

DEPARTMENT OF HUMAN SERVICES, DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

SUBJECT: Community and Employment Supports (CES) Agency Provider Standards & REPEALS: Arkansas Refugee Resettlement Program State Plan; DHS Policy 3007 – Options Counseling

DESCRIPTION:

Statement of Necessity

This rule establishes the minimum standards for community providers delivering services to beneficiaries enrolled in the Arkansas 1915(c) home and community-based waiver number, AR.0188, which is known as the Community and Employment Support Waiver (CES Waiver).

Rule Summary

Since the implementation of the Provider-led Arkansas Shared Savings Entity (PASSE) managed care model, each PASSE has established its own minimum standards for the CES Waiver providers in its network. Since many providers are enrolled in multiple PASSE networks, this has resulted in the inconsistent application of standards across the PASSE model. This single set of CES Waiver minimum standards establishes a uniform set of standards and provides PASSEs and providers with certainty in the requirements and expectations when delivering CES Waiver services to beneficiaries.

Repeals pursuant to the Governor’s Executive Order 23-02:

- (1) Arkansas Refugee Resettlement Program State Plan; and
- (2) DHS Policy3007, Options Counseling.

Updates made in Response to Public Comments

- Revised Section 302(b)(2): “Each individual eighteen (18) years of age or older residing in an alternative living home that is not a family member of the beneficiary must successfully pass the checks and searches required by Ark. Code Ann. §20-48-812(c)(1-4).”
- Revised Section 302(b)(3): “(3) The checks, screens, and searches prescribed in subdivision (b)(1) of this part are not required for any:
(A) Licensed professional; or
(B) Legal guardian of a beneficiary.”
- Added Section 305(a)(3): “A beneficiary service record must be made immediately available to a beneficiary and their legal guardian upon request.”
- Revised Section 403(c): “The new Provider must hold a transition conference to develop a transition plan for the beneficiary within fourteen (14) business days of issuing the notification required in subsection (b) above. If the new Provider is

unable to hold the a transition conference within the required timeframe, reasonable justification for the delay must be documented.”

- Revised Section 403(d)(1)(f) to read “Documentation or other evidence that demonstrated both the current and new provider’s consent to the transition plan (i.e. signatures on plan, email approval, etc.)” to expand the ways agreement can be demonstrated beyond signatures.
- Added Section 403(e)(3): “If a current provider is denied access to deliver services by the beneficiary or the beneficiary’s family/guardian before transition to the new provider is complete, then the current provider must specifically document its attempts and the family/guardian’s denial of access to provide services.”
- Revised Section 404(d): “If a Provider is currently serving a beneficiary when declaring a refusal to serve, the Provider shall remain responsible for the delivery of CES Waiver Services until the beneficiary transitions to their new Provider or other placement unless there is an immediate health or safety risk to Provider employees. A detailed description of any health and safety risk justifying the ceasing of service delivery prior to a completed transition of beneficiary to a new Provider must be documented.”
- Revised Section 703(a): “If a beneficiary has a legal guardian, then a Provider must notify the legal guardian of any reportable incident involving the beneficiary within one (1) hour of discovery.”

PUBLIC COMMENT: A public hearing was held on this rule on January 24, 2024. The public comment period expired on February 12, 2024. The agency provided a public comment summary which, due to its length, is attached separately.

The proposed effective date is April 1, 2024.

FINANCIAL IMPACT: The agency indicated that this rule has no financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).



ARKANSAS
DEPARTMENT OF
**HUMAN
SERVICES**

Division of Developmental Disabilities Services
P.O. Box 1437, Slot N501, Little Rock, AR 72203-1437
P: 501.682.8665 F: 501.682.8380 TDD: 501.682.1332

January 12, 2024

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Community and Employment Supports (CES) Agency Standards

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact Mac Golden, Office of Rules Promulgation at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Thomas Tarpley', written over a horizontal line.

Thomas Tarpley
Interim Director

TP:rj

Attachments

**QUESTIONNAIRE FOR FILING PROPOSED RULES WITH
THE ARKANSAS LEGISLATIVE COUNCIL**

DEPARTMENT _____
 BOARD/COMMISSION _____
 BOARD/COMMISSION DIRECTOR _____
 CONTACT PERSON _____
 ADDRESS _____
 PHONE NO. _____ EMAIL _____
 NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING _____
 PRESENTER EMAIL(S) _____

INSTRUCTIONS

In order to file a proposed rule for legislative review and approval, please submit this Legislative Questionnaire and Financial Impact Statement, and attach (1) a summary of the rule, describing what the rule does, the rule changes being proposed, and the reason for those changes; (2) both a markup and clean copy of the rule; and (3) all documents required by the Questionnaire.

If the rule is being filed for permanent promulgation, please email these items to the attention of Rebecca Miller-Rice, miller-ricer@blr.arkansas.gov, for submission to the Administrative Rules Subcommittee.

If the rule is being filed for emergency promulgation, please email these items to the attention of Director Marty Garrity, garritym@blr.arkansas.gov, for submission to the Executive Subcommittee.

Please answer each question completely using layman terms.

1. What is the official title of this rule?

2. What is the subject of the proposed rule? _____
3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes No

If yes, please attach the statement required by Ark. Code Ann. § 25-15-204(c)(1).

If yes, will this emergency rule be promulgated under the permanent provisions of the Arkansas Administrative Procedure Act? Yes No

4. Is this rule being filed for permanent promulgation? Yes No

If yes, was this rule previously reviewed and approved under the emergency provisions of the Arkansas Administrative Procedure Act? Yes No

If yes, what was the effective date of the emergency rule? _____

On what date does the emergency rule expire? _____

5. Is this rule required to comply with a *federal* statute, rule, or regulation? Yes No

If yes, please provide the federal statute, rule, and/or regulation citation.

6. Is this rule required to comply with a *state* statute or rule? Yes No

If yes, please provide the state statute and/or rule citation.

7. Are two (2) rules being repealed in accord with Executive Order 23-02? Yes No

If yes, please list the rules being repealed.

If no, please explain.

8. Is this a new rule? Yes No

Does this repeal an existing rule? Yes No

If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes No

If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

9. What is the state law that grants the agency its rulemaking authority for the proposed rule, outside of the Arkansas Administrative Procedure Act? Please provide the specific Arkansas Code citation(s), including subsection(s).

10. Is the proposed rule the result of any recent legislation by the Arkansas General Assembly?
Yes No

If yes, please provide the year of the act(s) and act number(s).

11. What is the reason for this proposed rule? Why is it necessary?

12. Please provide the web address by which the proposed rule can be accessed by the public as provided in Ark. Code Ann. § 25-19-108(b)(1).

13. Will a public hearing be held on this proposed rule? Yes No

If yes, please complete the following:

Date: _____

Time: _____

Place: _____

Please be sure to advise Bureau Staff if this information changes for any reason.

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. _____

15. What is the proposed effective date for this rule? _____

16. Please attach (1) a copy of the notice required under Ark. Code Ann. § 25-15-204(a)(1) and (2) proof of the publication of that notice.

17. Please attach proof of filing the rule with the Secretary of State, as required by Ark. Code Ann. § 25-15-204(e)(1)(A).

18. Please give the names of persons, groups, or organizations that you anticipate will comment on these rules. Please also provide their position (for or against), if known.

19. Is the rule expected to be controversial? Yes No

If yes, please explain.

From: [Legal Ads](#)
To: [Renita Jones](#)
Subject: Re: Full Run AD - Community and Employment Supports (CES) Agency Standards (Rule #253)
Date: Friday, January 12, 2024 7:51:58 AM
Attachments: [image001.png](#)
[image002.png](#)

[EXTERNAL SENDER]

Will run Sun 1/14, Mon 1/15, and Tues 1/16. You will receive a separate invoice for the Sunday run and the other days.

Thank you.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Renita Jones" <Renita.Jones@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Renita Jones" <Renita.Jones@dhs.arkansas.gov>, "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>, "Thomas Tarpley" <Thomas.Tarpley@dhs.arkansas.gov>
Sent: Thursday, January 11, 2024 8:52:20 AM
Subject: Full Run AD - Community and Employment Supports (CES) Agency Standards (Rule #253)

Good morning,

Please run the attached public notice on **Sunday, January 14th, Monday, January 15th**, and **Tuesday, January 16th**. I am aware that the print version will only be provided to all counties on Sundays. Please let me know if you have any questions or concerns. Please reply to this email using REPLY ALL.

Please invoice to: **AR Dept. of Human Services**

P.O. Box 1437

Slot S535

Little Rock, AR 72203

ATTN: Elaine Stafford (Elaine.Stafford@dhs.arkansas.gov)

Or email invoices to : dms.invoices@arkansas.gov

Thank you,



Renita Jones

[Office of Policy & Rules](#)

Program Administrator

P: 501.320.3949

F: 501.404.4619

700 Main St.

Little Rock, AR 72203

Renita.Jones@dhs.arkansas.gov

humanservices.arkansas.gov



This email may contain sensitive or confidential information.

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From: [Renita Jones](#)
To: register@sos.arkansas.gov
Cc: [Renita Jones](#); [Mac Golden](#); [Jack Tiner](#); [Amanda Cox](#); [Lakeya Gipson](#)
Subject: DHS/DDS - Proposed Filing - Community and Employment Supports (CES) Agency Standards (Rule #253)
Date: Friday, January 12, 2024 8:46:00 AM
Attachments: [Sec of State Initial Filing - Rule #253 CES Standards.pdf](#)
[image001.png](#)
[image002.png](#)

Good morning,

Please see attached for initial filing. This rule will run in the Arkansas Democrat Gazette on Sunday, January 14th, Monday, January 15th and Tuesday, January 16th. The public comment period ends on February 12, 2024. Let me know if you have any questions.

Thank you,



Renita Jones

[Office of Policy & Rules](#)

Program Administrator

P: 501.320.3949

F: 501.404.4619

700 Main St.

Little Rock, AR 72203

Renita.Jones@dhs.arkansas.gov

humanservices.arkansas.gov



This email may contain sensitive or confidential information.

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NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129.

The Director of the Division of Developmental Disabilities Services proposes a new rule that for community providers delivering services to beneficiaries enrolled in the Arkansas 1915(c) home and community-based waiver number, which is known as the Community and Employment Support Waiver (CES Waiver). The standards contained in the new rule manual establishes a uniform set of standards and provides Provider-led Arkansas Shared Savings Entities and providers with certainty in the requirements and expectations when delivering CES Waiver services to beneficiaries. The proposed effective date of the rule is April 1, 2024, and there is no fiscal impact.


Pursuant to the Governor's Executive Order 23-02, DHS repeals the following two rules as part of this promulgation: (1) Arkansas Refugee Resettlement Program State Plan, and (2) DHS Policy3007, Options Counseling.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than February 12, 2024. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on January 24, 2024, at 10:00am and public comments may be submitted at the hearing. Individuals can access this public hearing at <https://us02web.zoom.us/j/84368376054>. The webinar ID is 843 6837 6054. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502172997



Thomas Tarpley, Interim Director
Division of Developmental Disabilities Services

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT _____
BOARD/COMMISSION _____
PERSON COMPLETING THIS STATEMENT _____
TELEPHONE NO. _____ **EMAIL** _____

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE _____

1. Does this proposed, amended, or repealed rule have a financial impact?
Yes No

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
Yes No

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes No

If no, please explain:

(a) how the additional benefits of the more costly rule justify its additional cost;

(b) the reason for adoption of the more costly rule;

(c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

(d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:
 - (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

Next Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

Next Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year

\$ _____

Next Fiscal Year

\$ _____

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year

\$ _____

Next Fiscal Year

\$ _____

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars (\$100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes No

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

- (1) a statement of the rule's basis and purpose;
- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
- (3) a description of the factual evidence that:
 - (a) justifies the agency's need for the proposed rule; and
 - (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;
- (4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and
- (7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
 - (a) the rule is achieving the statutory objectives;
 - (b) the benefits of the rule continue to justify its costs; and
 - (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Statement of Necessity and Rule Summary

Community and Employment Supports (CES) Agency Provider Standards

Why is this change necessary? Please provide the circumstances that necessitate the change.

This rule establishes the minimum standards for community providers delivering services to beneficiaries enrolled in the Arkansas 1915(c) home and community-based waiver number, AR.0188, which is known as the Community and Employment Support Waiver (CES Waiver).

What is the change? Please provide a summary of the change.

Since the implementation of the Provider-led Arkansas Shared Savings Entity (PASSE) managed care model, each PASSE has established its own minimum standards for the CES Waiver providers in its network. Since many providers are enrolled in multiple PASSE networks, this has resulted in the inconsistent application of standards across the PASSE model. This single set of CES Waiver minimum standards establishes a uniform set of standards and provides PASSEs and providers with certainty in the requirements and expectations when delivering CES Waiver services to beneficiaries.

