecondary, full-time (12 or more hours): Transcript showing passing grades for 1 semester.</u>

	<p><u>Postsecondary, part time (less than 12 hours): Transcript must show passing grades for a total of 12 hours, over 2 consecutive semesters:</u></p> <ol style="list-style-type: none"> <u>Satisfactory or better progress report towards established milestones, such as completion of OJT or completion of one year of an apprenticeship program or similar milestones, from an employer or training provider; or</u> <u>Successful passage of an exam that is required for a particular occupation or progress in attaining technical or occupational skills as evidenced by trade-related benchmarks such as knowledge-based exams.</u> <ul style="list-style-type: none"> <u>Measurable Skill Gains are reported on a yearly basis and are not an exit-based measure.</u> <u>Clients are generally given credit for 1 Measureable Skill Gain per year, even if they earn more than 1 during a program year.</u> <u>Record all Measurable Skill Gains in the case management system—the reporting system will count them appropriately.</u> <p><u>Participants counted for this indicator include clients whose record of services is closed successfully after development of an IPE, and clients whose record is closed unsuccessfully after development of an IPE.</u></p>
6. <u>Effectiveness in Serving Employers</u>	<p><u>There are three approaches to measuring this indicator. The core partners are required to report on two of the three following measures. The core programs for the Combined State Plan in Arkansas, including VR, are in the pilot phase of choosing a common approach:</u></p> <ul style="list-style-type: none"> <u>Approach 1 - Retention with the same employer - addresses the programs' efforts to provide employers with skilled workers;</u> <u>Approach 2 - Repeat Business Customers - addresses the programs' efforts to provide quality engagement and services to employers and sectors and establish productive relationships with employers and sectors over extended periods of time; and</u> <u>Approach 3 - Employer Penetration Rate - addresses the programs' efforts to provide quality engagement and services to all employers and sectors within a State and local economy.</u>

Clients Counted in the Performance Measures

A “participant” for VR purposes is someone who is eligible for services, has an individualized plan for employment, and is receiving services. These policies apply to all cases in the case-management system involving clients who meet the definition of participant.

Exit Wage Calculations

All earnings are reported before deductions of Federal, State and local income taxes and Social Security payroll tax. The entire amount received for the quarter is reported. Wages for salespersons, consultants, self-employed individuals, and other similar occupations are based on their adjusted gross income. Estimates of in-kind payments, such as meals and lodging, cannot be reported.

Exclusions

Things may happen in clients’ lives that exclude them from certain performance measures. These exclusions occur due to:

- Incarceration in a correctional institution, or becoming a resident of an institution or facility providing 24-hour support (such as hospital or treatment center) for 90 days or longer, which is considered enough time to prevent the client from participation in a workforce program;
- Medical treatment where the treatment is expected to last longer than 90 days and precludes entry into unsubsidized employment or continued participation;
- Death; or
- Membership in the National Guard or other reserve military unit of the armed forces, and being called to active duty for at least 90 days.

Data Validation Generally

Under WIOA section 116(d), the U.S. Departments of Education and Labor have established data-validation guidelines in order to ensure that information included in program reports is valid and reliable. For ARS, this means the data supporting our performance indicators (and reported to RSA) must first meet internal, quality-assurance standards. Ultimately, data validation will improve ARS’s performance accountability and help achieve better outcomes for our clients. ARS complies with all State and Federal laws applicable to performance-measure collection and reporting.

Quality-Assurance Standards for Data Validation

1) Data Collection for Effective and Efficient Operations. ARS counselors will be provided a monitoring tool, based on the 911 report and technical assistance from RSA, in order to review case data and supporting documentation. Using the monitoring tool, counselors will enter information into the electronic case management system the appropriate clients. The monitoring tool may also be used by managers each quarter to review cases for accuracy.

ARS staff responsible for monitoring will provide counselors and managers a written report of errors and missing data, with a request for corrections. Monitoring staff will also provide ongoing training and technical assistance. By the quarter prior to the due date for the next 911 report, counselors will provide a written response to their managers, showing that the errors identified by monitoring staff have been corrected. This statement will be forwarded to the monitoring staff, with a copy to the Chief of Field Services.

After receiving the statement from counselors, ARS monitoring staff will screen the electronic case files again for errors. At this time, any corrections still needed will be made by the monitoring staff or manager prior to the report's due date. Remedial training will be provided to counselors with recurring error corrections, as needed.

2) Retention. The ARS case management system maintains clients' full record of services, including assessments, evaluations, reports, financial records, and supporting documents. These records are kept electronically for the life of the case on the counselor's caseload. With the exception of certain files in Status 00, ARS will continue to keep all records of services for a period of seven (7) years. See 34 C.F.R. § 361.47; ARS Policy & Procedure Manual, sec. X; Ark. Code Ann. § 25-18-604; and current Arkansas Record Retention Schedule.

3) Timely Reporting to RSA. On a quarterly basis within each program year, the ARS Data Analyst will compile performance-indicator data to prepare 911 Reports, which are submitted to RSA as required by the Rehabilitation Act. The 911 Report collects case-service data, with a focus on performance indicators. As the 911 Reports are prepared, the Data Analyst will make note of errors and missing data from the counselors' caseloads. The Data Analyst will distribute summaries of the errors and omissions, along with a correction guide, to each counselor prior to the close of the quarter. Any errors will be addressed using the correction guide. This is intended to supplement the written report/correction/screening process involving ARS monitoring staff, described above.

The Data Analyst's summaries and correction guides will be distributed on the following timeline:

Q1: July 1 to September 30

Q2: October 1 to December 31

Q3: January 1 to March 31

Q4: Reporting Period: April 1-June 30

4) Reliability of Performance Indicators. Generally speaking, any information entered into the case management system must be verified using the supporting documents identified in TAC 19-01 (RSA) and TEGL 7-18 (U.S. Departments of Labor and Education). Allowable supporting documentation is listed for each performance indicator in the table following Attachment I of the TEGL, Source Documentation for WIOA Core Programs.

Continuous Performance Improvement Plan

When internal monitoring for accuracy in data validation reveals consistent best practices, or innovative practices, the counselors and managers responsible will be recognized by ARS

administration. Their best practices will be shared with all ARS staff to improve performance and further the agency's mission.

Likewise, internal monitoring may lead to recommendations for corrective action when errors in supporting documentation are noted, or when a case file lacks supporting documentation. Recommendations for corrective action will reference the law, regulation, or policy that was not being followed, along with remedial steps that are proportional to the level and frequency of the errors.

[Appendix J, WIOA Common Performance Measures]