Repeals pursuant to the Governor's Executive Order 23-02:
(1) Arkansas Refugee Resettlement Program State Plan; and
(2) DHS Policy3007, Options Counseling.

Updates made in Response to Public Comments

- Revised Section 302(b)(2): "Each individual eighteen (18) years of age or older residing in an alternative living home that is not a family member of the beneficiary must successfully pass the checks and searches required by Ark. Code Ann. §20-48-812(c)(1-4)."
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 - (A) Licensed professional; or
 - (B) Legal guardian of a beneficiary."
- Added Section 305(a)(3): "A beneficiary service record must be made immediately available to a beneficiary and their legal guardian upon request."
- Revised Section 403(c): "The new Provider must hold a transition conference to develop a transition plan for the beneficiary within fourteen (14) business days of issuing the notification required in subsection (b) above. If the new Provider is unable to hold the a transition conference within the required timeframe, reasonable justification for the delay must be documented."
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- Added Section 403(e)(3): "If a current provider is denied access to deliver services by the beneficiary or the beneficiary's family/guardian before transition to the new provider is complete, then the current provider must specifically document its attempts and the family/guardian's denial of access to provide services."

- Revised Section 404(d): “If a Provider is currently serving a beneficiary when declaring a refusal to serve, the Provider shall remain responsible for the delivery of CES Waiver Services until the beneficiary transitions to their new Provider or other placement unless there is an immediate health or safety risk to Provider employees. A detailed description of any health and safety risk justifying the ceasing of service delivery prior to a completed transition of beneficiary to a new Provider must be documented.”
- Revised Section 703(a): “If a beneficiary has a legal guardian, then a Provider must notify the legal guardian of any reportable incident involving the beneficiary within one (1) hour of discovery.”

**Rules for the Division of Developmental Disabilities Services
Community and Employment Support (CES) Agency Providers**

PROPOSED



LAST UPDATED: April 1, 2024

Subchapter 1. General.

101. Authority.

These standards are promulgated under the authority of Ark. Code Ann. § 20-76-201, and Ark. Code Ann. §§ 20-48-101 to -1108.

102. Purpose.

The purpose of these standards is to:

- (1) Serve as the minimum standards for community providers delivering services to beneficiaries enrolled in the Arkansas 1915(c) home and community-based waiver number AR.0188, which is known as the Community and Employment Support Waiver (CES Waiver); and
- (2) Ensure the health and safety of beneficiaries who are enrolled in the CES Waiver.

103. Definitions.

- (a) “Adverse agency action” means:
 - (1) A denial of an application for CES Waiver Service certification;
 - (2) Any enforcement action taken by DDS pursuant to sections 803 through 807; and
 - (3) Any other adverse regulatory action or claim covered by the Medicaid Fairness Act, Ark. Code Ann §§ 20-77-1701 to -1718.
- (b) “Alternative living home” means beneficiary residential setting that is not owned, leased, or controlled by the beneficiary, the beneficiary’s legal guardian, or a family member of the beneficiary.
- (c) “Applicant” means an applicant for CES Waiver Service certification.
- (d) “Beneficiary” means an individual receiving one (1) or more CES Waiver Services.
- (e) “Business Day” means Monday through Friday, except for any day that is recognized as a holiday by the State of Arkansas.

- (f) “Change of ownership” means any fifty percent (50%) or greater change in the financial interests, governing body, operational control, or other operational or ownership interests of a Provider within a twelve (12) month period.
- (g) “CES Waiver” means the Arkansas 1915(c) home and community-based waiver number AR.0188, which is known as the Community and Employment Support Waiver.
- (h) “CES Waiver Service” means one of the following services each as defined in section 220.000 of the Home and Community-Based Services for Client with Intellectual Disabilities and Behavioral Health Needs Medicaid Manual and the CES Waiver:
- (1) Respite;
 - (2) Supported Employment;
 - (3) Supportive Living;
 - (4) Specialized Medical Supplies;
 - (5) Adaptive Equipment;
 - (6) Community Transition Services;
 - (7) Consultation;
 - (8) Environmental Modifications; and
 - (9) Supplemental Support.
- (i) “Chemical restraint” means the use of medication or any drug that:
- (1) Is administered to manage a beneficiary’s behavior;
 - (2) Has the temporary effect of restricting the beneficiary; and
 - (3) Is not a standard treatment for the beneficiary’s medical or psychiatric condition.
- (j) “DDS” means the Arkansas Department of Human Services, Division of Developmental Disabilities Services, or its delegate.
- (k) “DMS” means the Arkansas Department of Human Services, Division of Medical Services.
- (l) “Directed in-service training plan” means a plan of action that:
- (1) Provides training to a Provider to correct non-compliance with these standards;

- (2) Establishes the topics covered and materials used in the training;
- (3) Specifies the length of the training;
- (4) Specifies the employees required to attend the training; and
- (5) Is approved by DDS.

(m)

- (1) “Employee” means an employee or other agent of a Provider who has or will have direct contact with a beneficiary or their personal property or funds, including without limitation any employee, independent contractor, sub-contractor, intern, volunteer, trainee, or agent.
- (2) “Employee” does not mean an independent contractor if:
 - (A) The independent contractor does not assist in the day-to-day operations of Provider; and
 - (B) The independent contractor has no beneficiary contact.

(n)

- (1) “Licensed professional” means a person who holds a State of Arkansas professional certificate or license in good standing that is operating within the scope of practice of their license or certification.
- (2) “Licensed professional” includes without limitation the following independently licensed or certified professionals: general contractor, physician, psychiatrist, psychologist, social worker, psychological examiner, parent educator, communication and environmental control specialist, behavior support specialist, professional counselor, behavioral analyst, master social worker, licensed practical nurse, registered nurse, speech-language pathologist, dietician, occupational therapist, physical therapist, and recreational therapist.

(o)

- (1) “Market” means the accurate and honest advertisement of a Provider that does not also constitute an attempt to solicit.
- (2) “Market” includes without limitation:
 - (A) Advertising using traditional media;

- (B) Distributing brochures or other informational materials regarding the services offered by a Provider;
 - (C) Conducting tours of a Provider to interested beneficiaries and their families;
 - (D) Mentioning services offered by a Provider in which a beneficiary or their family might have an interest; and
 - (E) Hosting informational gatherings during which the services offered by a Provider are described.
- (p) “Mechanical restraint” means the use of any device attached or adjacent to a beneficiary that:
- (1) The beneficiary cannot easily remove; and
 - (2) Restricts the beneficiary’s freedom of movement.
- (q) “Medication error” means any one of the following:
- (1) Loss of medication;
 - (2) Unavailability of medication;
 - (3) Falsification of medication logs;
 - (4) Theft of medication;
 - (5) Missed dose of medication;
 - (6) Incorrect medications administered;
 - (7) Incorrect dose of medication administered;
 - (8) Incorrect time of medication administration;
 - (9) Incorrect route of medication administration; and
 - (10) The discovery of an unlocked medication container that is always supposed to be locked.
- (r) “Mental health professional” or “MHP” means a person who holds an Arkansas professional license in good standing to provide one or more of the services set out in the Counseling Services Medicaid manual.

- (s) “Non-clinical treatment plan” means a Provider’s written, individualized service plan for a beneficiary, outlining the specific method and goals for CES Waiver Services delivery by Provider.
- (t) “PASSE” means a beneficiary’s assigned Provider-led Arkansas Shared Savings Entity.
- (u) “PCSP” means a person-centered service plan, which is a written, individualized service and support plan developed by the beneficiary’s PASSE care coordinator, which sets out the home and community-based services to be received by a beneficiary.
- (v) “Plan of correction” means a plan of action that:
- (1) Provides the steps a Provider must take to correct noncompliance with these standards;
 - (2) Establishes a timeframe for each specific action included in the plan; and
 - (3) Is approved by DDS.
- (w) “Provider” means an individual, organization, or entity certified to provide one or more CES Waiver Services.
- (x) “Provider owned, leased, or controlled CES Waiver Service residential setting” means any residential setting that is owned, leased, or controlled by a Provider within the meaning of the CBS Home and Community-Based Services Settings Final Rule, 79 Federal Register 2948 (2014).
- (y)
- (1) “Restraint” means the application of force for the purpose of restraining the free movement of a beneficiary, which includes without limitation any chemical restraint and mechanical restraint.
 - (2) “Restraint” does not include:
 - (A) Briefly holding, without undue force, a beneficiary to calm or comfort the beneficiary; or
 - (B) Holding a beneficiary’s hand to safely escort the beneficiary from one area to another.
- (z) “Risk mitigation plan” means an individualized risk management plan developed by a beneficiary’s PASSE care coordinator that outlines a beneficiary’s risk factors and the action steps that must be taken to mitigate those risks.

- (aa) “Seclusion” means the involuntary confinement of a beneficiary alone or in a room or area from which the beneficiary is physically prevented from leaving.
- (bb) “Serious injury” means any injury to a beneficiary that:
- (1) May cause death;
 - (2) May result in substantial permanent impairment;
 - (3) Requires hospitalization; or
 - (4) Requires the attention of:
 - (A) An emergency medical technician;
 - (B) A paramedic; or
 - (C) An emergency room.
- (cc)
- (1) “Solicit” means when a Provider intentionally initiates contact with a beneficiary (or their family) that is currently receiving services from another provider and Provider is attempting to persuade the beneficiary or their family to switch to or otherwise use the services of Provider.
 - (2) “Solicit” includes without limitation the following acts to induce a beneficiary or their family by:
 - (A) Contacting a beneficiary or the family of a beneficiary that is currently receiving services from another provider;
 - (B) Offering cash or gift incentives to a beneficiary or their family;
 - (C) Offering free goods or services not available to other similarly situated beneficiaries or their families;
 - (D) Making negative comments to a beneficiary or their family regarding the quality of services performed by another provider;
 - (E) Promising to provide services in excess of those necessary;
 - (F) Giving a beneficiary or their family the false impression, directly or indirectly, that Provider is the only provider that can perform the services desired by the beneficiary or their family; or

- (G) Engaging in any activity that DDS reasonably determines to be “solicitation.”

PROPOSED

Subchapter 2. Certification.

201. Certification Required.

- (a)
 - (1) An individual, entity, or organization must be certified by DDS to provide a CES Waiver Service.
 - (2) A separate DDS certification is required for each type of CES Waiver Service.
- (b) A Provider that wishes to operate a complex care home (see section 602) must have the residential setting certified as a complex care home in addition to being certified to provide CES Waiver Supportive Living services.
- (c) A Provider must comply with all applicable requirements in these standards to maintain certification for a CES Waiver Service.
- (d) An individual, entity, or organization that is on the Medicaid excluded provider list is prohibited from receiving CES Waiver Service certification.

202. Application for Certification.

- (a) To apply for CES Waiver Service or complex care home certification, an applicant must submit a complete application to DDS.
- (b) A complete application includes:
 - (1) Documentation demonstrating the applicant's entire ownership, including without limitation the applicant's governing body and all financial and business interests;
 - (2) Documentation of the applicant's management, including without limitation the management structure and members of the management team;
 - (3) Documentation of the employees that the applicant intends to use as part of operating as a Provider;
 - (4) Documentation of all checks, screens, and searches required pursuant to section 302(b);
 - (5) Documentation demonstrating compliance with these standards; and
 - (6) All other documentation or other information requested by DDS.

203. Certification Process.

- (a) DDS may issue CES Waiver Service or complex care home certification to an applicant if:
- (1) The applicant submits a complete application under section 202;
 - (2) DDS determines that all employees have successfully passed all checks, screens, and searches required pursuant to section 302(b); and
 - (3) DDS determines that the applicant satisfies these standards.
- (b) DDS may approve an application involving a change of ownership for an existing Provider if:
- (1) The applicant submits a complete application under section 202;
 - (2) DDS determines that all employees and owners have successfully passed all checks, screens, and searches required pursuant to section 302(b); and
 - (3) DDS determines that the applicant satisfies these standards.
- (c) Certification to perform a CES Waiver Service once issued does not expire until terminated under these standards.

Subchapter 3. Administration.

301. Organization and Ownership.

- (a) A Provider must be in good standing to do business under the laws of the state of Arkansas.
- (b)
 - (1) A Provider must appoint a single manager as the point of contact for all DDS and DMS matters and provide DDS and DMS with updated contact information for that manager.
 - (2) The manager must have authority over Provider and all its employees and be responsible for ensuring that requests, concerns, inquires, and enforcement actions are addressed and resolved to the satisfaction of DDS and DMS.
- (c)
 - (1) A Provider cannot transfer CES Waiver Service certification to any other person or entity.
 - (2) A Provider cannot complete a change of ownership unless DDS approves the application of the new ownership pursuant to sections 202 and 203.
 - (3) A Provider cannot change its name or otherwise operate under a different name than the name listed on its certification without notice to DDS.

302. Employee and Staffing Requirements.

- (a) A Provider must appropriately supervise all beneficiaries based on each beneficiary's needs when performing CES Waiver Services.
- (b)
 - (1) Except as provided in subdivision (b)(3) of this part, each employee must successfully pass the following:
 - (A) All checks, screens, and searches required pursuant to Ark. Code Ann. § 20-48-812; and
 - (B) A Medicaid excluded provider list check.

- (2) Each individual eighteen (18) years of age or older residing in an alternative living home that is not a family member of the beneficiary must successfully pass the checks and searches required by Ark. Code Ann. §20-48-812(c)(1-4).
 - (3) The checks, screens, and searches prescribed in subdivision (b)(1) of this part are not required for any:
 - (A) Licensed professional; or
 - (B) Legal guardian of a beneficiary
- (c)
- (1) Employees must be eighteen (18) years of age or older.
 - (2) Employees must have a:
 - (A) High school diploma; or
 - (B) GED or equivalent.
 - (3) Employees performing Consultation and Environmental Modification CES Waiver Services must be a licensed or certified professional in the appropriate field for the type of service performed.
- (d) A Provider must verify an employee meets all requirements under these standards upon the request of DDS or whenever a Provider receives information after hiring that would create a reasonable belief that an employee no longer meets all requirements under these standards.

303. Employee Training and Certifications.

- (a) All employees must receive training on the following topics prior to having any beneficiary direct contact that is unsupervised by another employee:
 - (1) The Health Insurance Portability and Accountability Act (HIPAA), and other applicable state and federal laws and regulations governing the protection of medical, social, personal, financial, and electronically stored records;
 - (2) Mandated reporter requirements and procedures;
 - (3) Incident and accident reporting;
 - (4) Basic health and safety practices;

- (5) Infection control practices;
 - (6) Trauma informed care;
 - (7) Verbal intervention; and
 - (8) De-escalation techniques.
- (b)
- (1) All employees must receive beneficiary-specific training in the amount necessary to safely meet the individualized needs of those beneficiaries prior to having any direct contact that is unsupervised by another employee.
 - (2) Every employee's beneficiary-specific training must at a minimum must include training on the beneficiary's:
 - (A) Non-clinical treatment plan;
 - (B) Diagnosis and medical needs;
 - (C) Medication management plan, if applicable;
 - (D) Positive behavioral support plan, as applicable;
 - (E) Behavioral prevention and intervention plan, as applicable;
 - (F) Permitted interventions, if applicable; and
 - (G) Emergency and evacuation procedures.
- (c) All employees must receive appropriate refresher training on the topics listed in sections 303(a) and 303(b) at least every other calendar year.
- (d) All employees must obtain and maintain in good standing the following credentials when performing services on behalf of Provider:
- (1) CPR certification in accordance with one of the following:
 - (A) American Heart Association;
 - (B) Medic First Aid, or
 - (C) American Red Cross; and
 - (2) First aid certification in accordance with one of the following:

- (A) American Heart Association;
 - (B) Medic First Aid; or
 - (C) American Red Cross.
- (e) A licensed professional is not required to receive the trainings or certifications prescribed in this section 303.

304. Employee Records.

- (a) A Provider must maintain a personnel record for each employee that includes:
- (1) A detailed current job description;
 - (2) All required criminal background checks;
 - (3) All required Child Maltreatment Central Registry checks;
 - (4) All required Adult and Long-term Care Facility Resident Maltreatment Central Registry checks;
 - (5) All conducted drug screens;
 - (6) All required sex offender registry searches;
 - (7) All required Medicaid excluded provider list checks;
 - (8) Signed statement that the employee will comply with Provider's drug screen and drug use policies;
 - (9) Copy of current state or federal identification;
 - (10) Copy of valid state-issued driver's license, if driving is required in the job description;
 - (11) Documentation demonstrating the employee received all required trainings and certifications; and
 - (12) Documentation demonstrating the employee obtained and maintains in good standing all professional licenses, certifications, or credentials required for the CES Waiver Service performed by the employee.

- (b) A Provider must retain all employee personnel records for five (5) years from the date an employee ceases providing services to Provider or, if longer, the conclusion of all reviews, appeals, investigations, administrative actions, or judicial actions related to the employee that are pending at the end of the five (5) -year period.

305. Beneficiary Service Records.

- (a)
 - (1) A Provider must maintain a separate, updated, and complete service record for each beneficiary documenting the services provided to the beneficiary and any other documentation required under these standards.
 - (2) A Provider must maintain each beneficiary service record in a uniformly organized manner.
 - (3) A beneficiary service record must be made immediately available to a beneficiary and their legal guardian upon request.
- (b) A beneficiary's service record must include a summary document at the front that includes:
 - (1) The beneficiary's:
 - (A) Full name;
 - (B) Address and county of residence;
 - (C) Telephone number and email address, if available;
 - (D) Date of birth;
 - (E) Primary language;
 - (F) Diagnoses;
 - (G) Medications, dosage, and frequency, if applicable;
 - (H) Known allergies;
 - (I) Social Security Number;
 - (J) Medicaid number;
 - (K) Commercial or private health insurance information, if applicable; and
 - (L) Assigned Provider-Led Arkansas Shared Savings Entity (PASSE);

- (2) The date beneficiary began receiving each CES Waiver Service from Provider;
 - (3) The date beneficiary ceased receiving each CES Waiver Service from Provider, if applicable;
 - (4) The name, address, phone number, and email address, if available, of the beneficiary's legal guardian, if applicable; and
 - (5) The name, address, and phone number of the beneficiary's primary care provider (PCP).
- (c) A beneficiary's service record must include at least the following information and documentation:
- (1) PCSP, or documentation demonstrating a copy of PCSP has been requested from PASSE;
 - (2) Non-clinical treatment plan;
 - (3) PASSE prior authorizations for all CES Waiver Services performed by Provider;
 - (4) Positive behavior support plan, as applicable;
 - (5) Behavioral prevention and intervention plan, as applicable;
 - (6) Daily activity logs or other documentation for each CES Waiver Service;
 - (7) Medication management plan, if applicable;
 - (8) Medication logs, if applicable;
 - (9) Copies of any court orders that place the beneficiary in the custody of another person or entity; and
 - (10) Copies of any leases or residential agreements related to Provider owned, leased, or controlled CES Waiver Service residential settings.
- (d)
- (1) A Provider must ensure that each beneficiary service record is kept confidential and available only to:
 - (A) Employees who need to know the information contained in the beneficiary's service record;

- (B) DDS and any governmental entity with jurisdiction or other authority to access the beneficiary's service record;
- (C) The beneficiary's assigned PASSE;
- (D) The beneficiary's legal guardian, if applicable; and
- (E) Any other individual authorized in writing by the beneficiary or, if applicable, the beneficiary's legal guardian.

(2)

(A) A Provider must keep beneficiary service records in a file cabinet or room that is always locked.

(B)

(i) A Provider may use electronic records in addition to or in place of physical records to comply with these standards.

(ii) A Provider that uses electronic records must take reasonable steps to backup all electronic records and reconstruct a beneficiary's service record in the event of a breakdown in the Provider's electronic records system.

(e) A Provider must retain all beneficiary service records for five (5) years from the date the beneficiary exits from the Provider or, if longer, the conclusion of all reviews, appeals, investigations, administrative actions, or judicial actions related to the beneficiary that are pending at the end of the five (5)-year period.

306. Marketing and Solicitation.

- (a) A Provider can market its services.
- (b) A Provider cannot solicit a beneficiary or their family.

307. Third-party Service Agreements.

- (a) A Provider may contract in writing with third-party vendors to provide services or otherwise satisfy requirements under these standards.
- (b) A Provider must ensure that all third-party vendors comply with these standards and all other applicable laws, rules, and regulations.

308. Financial Safeguards.

(a)

- (1) A beneficiary must have full use and access to their own funds or other assets.
- (2) A Provider may not limit a beneficiary's use or access to their own funds or other assets unless:
 - (A) The beneficiary or, if applicable, the beneficiary's legal guardian, provides informed written consent; or
 - (B) Provider otherwise has the legal authority.
- (3) A Provider is deemed to be limiting a beneficiary's use or access to the beneficiary's own funds and assets when:
 - (A) Designating the amount of funds a beneficiary may use or access;
 - (B) Limiting the amount of funds a beneficiary may use for a particular purpose; and
 - (C) Limiting the timeframes during which a beneficiary may use or access their funds or other assets.

(b)

- (1) A Provider may use, manage, or access a beneficiary's funds or other assets only when:
 - (A) The beneficiary or, if applicable, the beneficiary's legal guardian, has provided informed written consent; or
 - (B) Provider otherwise has the legal authority.
- (2) A Provider is deemed to be managing, using, or accessing a beneficiary's funds or other assets when:
 - (A) Serving as a representative payee of a beneficiary;
 - (B) Receiving benefits on behalf of a beneficiary; and
 - (C) Safeguarding funds or personal property for a beneficiary.

- (3) A Provider may only use, manage, or access a beneficiary's funds or other assets for the benefit of the beneficiary.
 - (4) A Provider may only use, manage, or access a beneficiary's funds or other assets to the extent permitted by law.
 - (5) A Provider must safeguard beneficiary funds or other assets whenever a Provider manages, uses, or has access to a beneficiary's funds or other assets.
 - (6) A Provider must ensure that a beneficiary receives the benefit of the goods and services for which the beneficiary's funds or other assets are used.
- (c)
- (1) A Provider must maintain financial records that document all uses of a beneficiary's funds or other assets.
 - (2) Financial records for beneficiary funds must be maintained in accordance with generally accepted accounting practices.
 - (3) A Provider must make beneficiary financial records available to a beneficiary or a beneficiary's legal guardian upon request.
- (d)
- (1) A Provider must maintain separate accounts for each beneficiary whenever the Provider uses, manages, or accesses beneficiary funds or other assets.
 - (2) Every beneficiary is not required to have separate commercial bank account. A single, collective commercial bank account may be used to hold the personal funds of multiple beneficiaries so long as Provider uses an accounting system that maintains a separate record for each beneficiary's deposit and withdrawal transactions from the single, collective commercial bank account.
 - (3) All interest derived from a beneficiary's funds or other assets shall accrue to the beneficiary's account.

309. Infection Control.

- (a)
- (1) A Provider must follow all applicable guidance from the Arkansas Department of Health related to infection control.

- (2) A Provider must provide personal protective equipment for all employees and beneficiaries as may be required in the circumstances.
- (b) If applicable, a Provider must notify a beneficiary's legal guardian if the beneficiary becomes ill.

310. Compliance with State and Federal Laws, Rules, and Other Standards.

- (a) A Provider must comply with all applicable local, state, and federal laws, rules, codes, or regulations and violation of any applicable local, state, or federal law, rule, code, or regulation constitutes a violation of these standards.
- (b)
 - (1) In the event of a conflict between these standards and another applicable local, state, or federal law, rule, code, or regulation the stricter requirement shall apply.
 - (2) In the event of an irreconcilable conflict between these standards and another applicable local, state, or federal law, rule, code, or regulation these standards shall govern to the extent not governed by local, state, or federal law.

311. Restraints and Other Restrictive Interventions.

- (a)
 - (1) A Provider cannot use a restraint on a beneficiary unless the restraint is required as an emergency safety intervention.
 - (2) An emergency safety intervention is required when:
 - (A) An immediate response with a restraint is required to address an unanticipated beneficiary behavior; and
 - (B) The beneficiary's behavior places the beneficiary or others at serious threat of harm if no intervention occurs.
 - (3) The use of seclusion for a beneficiary is strictly prohibited.
 - (4) The use of the following types of restraints on a beneficiary are strictly prohibited:
 - (A) Mechanical restraint; and
 - (B) Chemical restraint.

- (b) If a Provider uses a restraint, the Provider must:
 - (1) Comply with the use of the restraint as prescribed by the beneficiary's:
 - (A) Behavioral prevention and intervention plan, if applicable; and
 - (B) Positive behavior support plan, if applicable;
 - (2) Continuously monitor the beneficiary during the entire use of the restraint; and
 - (3) Maintain in-person visual and auditory observation of the beneficiary by an employee during the entire use of the restraint.
- (c)
 - (1) A Provider must document each use of a restraint whether the use was permitted or not.
 - (2) The documentation must include at least the following:
 - (A) The behavior precipitating the use of the restraint;
 - (B) The length of time the restraint was used;
 - (C) The name of the individual that authorized the use of the restraint;
 - (D) The names of all individuals involved in the use of the restraint; and
 - (E) The outcome of the use of the restraint.

312. Medications.

- (a)
 - (1) A beneficiary, or, if applicable, the beneficiary's legal guardian, can self-administer medication.
 - (2) When a beneficiary or legal guardian chooses to self-administer medication, a Provider must obtain a signed and dated election to self-administer medication that is renewed on an annual basis.
- (b)
 - (1) A Provider can administer medication only as:

- (A) Provided in the beneficiary's medication management plan; or
 - (B) Otherwise ordered by:
 - (i) A physician; or
 - (ii) Other health care professional authorized to prescribe or otherwise order the administration of medication.
 - (2) A Provider must administer medication in accordance with the Nurse Practice Act and the Consumer Directed Care Act.
- (c)
- (1)
 - (A) A Provider must develop a medication management plan for any non-self-administered prescribed and over-the-counter medication that is to be administered during the time the beneficiary is receiving a CES Waiver Service.
 - (B) A medication management plan does not have to be a standalone document, and may be included within the beneficiary's non-clinical treatment plan, medication log, or other document.
 - (2) A medication management plan must include without limitation:
 - (A) The name of each medication;
 - (B) The name of the prescribing physician or other health care professional if the medication is by prescription;
 - (C) A description of the symptom or symptoms to be addressed by each medication;
 - (D) How each medication will be administered, including without limitation time(s) of administration, dose(s), route of administration, and persons who may lawfully administer each medication;
 - (E) A list of the most common potential side effects caused by each medication; and
 - (F) The consent to the administration of each medication by the beneficiary, or, if applicable, the beneficiary's legal guardian.

(d)

- (1) A Provider must maintain a medication log for each beneficiary to document all non-self-administered prescribed and over-the-counter medications.
- (2) A medication log must be available at each location a beneficiary receives CES Waiver Services and must document the following for each administration of a medication:
 - (A) The name and dosage of medication administered;
 - (B) The route of medication administration;
 - (C) The date and time the medication was administered;
 - (D) The name of each employee who administered the medication or assisted in the administration of the medication;
 - (E) If an over-the-counter medication administered for a specific symptom, the specific symptom addressed and the effectiveness of the medication;
 - (F) Any adverse reaction or other side effect caused by the medication;
 - (G) Any transfer of medication that is not self-administered from the medication's original container into individual dosage containers;
 - (H) Any error in administering the medication; and
 - (I) The prescription and the name of the prescribing physician or other health care professional if the medication was not previously listed in the medication management plan.
- (3) All medication errors must be:
 - (A) Immediately reported to a supervisor;
 - (B) Documented in the medication log; and
 - (C) Reported as required under all applicable laws and rules including without limitation the laws and rules governing controlled substances.
- (4) A supervisory level employee must review and sign each medication log on at least a monthly basis.

(e) All medications stored for a beneficiary by a Provider must be:

- (1) Kept in the original medication container unless the beneficiary, or, if applicable, the beneficiary's legal guardian, transfers the medication into individual dosage containers;
 - (2) Labeled with the beneficiary's name; and
 - (3) Stored in an area, medication cart, or container that is always locked.
- (f) If a medication stored by a Provider is no longer to be administered to the beneficiary, then the medication must be:
- (1) Returned to the beneficiary's legal guardian, if applicable;
 - (2) Destroyed; or
 - (3) Otherwise disposed of in accordance with applicable laws and rules.

313. Behavioral Management Plans.

- (a)
- (1) The selected Provider for supportive living services must develop a behavioral prevention and intervention plan for a beneficiary if the beneficiary's risk mitigation plan identifies the beneficiary as a risk to display behaviors that can lead to harm to self or others, but below a risk level requiring a positive behavior support plan.
 - (2) The development and drafting of a behavioral prevention and intervention plan must be performed by an employee who:
 - (A) Has completed all the trainings and certifications required in section 303; or
 - (B) Is a licensed professional.
 - (3) A behavioral prevention and intervention plan must at a minimum include:
 - (A) A description of the beneficiary's inappropriate behaviors;
 - (B) What triggers the inappropriate behaviors;
 - (C) What actions to take when an inappropriate behavior occurs; and

- (D) A statement that restraints and restrictive interventions are prohibited except during an emergency safety intervention.
 - (4) A behavioral prevention and intervention plan does not have to be a standalone document and may be included within the beneficiary's non-clinical treatment plan or other document.
- (b)
- (1) The selected Consultation Provider must develop and implement a positive behavior support plan if a beneficiary's risk mitigation plan identifies the beneficiary as a high behavioral risk that can lead to harm to self or others, as defined in the risk assessment and mitigation plan tool.
 - (2)
 - (A) The development and drafting of the positive behavior support plan is a consultation service that must be performed by one of the following certified Providers of consulting services as defined in section 608:
 - (i) Psychologist;
 - (ii) Psychological Examiner;
 - (iii) Positive Behavior Support Specialist;
 - (iv) Board Certified Behavior Analyst;
 - (v) Licensed Clinical Social Worker; or
 - (vi) Licensed Professional Counselor.
 - (B) The Provider of consultation services that develops and implements the positive behavior support plan does not have to be the Provider performing supportive living services for the beneficiary.
 - (3) A positive behavior support plan must at minimum include all items listed in subsection (a)(3) of this part in addition to the following:
 - (A) Who will be implementing the positive behavior support plan;
 - (B) The skills or appropriate behaviors that will be taught to reduce or minimize the inappropriate behaviors;

- (C) The prompts that will be added to the environment to help reduce the occurrence of, or assist the beneficiary to overcome, the trigger;
- (D) An incentive and reinforcement system for appropriate beneficiary behavior that includes more than social praise;
- (E) Specific criteria the beneficiary needs to meet to earn reinforcement;
- (F) A detailed emergency safety intervention action plan, that at a minimum includes:
 - (i) The behavioral context that will trigger the use of emergency safety intervention procedures;
 - (ii) The exact emergency safety intervention procedures that will be used and by whom; and
 - (iii) The process that will be used for a review of the positive behavior support plan within forty-eight (48) hours of the emergency safety intervention; and
- (G) The next positive behavior support plan review date.

Subchapter 4. Entries and Exits.

401. Entries.

- (a) A Provider may enroll and provide those CES Waiver Services it is certified to deliver pursuant to its CES Waiver Service certification(s) to an eligible beneficiary.
- (b) A Provider must document the enrollment of all beneficiaries.

402. Exits.

- (a) A Provider may exit a beneficiary:
 - (1) If the beneficiary becomes ineligible for CES Waiver as provided in section 405;
 - (2) If the beneficiary chooses to use another Provider; or
 - (3) For any other lawful reason.
- (b) A Provider must provide reasonable assistance to all exiting beneficiaries, which at a minimum includes:
 - (1) Assisting the beneficiary in transitioning to another Provider (in accordance with section 403) or other service provider, when applicable;
 - (2) Submitting within fourteen (14) days of the beneficiary's exit or, if earlier, transition conference, all necessary transfer paperwork to the Social Security Administration and any other necessary agency or financial institution, when Provider is serving as the beneficiary's representative payee; and
 - (3)
 - (A) Providing copies of the beneficiary's service records to:
 - (i) The beneficiary;
 - (ii) The beneficiary's legal guardian, if applicable; and
 - (iii) Any new Provider or other service provider to which the beneficiary transfers after exiting.
 - (B) Service records must include:
 - (i) The beneficiary's non-clinical treatment plan;

- (ii) Medication management plan; and
- (iii) Any other records requested by the beneficiary.

(C) If copies of the exiting beneficiary's service record are not provided within thirty (30) days of a written request, it is presumed to be an unreasonable delay in violation of these standards.

403. Transitions from one CES Waiver Provider to another.

(a)

(1) When a beneficiary transitions from one Provider to another Provider the requirements of this section 403 apply in addition to those in section 402.

(2) The requirements of this section 403 apply to any Provider-to-Provider transfer, including without limitation when:

(A) A beneficiary, or, if applicable, their legal guardian, elects to change Providers; and

(B) A Provider declares a refusal to serve in accordance with section 404.

(b) A newly selected Provider must notify the current Provider of its selection within fourteen (14) business days of receiving notification of its selection from the PASSE.

(c) The new Provider must hold a transition conference to develop a transition plan for the beneficiary within fourteen (14) business days of issuing the notification required in subsection (b) above. If the new Provider is unable to hold the transition conference within the required timeframe, reasonable justification for the delay must be documented.

(d)

(1) The transition plan must at a minimum include:

(A) The effective date of the beneficiary's transition to the new Provider;

(B) Any upcoming or pending medical, counseling, or other appointments for the beneficiary;

(C) The date of the transition conference;

(D) How the transition conference was held (i.e. in person, by phone, zoom, etc.);

- (E) All individuals that attended the transition conference; and
 - (F) Documentation or other evidence that demonstrated both the current and new provider's consent to the transition plan (i.e. signatures on plan, email approval, etc.).
- (2) The following parties must participate in the transition conference:
- (A) Newly selected Provider;
 - (B) Current Provider;
 - (C) Assigned PASSE care coordinator; and
 - (D) The beneficiary or, if applicable, the beneficiary's legal guardian (unless they decline to attend).
- (e)
- (1) The current Provider will remain responsible for the delivery of services until such time as the beneficiary's transition to the new Provider is complete, which shall not exceed ninety (90) days from the date of the transition conference.
 - (2) Any new Provider not able to accept full responsibility for beneficiary service delivery within ninety (90) days from the date of the transition conference may be subject to the full array of available enforcement actions unless justified extenuating circumstances can be demonstrated.
 - (3) If a current provider is denied access to deliver services by the beneficiary or the beneficiary's family/guardian before transition to the new provider is complete, then the current provider must specifically document its attempts and the family/guardian's denial of access to provide services.
- (f) The new Provider and current Provider must maintain a copy of the beneficiary's transition plan in the beneficiary's service record.
- (g) Nothing in this section 403 precludes a new Provider from declaring a refusal to serve as provided in section 404.

404. Refusal to Serve.

- (a)
 - (1) A selected Provider may refuse to serve any beneficiary:

- (A) When the Provider is unable to ensure the beneficiary's or their employees' health, safety, or welfare; or
 - (B) Upon the occurrence of one of the situations described subsections (1) – (4) of section 405.
- (2) A Provider must immediately notify DDS and the beneficiary's assigned PASSE care coordinator when refusing to serve a beneficiary.
- (b) If a Provider is unable to ensure a beneficiary's health, safety, or welfare because qualified personnel are unavailable to deliver a CES Waiver Service included on the beneficiary's PCSP, Provider must be able to demonstrate reasonable efforts to recruit and retain qualified personnel and the results of those efforts.
 - (c) Whether a Provider is refusing to serve based on legitimate beneficiary or employee health, safety, or welfare concerns is determined in the sole discretion of DDS.
 - (d) If a Provider is currently serving a beneficiary when declaring a refusal to serve, the Provider shall remain responsible for the delivery of CES Waiver Services until the beneficiary transitions to their new Provider or other placement unless there is an immediate health or safety risk to Provider employees. A detailed description of any health and safety risk justifying the ceasing of service delivery prior to a completed transition of beneficiary to a new Provider must be documented.

405. CES Waiver Eligibility Disqualification.

A beneficiary may be disenrolled from the CES Waiver under the following circumstances:

- (1) When the beneficiary or legal guardian refuses to participate in the PCSP or non-clinical treatment plan development;
- (2) When the beneficiary or legal guardian refuses to permit implementation of the PCSP, non-clinical treatment plan, or any part thereof that is deemed necessary to assure health and safety;
- (3) When the beneficiary or legal guardian refuses to permit the on-site entry of:
 - (A) The PASSE care coordinator to conduct scheduled/required visits;
 - (B) Direct care staff to provide scheduled care;
 - (C) The supervisory or management staff of a Provider to conduct a scheduled/required visit; or

- (D) DHS or its authorized representatives acting in their role as oversight authority for compliance or audit purposes;
- (4) When the beneficiary requires twenty-four (24) hour nursing care on a continuous basis as prescribed by a physician;
 - (5) When the beneficiary is fully admitted as a resident in a public institution or as an inmate in a federal, state, or local correctional facility;
 - (6) When the beneficiary is deemed ineligible based on assessment or reassessment finding that the beneficiary does not meet ICF/IID institutional level of care; and
 - (7) When the beneficiary is ineligible based on not meeting or not complying with Medicaid eligibility requirements.

PROPOSED

Subchapter 5. Settings Requirements.

501. Emergency Plans and Drills.

- (a) A Provider must have a written emergency plan for all Provider owned, leased, or controlled CES Waiver Service residential settings.
- (b) A written emergency plan must address all foreseeable emergencies, including without limitation:
 - (1) Fire;
 - (2) Flood;
 - (3) Tornado;
 - (4) Utility disruption;
 - (5) Bomb threat;
 - (6) Active shooter; and
 - (7) Infectious disease outbreak.
- (c) A Provider must evaluate and, if necessary, update, written emergency plans at least annually for all Provider owned, leased, or controlled CES Waiver Service residential settings.
- (d) Each written emergency plan must at a minimum include:
 - (1) Designated relocation sites and evacuation routes;
 - (2) Procedures for notifying legal guardians upon relocation, if applicable;
 - (3) Procedures for ensuring each beneficiary's safe return;
 - (4) Procedures to address the special needs of each beneficiary;
 - (5) Procedures to address interruptions in the delivery of services;
 - (6) Procedures for reassigning employee duties in an emergency; and
 - (7) Procedures for annual training of employees regarding the emergency plan.

(e)

- (1) A Provider must conduct emergency fire drills at least once a month for all Provider owned, leased, or controlled CES Waiver Service residential settings.
- (2) A Provider must conduct all other emergency drills set out in subsection (b) at least annually for all Provider owned, leased, or controlled CES Waiver Service residential settings.
- (3) A Provider must document all emergency drills, which must include:
 - (A) The date and time of the emergency drill;
 - (B) The type of emergency drill;
 - (C) The number of beneficiaries participating in the emergency drill;
 - (D) The length of time taken to complete the emergency drill; and
 - (E) Notes regarding any aspects of the emergency drill that need improvement.

502. Provider Owned Residential Setting Requirements.

- (a) Each Provider owned, leased, or controlled CES Waiver Service residential setting must meet the home and community-based services setting regulations as established by 42 CFR 441.301(c) (4)-(5).
- (b)
 - (1) A Provider owned, leased, or controlled CES Waiver Service residential setting is limited to no more than eight (8) beneficiaries.
 - (2) Previously grandfathered group home locations continuously licensed by DDS since July 1, 1995, may continue to serve up to fourteen (14) unrelated adult beneficiaries with intellectual or developmental disabilities.
- (c) All Provider owned, leased, or controlled CES Waiver Service residential settings must meet the following requirements:
 - (1) The interior of the location must:
 - (A) Be maintained at a comfortable temperature;
 - (B) Have appropriate interior lighting;

- (C) Be well-ventilated;
 - (D) Have a running source of potable water in each bathroom, and, if applicable, kitchen;
 - (E) Be maintained in a safe, clean, and sanitary condition;
 - (F) Be free of:
 - (i) Offensive odors;
 - (ii) Pests;
 - (iii) Lead-based paint; and
 - (iv) Hazardous materials.
- (2) The exterior of each Provider owned, leased, or controlled CES Waiver Service residential setting's physical structure must be maintained in good repair, and free of dangerous holes, cracks, and leaks, including without limitation the:
- (A) Roof;
 - (B) Foundation;
 - (C) Doors;
 - (D) Windows;
 - (E) Siding;
 - (F) Porches;
 - (G) Patios; and
 - (H) Walkways.
- (3) The surrounding grounds of each Provider owned, leased, or controlled CES Waiver Service residential setting must be maintained in a safe, clean, and manicured condition free of trash and other objects.
- (4) Broken equipment, furniture, and appliances on or about the premises of each Provider owned, leased, or controlled CES Waiver Service residential setting must be either immediately repaired or appropriately discarded off premises and replaced.

- (d) Provider owned, leased, or controlled CES Waiver Service residential settings must at a minimum include:
- (1) A functioning hot water heater;
 - (2) A functioning HVAC unit(s) able to heat and cool;
 - (3) An operable on-site telephone that is available at all hours and reachable with a phone number for outside callers;
 - (4) All emergency contacts and other necessary contact information related to a beneficiary's health, welfare, and safety in a readily available location, including without limitation:
 - (A) Poison control;
 - (B) The beneficiary's primary care provider (PCP); and
 - (C) Local police;
 - (5) One (1) or more working flashlights;
 - (6) A smoke detector;
 - (7) A carbon monoxide detector, unless there are no forms of gas services at the location;
 - (8) A first aid kit that includes at least the following:
 - (A) Adhesive band-aids of various sizes;
 - (B) Sterile gauze squares;
 - (C) Adhesive tape;
 - (D) Antiseptic;
 - (E) Thermometer;
 - (F) Scissors;
 - (G) Disposable gloves; and
 - (H) Tweezers;

- (9) Fire extinguishers in number and location to satisfy all applicable laws and rules, but at least one (1) functioning fire extinguisher is required at each location;
 - (10) Screens for all windows and doors used for ventilation;
 - (11) Screens or guards attached to the floor or wall to protect floor furnaces, heaters, hot radiators, exposed water heaters, air conditioners, and electric fans; and
 - (12) Written instructions and diagrams noting emergency evacuation routes to be used in case of fire, severe weather, or another emergency posted:
 - (A) By each exit;
 - (B) In all stairwells, if applicable; and
 - (C) In and by all elevators, if applicable.
- (e) Each Provider owned, leased, or controlled CES Waiver Service residential setting must provide each beneficiary with a bedroom that has:
- (1) An entrance that can be accessed without going through a bathroom or another person's bedroom;
 - (2) An entrance with a lockable door; and
 - (3) One (1) or more windows that can open and provide an outside view.
- (f) Each Provider owned, leased, or controlled CES Waiver Service residential setting must meet the following bathroom requirements:
- (1) At least one (1) bathroom must have a shower or bathtub;
 - (2) All toilets, bathtubs, and showers must provide for individual privacy;
 - (3) At least one (1) toilet, bathtub, and shower must be designed and installed in an accessible manner for each beneficiary; and
 - (4) Each bathroom must have the following:
 - (A) Toilet;
 - (B) Sink with running hot and cold water;
 - (C) Toilet tissue;
 - (D) Soap; and

- (E) Towels or paper towels.
- (g) Each Provider owned, leased, or controlled CES Waiver Service residential setting that houses more than one (1) beneficiary must ensure:
 - (1) Each beneficiary has fifty (50) or more square feet of separate bedroom space;
 - (2) Each beneficiary has an individual bed measuring at least thirty-six (36) inches wide with:
 - (A) A mattress;
 - (B) Pillows; and
 - (C) Linens, which must be cleaned or replaced at least weekly;
 - (3) Each beneficiary has storage space for clothes and personal items;
 - (4) At least one (1) bathroom with a shower/bathtub, sink, and toilet for every four (4) beneficiaries.
 - (5) A reasonably furnished living room;
 - (6) A reasonably furnished dining area; and
 - (7) A kitchen with equipment, utensils, and supplies necessary to properly store, prepare, and serve three (3) or more meals a day for up to one (1) week.

503. Provider Owned Residential Setting Exceptions and Variations.

- (a) Any beneficiary need or behavior that requires a variation or exception to the Provider owned, leased, or controlled CES Waiver Service residential setting requirements set out in section 502 must be justified in their behavioral prevention and intervention plan, positive behavior support plan, or non-clinical treatment plan.
- (b) The justification for a variation or exception to any Provider owned, leased, or controlled CES Waiver Service residential setting requirement must at a minimum include:
 - (1) The specific, individualized need or behavior that requires a variation or exception;
 - (2) The positive interventions and supports used prior to the implementation of the variation or exception;
 - (3) The less intrusive methods of meeting the need or managing the behavior that were attempted but did not work;

- (4) A clear description of the applicable variation or exception;
- (5) The regular data collection and reviews that will be conducted to measure the ongoing effectiveness of the variation or exception;
- (6) A schedule of periodic reviews to determine if the variation or exception is still necessary or can be terminated;
- (7) The informed consent of the beneficiary or, if applicable, legal guardian; and
- (8) An assurance that interventions and supports will cause no harm to the beneficiary.

PROPOSED

Subchapter 6. Programs and Services.

601. Supportive Living.

- (a) Supporting living services are individually tailored rehabilitative services and activities to enable a beneficiary to reside successfully in their own home, with family, or in an alternative living setting.
- (b)
 - (1) Supportive living services must be provided in an integrated community setting.
 - (2) Supportive living services must directly relate to goals and objectives in the beneficiary's non-clinical treatment plan.
 - (3) Providers must ensure that a sufficient number of direct care staff are scheduled during the performance of supportive living services to guarantee the health, safety, and welfare of each beneficiary.
 - (4) Providers must have backup plans in place to address contingencies if direct care staff are unable, fail, or refuse to provide scheduled supportive living services.
- (b) A Provider of supportive living services must maintain the following documentation in the beneficiary's service record for each day the beneficiary receives supportive living services:
 - (1) The name and sign-in/sign-out times for each direct care staff member providing supportive living services;
 - (2) The specific supportive living activities performed;
 - (3) Name(s) of the direct care staff providing each supportive living activity;
 - (4) The relationship of the activities to the goals and objectives described in the beneficiary's non-clinical treatment plan; and
 - (5) Daily progress notes/narrative signed and dated by one of the direct care staff performing the services and activities, describing the beneficiary's progress or lack thereof with respect to each of their individualized goals and objectives.

602. Complex Care Home.

- (a) A complex care home is a specific type of Provider owned, leased, or controlled supportive living residential setting that is certified to offer eligible beneficiaries a twenty-four (24)

hour, seven (7) days a week specialized medical, clinical, and habilitative support and service array.

(b)

(1) Complex care home placement for a beneficiary is intended to be temporary and transitional.

(2) Each beneficiary living in a complex care home must be diagnosed with an intellectual or developmental disability and a significant co-occurring deficit, which includes without limitation individuals with an intellectual disability and significant:

(A) Behavioral health needs; or

(B) Physical health needs.

(3)

(A) A Provider must maintain the beneficiary to staff ratio necessary to meet each beneficiary's needs as provided in their non-clinical treatment plan and PCSP and to ensure beneficiary and direct care staff health, safety, and welfare.

(B) Under no circumstances may there be less than a four-to-one (4:1) beneficiary to staff ratio in a complex care home at any time.

(c) A complex care home must be certified as provided in section 201(b) and 202.

(d)

(1) Each Provider operating a complex care home must employ or contract with a medical director who is a licensed physician in good standing with the Arkansas Medical Board.

(2) The medical director is responsible for:

(A) Oversight of all medical services performed by the Provider for beneficiaries residing in a complex care home;

(B) Oversight of complex care home medical care quality and compliance; and

(C) Ensuring all medical services performed for beneficiaries in a complex care home are provided:

- (i) Within each practitioner's scope of practice under Arkansas law; and
 - (ii) Under such supervision as required by law for practitioners not licensed to practice independently.
- (3) The medical director must ensure appropriate medical services are accessible twenty-four (24) hours a day, seven (7) days a week for all beneficiaries residing in a complex care home.
- (4)
 - (A) A Provider operating a complex care home must always have its medical director on-site or on-call during hours of operation.
 - (B) An on-call medical director must respond:
 - (i) Within twenty (20) minutes of initial contact; and
 - (ii) In-person if required by the circumstances.
 - (C) A Provider operating a complex care home must document each after-hours contact with a its medical director, including without limitation:
 - (i) The date and time the medical director was contacted;
 - (ii) The date and time the medical director responded; and
 - (iii) The date and time an on-call medical director came on-site when called in due to circumstances.
- (5) If the medical director is not a licensed psychiatrist, then the medical director must contact the licensed psychiatrist contracted or employed by the Provider within twenty-four (24) hours in the following situations:
 - (A) When antipsychotic or stimulant medications are used in dosages higher than recommended in guidelines published by DMS;
 - (B) When two (2) or more medications from the same pharmacological class are used; and
 - (C) When there is a beneficiary clinical deterioration or crisis causing risk of danger to the beneficiary or others.

(e)

- (1) Each Provider operating a complex care home must employ or contract with a licensed psychiatrist certified by one of the specialties of the American Board of Medical Specialties to serve as a consultant to the medical director and other employees, as needed.
- (2) If the medical director is certified by one of the specialties of the American Board of Medical Specialties, then a Provider is not required to retain a second licensed psychiatrist.

(f)

- (1) Each Provider operating a complex care home serving beneficiaries under the age of twenty-one (21) must employ or contract with a board-certified child psychiatrist to serve as a consultant to the medical director and other employees, as needed.
- (2) If the medical director is a board-certified child psychiatrist, then a Provider is not required to retain a second board-certified child psychiatrist.

(g)

- (1) Each Provider operating a complex care home must employ or contract with a full-time clinical director (or functional equivalent) who holds one (1) of the following State of Arkansas licenses or certifications:
 - (A) Psychologist;
 - (B) Certified Social Worker;
 - (C) Psychological Examiner – Independent;
 - (D) Professional Counselor;
 - (E) Marriage and Family Therapist ;
 - (F) Advanced Practice Nurse with:
 - (i) A specialty in psychiatry or mental health; and
 - (ii) A minimum of two (2) years' clinical experience post master's degree; or
 - (G) Clinical Nurse Specialist with:
 - (i) A specialty in psychiatry or mental health; and

- (ii) A minimum of two (2) years' clinical experience post master's degree.
 - (2) The clinical director is responsible for:
 - (A) Oversight of all services (professional and paraprofessional) provided to a beneficiary residing in a certified complex care home;
 - (B) Oversight of complex care home care and service quality and compliance;
 - (C) Ensuring all services (professional and paraprofessional) performed for beneficiaries in a complex care home are provided:
 - (i) Within each employee's or practitioner's scope of practice under Arkansas law; and
 - (ii) Under such supervision as required by law for employees and practitioners not licensed to practice independently; and
 - (D) Ensuring all licensed professionals appropriately supervise the delivery of all services in accordance with the beneficiary's treatment plan.
- (h)
 - (1) A Provider operating a complex care home must assign a multidisciplinary team to each beneficiary residing in the complex care home.
 - (2) The multidisciplinary team is responsible for:
 - (A) The development of the beneficiary's treatment plan for those services to be performed by the Provider; and
 - (B) The Provider's delivery of all services included in beneficiary's treatment plan.
 - (3)
 - (A) Each multidisciplinary team must have a designated multidisciplinary team leader.
 - (B) Each multidisciplinary team leader must be a mental health professional (MHP).
 - (C) The designated multidisciplinary team leader must have licensure and training applicable to the treatment of the beneficiary as indicated in the beneficiary's PCSP.

- (D) Each multidisciplinary team leader is responsible for:
 - (i) Overseeing the development of the treatment plan for those services to be performed by the Provider;
 - (ii) Monitoring the Provider's delivery of all services included in the beneficiary's treatment plan;
 - (iii) Directly supervising Provider employees performing the services included in the beneficiary's treatment plan; and
 - (iv) Providing case consultation and in-service training to members of the multidisciplinary team, as needed.
- (i)
 - (1) A Provider operating a complex care home must establish, implement, and maintain a site-specific crisis response plan at each complex care home location.
 - (2) Each site-specific crisis response plan must include a twenty-four (24) hour emergency telephone number that provides for a:
 - (A) Direct access call with a mental health professional (MHP) within fifteen (15) minutes of an emergency/crisis;
 - (B) Face-to-face crisis assessment of a beneficiary within two (2) hours of an emergency/crisis (which may be conducted through telemedicine) unless a different time frame is within clinical standards guidelines and mutually agreed upon by the requesting party and the responding MHP; and
 - (C) Clinical review by the clinical director within twenty-four (24) hours of the emergency/crisis.
- (j) A Provider operating a complex care home must:
 - (1) Provide the twenty-four (24)-hour emergency telephone number to all beneficiaries, and, if applicable, the legal guardians of all beneficiaries, residing in the complex care home;
 - (2) Post the twenty-four (24)-hour emergency telephone number on all public entrances to each complex care home location; and
 - (3) Include the twenty-four (24)-hour emergency telephone phone number on all answering machine greetings.

603. Respite.

- (a) Respite services are temporary, short-term services provided to relieve a beneficiary's primary caregiver(s) or because of a primary caregiver(s) emergency absence.
 - (1) Receipt of respite services does not preclude a beneficiary from receiving other CES Waiver services on the same day.
 - (2) Respite services cannot supplant the responsibility of a parent or legal guardian.
- (b) A Provider of respite services must maintain the following documentation in the beneficiary's service record for each day a beneficiary receives respite services:
 - (1) The name and sign-in/sign-out times for each direct care staff member providing respite services;
 - (2) The specific respite activities performed;
 - (3) The date and beginning and ending time of each respite activity performed; and
 - (4) Name(s) of the direct care staff performing each respite activity.

604. Supported Employment.

- (a) Supported employment services are a tailored array of services offering ongoing support to beneficiaries in their goal of working in competitive integrated work settings for at least minimum wage.
 - (1) Supported employment services may include any combination of the following services:
 - (A) Job assessment and discovery;
 - (B) Person centered employment planning;
 - (C) Job placement;
 - (D) Job development;
 - (E) Job coaching;
 - (F) Benefits support;
 - (G) Training and planning;

- (H) Transportation to and from a beneficiary's home and employment site (when no other transportation is available);
 - (I) Asset development;
 - (J) Career advancement services; and
 - (K) Other workplace support services not specifically related to job skill training that enable a beneficiary to successfully integrate into a job setting.
- (2) Supported employment services include services utilized to support beneficiaries who are self-employed.
- (b) A Provider of supported employment services must maintain the following documentation in a beneficiary's service record:
 - (1) Job development or transition plan for job supports;
 - (2) Copy of beneficiary remuneration statements or paycheck stubs, if available; and
 - (3) Copy of beneficiary's recent work schedule, if applicable.

605. Specialized Medical Supplies.

- (a) Specialized medical supplies may include medically necessary:
 - (1) Items necessary for life support or to address a beneficiary's physical conditions, along with any ancillary supplies and equipment necessary for the proper functioning of such items;
 - (2) Durable and non-durable medical equipment necessary to address a beneficiary's functional limitations that are not available under the Arkansas Medicaid state plan;
 - (3) Medical Supplies not available under the Arkansas Medicaid state plan;
 - (4) Nutritional supplements;
 - (5) Non-prescription medications approved by the Federal Drug Administration; and
 - (6) Prescription drugs.
- (b) Specialized medical supplies do not include:
 - (1) Medical equipment or medical supplies available under the Arkansas Medicaid state plan;

- (2) Items that are not of a direct medical or remedial benefit to a beneficiary; and
 - (3) Alternative medicines that are not approved by the Federal Drug Administration.
- (c) A Provider of specialized medical supplies must maintain the following documentation in a beneficiary's service record:
- (1) The date of the specialized medical supplies order;
 - (2) The quantity and price per item of the specialized medical supplies ordered;
 - (3) A written description of the beneficiary's medical need addressed, or the remedial benefit provided by the specialized medical supplies;
 - (4) The delivery date of the specialized medical supplies; and
 - (5) If installation is required, the installation date and any instructions that are provided to the beneficiary or legal guardian regarding use of the specialized medical supplies.

606. Adaptive Equipment.

- (a) Adaptive equipment is a piece of equipment or product system that is used to increase, maintain, or improve a beneficiary's functional ability to perform daily life tasks that would not otherwise be possible. Adaptive equipment specifically includes without limitation the following:
- (1) Home enabling technology that allows a beneficiary to safely perform activities of daily living without assistance;
 - (2) The purchase, installation fee, and monthly service fee related to a personal emergency response system that enables a beneficiary to secure help in an emergency;
 - (3) Computer equipment and software that:
 - (A) Allows a beneficiary increased control of their environment;
 - (B) Allows a beneficiary to gain independence; or
 - (C) Protects a beneficiary's health and safety; and
 - (4) Modifications to an automobile or van to:

- (A) Enable a beneficiary to integrate more fully into the community; or
 - (B) Ensure the beneficiary's health, safety, and welfare.
- (b) A medical professional must be consulted to ensure adaptive equipment will meet the needs of a beneficiary.
- (c) Adaptive equipment *does not* include adaptations and modifications to a vehicle that are of general utility and not of direct medical or habilitative benefit to the beneficiary, including without limitation:
- (1) Any portion of the purchase price or down payment for a vehicle;
 - (2) Monthly vehicle payments; and
 - (3) Regular vehicle maintenance.
- (d) A Provider of adaptive equipment must maintain the following documentation in a beneficiary's service record:
- (1) The date of the adaptive equipment order;
 - (2) The quantity and price per item of the adaptive equipment ordered;
 - (3) A written description of the beneficiary's medical need addressed or the remedial benefit provided by the adaptive equipment;
 - (4) The delivery date of the adaptive equipment; and
 - (5) If installation is required, the installation date and any instructions that are provided to the beneficiary or legal guardian regarding use of the adaptive equipment.

607. Community Transition Services.

- (a) Community transition services cover non-recurring setup expenses for beneficiaries who are transitioning from an institutional or provider-operated living arrangement, such as an intermediate care facility or group home, into a living arrangement in a private residence where the beneficiary or their legal guardian is directly responsible for their own living expenses. Community transition services include without limitation the following:
- (1) Security deposits required to obtain a lease on an apartment or home;
 - (2) Essential household furnishings required to occupy and use a private residence such as:

- (A) Furniture;
 - (B) Window coverings;
 - (C) Food preparation items; and
 - (D) Bed and bathroom linens;
- (3) Set-up fees and deposits for utility access such as:
- (A) Telephone;
 - (B) Electricity;
 - (C) Natural gas; and
 - (D) Water;
- (4) Services necessary for the beneficiary's health or safety such as one-time pest eradication or cleaning prior to occupying a private residence; and
- (5) Moving expenses.
- (b) Community transition services do not include:
- (1) Monthly rent or mortgage payments;
 - (2) Food expenses;
 - (3) Monthly utility bills;
 - (4) Household appliances; and
 - (5) Items to be used for recreational purposes.
- (c) A Provider of community transition services must maintain the following documentation in a beneficiary's service record:
- (1) The date the community transition service is paid, and, if applicable, delivered or performed;
 - (2) The price of the community transition service;
 - (3) A receipt or invoice related to the community transition service; and

- (4) Written description of the community transition service and what beneficiary need was met or remedial benefit accomplished.

608. Consultation.

- (a) Consultation services are direct clinical or therapeutic specialty services by a professional licensed or certified in the applicable specialty, which assist a beneficiary, legal guardians, responsible persons, and service providers in carrying out the beneficiary's PCSP and any associated non-clinical treatment plans included within the PCSP. Consultation services include without limitation the following:
 - (1) Administering or updating psychological and adaptive behavior assessments;
 - (2) Screening, assessing, and developing non-clinical treatment plans;
 - (3) Training direct care staff and beneficiary family members in carrying out special community living services and strategies identified in the non-clinical treatment plan and PCSP, -and applicable to the consultant's specialty;
 - (4) Providing information and assistance in the consultant's specialty to the individual developing the non-clinical treatment plan;
 - (5) Participating on the interdisciplinary team;
 - (6) Providing training and technical assistance to service providers, direct care staff, or beneficiary family members on carrying out the beneficiary's non-clinical treatment plan and PCSP that is applicable to the consultant's specialty;
 - (7) Assisting direct care staff or beneficiary family members with necessary non-clinical treatment plan and PCSP adjustments applicable to the consultant's specialty;
 - (8) Advising on the appropriateness, assisting with the selection, setup, and training on the use of adaptive equipment, communication devices, and software applicable to the consultant's specialty;
 - (9) Training beneficiaries and their family members on self-advocacy;
 - (10) Training beneficiary family members or direct care staff on:
 - (A) Implementing behavioral prevention and intervention plans and positive behavior support plans;
 - (B) Speech-language pathology, occupational therapy, and physical therapy treatment modalities; and

- (C) The administration of medical procedures not previously prescribed but now necessary to allow the beneficiary to remain in a private residence;
 - (11) Rehabilitation counseling;
 - (12) Developing, overseeing, implementing, and modifying behavioral prevention and intervention plans and positive behavior support plans; and
 - (13) Training and assisting a beneficiary and beneficiary family members in proper beneficiary nutrition and special dietary needs.
- (b)
- (1) The professional performing the consultation service must hold a current license or certification from the applicable licensing or certification board and organization in the applicable consultation specialty area.
 - (2) The following is a non-exhaustive list of examples of the licensed or certified professional a Provider must use in the applicable consultation specialty when providing consultation services:
 - (A) Psychologist: a licensed psychologist in good standing with the Arkansas Psychology Board;
 - (B) Psychological examiner: a licensed psychological examiner in good standing with the Arkansas Psychology Board;
 - (C) Master social worker: a licensed LMSW or ACSW in good standing with the Arkansas Social Work Licensing Board;
 - (D) Professional counselor: a licensed counselor in good standing with the Arkansas Board of Examiners in Counseling;
 - (E) Speech-language pathologist: a licensed speech-language pathologist in good standing with the Arkansas Board of Audiology and Speech Language Pathology;
 - (F) Occupational therapist: a licensed occupational therapist in good standing with the Arkansas State Medical Board;
 - (G) Physical therapist: a licensed physical therapist in good standing with the Arkansas Board of Physical Therapy;
 - (H) Registered nurse: a licensed registered nurse in good standing with the Arkansas Board of Nursing;

- (I) Certified parent educator: meets the qualifications of a Qualified Developmental Disabilities Professional as defined in 42 C.F.R. 483.430(a);
 - (J) Communication and environmental control adaptive equipment/aids provider: currently enrolled durable medical equipment provider with Arkansas Medicaid;
 - (K) Qualified developmental disabilities professional: meet the qualifications defined in 42 C.F.R. 483.430(a);
 - (L) Dietician: a degree in nutrition;
 - (M) Positive behavior support specialist: certified through the Center of Excellence University of Arkansas Partners for Inclusive Communities or any other entity that offers a similar certification curriculum;
 - (N) Rehabilitation counselor: a masters degree in Rehabilitation Counseling;
 - (O) Recreational therapist: a degree in Recreational Therapy; and
 - (P) Board certified behavior analyst: certified and in good standing with the Behavior Analyst Certification Board as defined in Ark. Code Ann. § 23-99-418.
- (c) A Provider of consultation services must maintain the following documentation in a beneficiary's service record:
- (1) The date the consultation was provided;
 - (2) The consultation service provided;
 - (3) The name and credentials of the professional providing the consultation services; and
 - (4) A detailed narrative regarding the content of each consultation service.

609. Environmental Modifications.

- (a) Environmental modifications are modifications made by a Provider to a beneficiary's place of residence that:
- (1) Are necessary to ensure the health, welfare, and safety of the beneficiary; or
 - (2) Enable the beneficiary to function with greater independence and without which the beneficiary would require institutionalization.

- (b) Environmental modifications include without limitation:
 - (1) Wheelchair ramps;
 - (2) Widening doorways;
 - (3) Modifications relating to a beneficiary's access to and use of a bathroom;
 - (4) Installation of specialized electrical or plumbing systems to accommodate a beneficiary's medical equipment;
 - (5) Installation of sidewalks or pads for beneficiaries with mobility deficits; and
 - (6) Fencing to prevent the elopement and wandering of beneficiaries.
- (c) Environmental modifications do not include:
 - (1) Repairs that are of general utility and not for a beneficiary's medical or rehabilitative need;
 - (2) Modification that are of aesthetic value only; and
 - (3) Modifications that add to the total square footage of the residence.
- (d) The individual performing an environmental modification must be licensed and bonded in the state of Arkansas, as required, and possess all appropriate credentials, skills, and experience to perform the job.
- (e) A Provider of environmental modifications must maintain the following documentation in a beneficiary's service record:
 - (1) If the residence is rented or leased, the written consent of the property owner to perform the environmental modifications;
 - (2) An original photo of the site where environmental modifications will be done;
 - (3) A to-scale sketch plan of the proposed environmental modification project;
 - (4) Any necessary inspections, inspection reports, and permits required by federal, state, and local laws either prior to commencing work or upon completion of each environmental modification to verify that the repair, modification, or installation was completed;
 - (5) The date(s) of the environmental modification installation;

- (6) The name of the individual/company performing the environmental modification, and copies of their licenses and bonding information, if applicable;
- (7) The signature of the legal guardian or beneficiary, if no legal guardian is appointed, at job completion certifying:
 - (A) The environmental modifications authorized are complete;
 - (B) The property was left in satisfactory condition; and
 - (C) Any incidental damages to the property were repaired; and
- (8) An itemized invoice or statement of all expenses including materials and labor associated with the environmental modification.

610. Supplemental Support.

- (a) Supplemental support services allow a beneficiary to continue living in the community when new and unforeseen problems arise that unless remedied would cause a disruption in the beneficiary's residential setting.
- (b) A Provider of supplemental support services must maintain the following documentation in the beneficiary's service record:
 - (1) The date the supplemental support service is paid, and, if applicable, delivered or performed;
 - (2) The price of the supplemental support service;
 - (3) A receipt or invoice related to the supplemental support service; and
 - (4) Written description of the supplemental support service and the unforeseen problem that without the supplemental support service would cause a disruption in the beneficiary's residential setting.

Subchapter 7. Incident and Accident Reporting.

701. Incidents to be Reported.

A Provider must report all alleged, suspected, observed, or reported occurrences of any of the following events while a beneficiary is receiving a paid CES Waiver Service:

- (1) Death of a beneficiary;
- (2) Serious injury to a beneficiary;
- (3) Maltreatment of a beneficiary;
- (4) Any event where an employee threatens or strikes a beneficiary;
- (5) Use of a restrictive intervention on a beneficiary, including without limitation:
 - (A) Seclusion;
 - (B) A restraint;
 - (C) A chemical restraint; or
 - (D) A mechanical restraint;
- (6) Any situation the whereabouts of a beneficiary are unknown for more than two (2) hours;
- (7) Any unscheduled situation where:
 - (A) A beneficiary's services are interrupted for more than two (2) hours; and
 - (B) The interruption would cause or have the potential to cause death, serious injury, or serious illness to a beneficiary;
- (8) Events involving a risk of death, serious physical or psychological injury, or serious illness to a beneficiary;
- (9) Medication errors that cause or have the potential to cause death, serious injury, or serious illness to a beneficiary;
- (10) Any act or omission that jeopardizes the health, safety, or quality of life of a beneficiary;
- (11) Motor vehicle accidents involving a beneficiary;

- (12) A beneficiary or employee testing positive for any infectious disease that is the subject of a public health emergency declared by the Governor, Arkansas Department of Health, the President of the United States, or the United States Department of Health and Human Services; and
- (13) Any event that requires notification of the police, fire department, or coroner.

702. Reporting Requirements.

- (a) A Provider must:
 - (1) Submit all reports of the following events within one (1) hour of the event:
 - (A) Death of a beneficiary;
 - (B) Serious injury to a beneficiary; and
 - (C) Any incident that a Provider should reasonably know might be of interest to the public or media.
 - (2) Submit reports of all other incidents within forty-eight (48) hours of the event, or, if later, the next business day.
- (b) A Provider must submit all reports to the beneficiary's assigned PASSE and to DDS.
- (c) Reporting under these standards does not relieve a Provider of complying with other applicable reporting or disclosure requirements under state or federal laws, rules, or regulations.

703. Notification to Legal Guardians.

- (a) If a beneficiary has a legal guardian, then a Provider must notify the legal guardian of any reportable incident involving the beneficiary within one (1) hour of discovery.
- (b) A Provider must maintain documentation evidencing notification as required in (a).

Subchapter 8. Enforcement.

801. Monitoring.

- (a)
 - (1) DDS shall monitor a Provider to ensure compliance with these standards.
 - (2)
 - (A) A Provider must cooperate and comply with all monitoring, enforcement, and any other regulatory or law enforcement activities performed or requested by DDS or law enforcement.
 - (B) Cooperation required under these standards includes without limitation cooperation and compliance with respect to investigations, surveys, site visits, reviews, and other regulatory actions taken by DDS or any third-party contracted by DHS to monitor, enforce, or take other regulatory action on behalf of DHS, DDS, or its delegatee.
- (b) Monitoring includes without limitation:
 - (1) On-site surveys and other visits including without limitation complaint surveys and initial site visits;
 - (2) On-site or remote file reviews;
 - (3) Written requests for documentation and records required under these standards;
 - (4) Written requests for information; and
 - (5) Investigations related to complaints received.
- (c) DHS may contract with a third party to monitor, enforce, or take other regulatory action on behalf of DHS or DDS.

802. Written Notice of Enforcement Action.

- (a) DDS shall provide written notice to a Provider of all enforcement actions taken against the Provider.
- (b) DDS shall provide written notice to a Provider by mailing the imposition of the enforcement action to the manager appointed by the Provider pursuant to section 301.

803. Enforcement Actions.

- (a)
- (1) DDS shall not impose an enforcement action unless:
 - (A) Provider is given written notice pursuant to section 802 and an opportunity to be heard pursuant to subchapter 10; or
 - (B) DDS determines that public health, safety, or welfare imperatively requires emergency action.
 - (2) If DDS imposes an enforcement action as an emergency action before a Provider receives written notice and an opportunity to be heard pursuant to subsection (a)(1) of this part, DDS shall:
 - (A) Provide immediate written notice to Provider of the enforcement action; and
 - (B) Allow Provider an opportunity to be heard pursuant to subchapter 10.
- (b) DDS may impose on a Provider any of the following enforcement actions for a failure to comply with these standards:
- (1) Plan of correction;
 - (2) Directed in-service training plan;
 - (3) Moratorium on new admissions;
 - (4) Transfer of beneficiaries;
 - (5) Monetary penalties;
 - (6) Suspension of certification;
 - (7) Revocation of certification; and
 - (8) Any remedy authorized by law or rule including without limitation Ark. Code Ann. § 25-15-217.
- (c) DDS shall determine the imposition and severity of these enforcement actions on a case-by-case basis using the following factors:
- (1) Frequency of noncompliance;
 - (2) Number of noncompliance issues;

- (3) Impact of noncompliance on a beneficiary's health, safety, or well-being;
 - (4) Responsiveness in correcting noncompliance;
 - (5) Repeated noncompliance in the same or similar areas;
 - (6) Noncompliance with previously or currently imposed enforcement actions;
 - (7) Noncompliance involving intentional fraud or dishonesty; and
 - (8) Noncompliance involving violation of any law, rule, or other legal requirement.
- (d)
- (1) DDS shall report any noncompliance, action, or inaction by a Provider to appropriate agencies for investigation and further action.
 - (2) DDS shall report noncompliance involving Medicaid billing requirements to DMS, the Arkansas Attorney General's Medicaid Fraud Control Unit, and the Office of Medicaid Inspector General.
- (e) These enforcement actions are not mutually exclusive and DDS may apply multiple enforcement actions simultaneously to a failure to comply with these standards.
- (f) The failure to comply with an enforcement action imposed by DDS constitutes a separate violation of these standards.

804. Moratorium.

- (a) DDS may prohibit a Provider from accepting new beneficiaries.
- (b) A Provider prohibited from accepting new admissions may continue to provide services to existing beneficiaries.

805. Transfer of Beneficiaries.

- (a) DDS may require a Provider to transfer a beneficiary to another provider if DDS finds that the Provider cannot adequately provide services to the beneficiary.
- (b) If directed by DDS, a Provider must continue providing services until the beneficiary is transferred to their new service provider of choice.

- (c) A transfer of a beneficiary may be permanent or for a specific term depending on the circumstances.

806. Monetary Penalties.

- (a) DDS may impose on a Provider a civil monetary penalty not to exceed five hundred dollars (\$500) for each violation of these standards.
- (b)
 - (1) DDS may file suit to collect a civil monetary penalty assessed pursuant to these standards if the Provider does not pay the civil monetary penalty within sixty (60) calendar days from the date DDS provides written notice to the Provider of the imposition of the civil monetary penalty.
 - (2) DDS may file suit in Pulaski County Circuit Court or the circuit court of any county in which the Provider is located.

807. Suspension and Revocation of Certification.

- (a)
 - (1) DDS may temporarily suspend a Provider's certification if Provider fails to comply with these standards.
 - (2) If a Provider's certification is suspended, Provider must immediately stop providing the CES Waiver Service until DDS reinstates its certification.
- (b)
 - (1) DDS may permanently revoke a Provider's certification if Provider fails to comply with these standards.
 - (2) If a Provider's certification is revoked, Provider must immediately stop providing the CES Waiver Service and comply with the permanent closure requirements in section 901(a).

Subchapter 9. Closure.

901. Closure.

(a)

- (1) A CES Waiver Service certification ends if a Provider permanently closes, whether voluntarily or involuntarily, and is effective the date of the permanent closure as determined by DDS.
- (2) A Provider that intends to permanently close, or does permanently close without warning, whether voluntarily or involuntarily, must immediately:
 - (A) Provide the beneficiary or, if applicable, the beneficiary's legal guardian, with written notice of the closure;
 - (B) Assist each beneficiary and, if applicable, their legal guardian, in transferring services and copies of beneficiary records to any new service providers;
 - (C) Assist each beneficiary and, if applicable, their legal guardian, in transitioning to new service providers; and
 - (D) Arrange for the storage of beneficiary service records to satisfy the requirements in section 305.

(b)

- (1) A Provider that intends to voluntarily close temporarily due to natural disaster, pandemic, completion of needed repairs or renovations, or for similar circumstances may request to temporarily close while maintaining its CES Waiver Service certification for up to one (1) year from the date of the request.
- (2) A Provider must comply with subdivision (a)(2)'s requirements for notice, referrals, assistance, and storage of beneficiary records if DDS grants Provider's request for a temporary closure.
- (3)
 - (A) DDS may grant a temporary closure if Provider demonstrates that it is reasonably likely it will be able to reopen after the temporary closure.
 - (B) DDS shall end a Provider's temporary closure and direct Provider to permanently close if Provider fails to demonstrate that it is reasonably likely that Provider will be able to reopen after the temporary closure.

(4)

- (A) DDS may end a Provider's temporary closure if Provider demonstrates that it is in full compliance with these standards.
- (B) DDS shall end a Provider's temporary closure and direct Provider to permanently close if Provider fails to become fully compliant with these standards within one (1) year from the date of the request.

PROPOSED

Subdivision 10. Appeals.

1001. Reconsideration of Adverse Regulatory Actions.

(a)

- (1) A Provider may ask for reconsideration of any adverse regulatory action taken by DDS by submitting a written request for reconsideration in accordance with DDS Policy 1076.
- (2) The written request for reconsideration of an adverse regulatory action taken by DDS must be submitted by Provider and received by DDS within thirty (30) calendar days of the date of the written notice of the adverse regulatory action received by Provider.
- (3) The written request for reconsideration of an adverse regulatory action must include without limitation:
 - (A) The specific adverse regulatory action taken;
 - (B) The date of the adverse regulatory action;
 - (C) The name of Provider against whom the adverse regulatory action was taken;
 - (D) The address and contact information for Provider; and
 - (E) The legal and factual basis for reconsideration of the adverse regulatory action.

(b)

- (1) DDS shall review each timely received written request for reconsideration and determine whether to affirm or reverse the adverse regulatory action taken.
- (2) DDS may request, at its discretion, additional information as needed to review the adverse regulatory action and determine whether the adverse regulatory action taken should be affirmed or reversed.

(c)

- (1) DDS shall issue in writing its determination on reconsideration within thirty (30) days of receiving the written request for reconsideration or within thirty (30) days of receiving all information requested by DDS under subdivision (b)(2) of this part, whichever is later.

- (2) DDS shall issue its determination to Provider using the address and contact information provided in the request for reconsideration.
- (d) DDS may also decide to reconsider any adverse regulatory action on its own accord any time it determines, in its discretion, that an adverse regulatory action is not consistent with these standards.

1002. Appeal of Regulatory Actions.

- (a)
 - (1) A Provider may administratively appeal any adverse regulatory action covered by the Medicaid Fairness Act, Ark. Code Ann §§ 20-77-1701 to -1718, which shall be governed by that Act.
 - (2) The DHS Office of Appeals and Hearings shall conduct administrative appeals of adverse regulatory actions pursuant to DHS Policy 1098 and other applicable laws and rules.
 - (3) Any administrative appeal must be submitted by Provider and received by the DHS Office of Appeals and Hearings within thirty (30) calendar days of the date of the written notice of the adverse regulatory action received by Provider, or, if later, thirty (30) calendar days of the date of the denial letter received by Provider related to a written request for reconsideration.
- (b) A Provider may appeal any adverse regulatory action or other agency action to circuit court as allowed by the Administrative Procedures Act, Ark. Code Ann. §§ 25-15-201 to -220.

RULES SUBMITTED FOR REPEAL

**Rule #1: Arkansas Refugee Resettlement Program
State Plan**

Rule #2: DHS Policy3007, Options Counseling



Mike Huckabee
Governor

Arkansas Department of Human Services Office of the Director

329 Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Telephone (501) 682-8650 FAX (501) 682-6836 TDD (501) 682-7958

January 31, 2003

Nguyen Van Hanh, Ph.D.
Director
Office of Refugee Resettlement
Administration for Children and Families
Office of Family Assistance
370 L'Enfant Promenade
Washington, D.C. 20447

Dear Dr. Van Hanh:

Enclosed for approval is Arkansas' revised State Plan for the Refugee Resettlement Program.

The Plan reflects the discontinuance of the State's participation in the Social Services portion of the program. It is the intent of the State of Arkansas to continue serving eligible refugees with cash assistance and medical assistance as required by the Final Rule, Federal Register Vol. 65, number 56, published March 22, 2000.

REPEAL-EO 23-02

With the State of Arkansas' withdrawal from the service portion of the program, the responsible staff will need instruction regarding which of the previous reports will still be required. Your assistance in this will be greatly appreciated.

If you have any questions, please contact Lorie Williams at (501) 682-8256.

Sincerely yours,

Kurt Knickrehm
Director

KK:JJ:lw

Enclosure

cc: Carl Rubenstein, Refugee Program Specialist
file

ARKANSAS

**STATE PLAN
REFUGEE RESETTLEMENT
PROGRAM**

2002

Arkansas Department of Human Services

Division of County Operations

P.O. Box 1437

Little Rock, AR 72203

REPEAL-EO 23-02

CERTIFICATION

STATE OF ARKANSAS

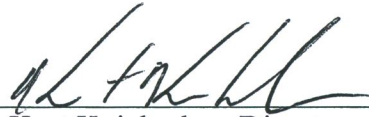
The Department of Human Services has the authority to prepare the State Plan for the Refugee Resettlement Program and is the sole State Agency responsible for administering the Refugee Resettlement Program within the State.

I hereby certify that I am authorized by the Governor of Arkansas to submit the State Plan for the Refugee Resettlement program.

I hereby approve the State Plan for the Refugee Resettlement Program, which has been prepared in accordance with the guidelines established for Refugee State Plan Amendment submissions.

January 31, 2003

Date



Kurt Knickrehm, Director
Department of Human Services

REPEAL-EO 23-02

INTRODUCTION

Ref. 45 CFR 400.4 (a): This document, known as ARKANSAS STATE PLAN for the REFUGEE RESETTLEMENT PROGRAM, serves to consolidate and update all previous State Plan submissions into one document. Upon approval, this revised State Plan will replace all previously submitted State Plan Documents.

Ref. 45 CFR 400.4 (b): Upon approval, the State Plan for the Refugee Resettlement Program will become effective October 1, 2002. The plan will remain in effect until the State expressly amends or revokes the plan, or the Office of Refugee Resettlement notifies the State that the plan no longer meets requirements of the Title IV of the Immigration and Nationality Act.

REPEAL-EO 23-02

PROGRAM AUTHORIZATION

The Refugee Act of 1980 and Public Law 96-212 provide for special refugee cash and medical assistance, and refugee social services in order to increase refugee self-sufficiency.

PROGRAM GOALS

The Refugee Act of 1980 has established that the state, in order to receive Federal funds under the Refugee Resettlement program, submit a plan that describes how the State delivers cash assistance, medical assistance and social services to the refugees to encourage effective refugee resettlement, and to promote economic self-sufficiency.

The Arkansas Department of Human Services, through the Division of County Operations, sets the following goal for the Arkansas Refugee Resettlement Program:

To promote economic self-sufficiency for refugees within the shortest possible time after entrance into the State of Arkansas. This is promoted through cash and medical assistance as may be required. Economic self-sufficiency is defined as gainful employment in non-subsidized jobs with at least a 90-day retention and receipt of a wage adequate for the basic economic needs of the person and family without reliance on public assistance. The State will comply with all other applicable Federal Statutes and regulations in effect during the time that it is receiving grant funding. (§400.5 (1) (3)).

Arkansas will provide statewide access to the medical and cash assistance portion of the program for all refugees, including asylees and Cuban Haitian entrants as required by Office of Refugee State Letter # 94-22, dated September 9, 1994 and State Letter # 00/12 dated June 15, 2000. (See Attachment I & II).

PROGRAM PRIORITIES

The provision of cash and medical assistance to refugees in the State of Arkansas is linked with their willingness to accept employment, or training designed to lead to employment. Every attempt is made to place capable and non-exempt refugees to work within 30 days of their resettlement. Those refugees who refuse to register or accept appropriate employment, including entry-level and minimum wage jobs are sanctioned. The State will use the same mediation/conciliation procedures as those for the State's TANF program. The State will use the hearing standards and procedures as set forth in §400.83 (b).

ASSURANCE OF COMPLIANCE WITH TITLE IV OF THE
IMMIGRATION AND NATIONALITY ACT

The plan has been developed in accordance with the Refugee act of 1980 and 45 CFR, Chapter IV, parts 400 and 401. The plan encompasses cash and medical assistance to refugees during the first eight months of residence in the United States.

400.5 (a): The single state agency, in Arkansas, which is responsible for the development and administration of this plan, is the Arkansas Department of Human Services. The position of State Refugee Coordinator will be maintained within the Division of County Operations, Office of Program Planning and Development. The State Refugee Coordinator is given the responsibility and authority to ensure coordination of public and private resources in refugee resettlement within the State. The state coordinator maintains responsibility for the projection of estimated expenditures, accountability for Federal funds, coordination of the administration and provision of services and maintaining a working relationship between the department of Human Services and the Governor's Office.

400.22 (a): The Arkansas Department of Human Services assures that it will not delegate, to other than its own officials, responsibility for administering or supervising the administration of this plan.

400.5 (b): All policy changes will be communicated to staff and any appropriate public agencies by memos circulated from the State Coordinator's office.

400.5 (I): The State assures that it will comply with Title IV, Chapter 2, of the Immigration and Nationality Act, with official issuance of the Director of the Office of Refugee Resettlement, and with all other applicable Federal statutes and regulations. The department further assures that it will amend this State Plan to meet the requirements of this part as needed to comply with standards, goals, and priorities established by the Director of the Office of Refugee Resettlement.

400.5 (g) The State assures that assistance and services funded under the plan will be provided without regard to race, religion, sex, political opinion, national origin, or sexual orientation. The state will use the same procedures for mediation/conciliation policies as those used in its TANF program in its publicly administered program.

400.83 (h): The State will use the hearing standards and procedures as set forth in 400.83 (b). The State will provide an applicant for, or recipient of, Refugee Cash Assistance an opportunity for a hearing, using the

procedures and standards set forth in 45 CFR 400.54 of the ORR regulations, to contest a determination concerning employability, or failure or refusal to carry out a job search or to accept an appropriate offer of employability, services or employment, resulting in termination of assistance.

400.25: The State assures that no requirements as to the duration of residence will be imposed as a condition of participation in services or receipt of assistance.

400.27: The State recognizes that information about, or obtained from, an individual and in possession of an agency providing assistance or services to such individuals under the plan, will not be disclosed in a form identifiable with the individual without the individual's consent, or in the case of a minor, the consent of his or her parent or guardian.

400.28: The State will assure that operational records are maintained which fully and accurately reflect and account for all of the transactions of the program. The State Refugee Coordinator shall be responsible for reporting on all the activities of the program as needed, or at regularly required intervals, and for submitting needed plan amendments.

Responsibility for certification of eligibility for cash and medical assistance will be handled by the same State apparatus and personnel that deals with Title XIX and Title IV-A, TANF programs. All special Federal provisions pertaining to the refugee-related activities have been incorporated.

This plan is based on the State's experience with refugees since 1975, and is sufficiently flexible to accommodate minor fluctuations in refugee population. Major influx or eligibility changes could require plan amendment.

I. PROGRAM ORGANIZATION

Arkansas continues a publicly administered program. The Department of Human Services continues to be the single State agency, designated by the governor, for the administration and development of the Refugee Resettlement program Plan. (See attachment III.)

- A. The Refugee Resettlement Program is organizationally placed within the Division of County Operations (DCO). (See attachment IV (a), IV (b).)
- B. The Division of County Operations is divided into five offices: Office of Program Planning and Development, Office of Field Operations, Office of Administrative Support, Office of Program Support, and Office of Community Services.

- C. The Division of County Operations is responsible for setting all policy for the Refugee Resettlement Program in Arkansas, and providing and supervising all services to refugees.
1. The chief administrative officer is the DCO Director, who is responsible to the DHS Director. This person has general direction and supervision of the Refugee Resettlement Program (RRP).
 2. RRP program responsibilities of the office are:
 - (a) Provide income support to refugees, as needed, through the Refugee Cash Assistance (RCA). This support will be available to refugees at all local DHS offices.
 - (b) Provide medical assistance to refugees, as needed, through the Refugee Medical Assistance (RMA). This support will be available to refugees at all local DHS offices.
 3. The State agency will not delegate to other than its official's responsibility for administering, or supervising the administering of the State Plan.

C. DESIGNATED STATE AGENCY OFFICIAL

REPEAL-EO 23-02

The Governor's office has named the Director of the Department of Human Services as the Designated State Agency Official. This individual will be responsible for the coordination of all publicly administered services for refugees.

II. RELATIONSHIP TO AND USE OF OTHER AGENCIES

- A. There will be maximum utilization of and coordination with all public and voluntary agencies providing similar or related services.
- B. Relationships with other programs within the Department include licensing responsibilities for childcare agencies; foster care; providing social services to families and children.
- C. DHS/DCO may use, in addition to regular agency staff, professional and voluntary sources, who are multilingual.
- D. The DHS/Division of County Operations may purchase services from public or private agencies as needed.

III. METHOD OF PROVIDING INFORMATION TO THE STATE STAFF

The State agency has a manual policy system covering all Income Maintenance Programs. One of these programs is the Refugee Resettlement Program. This is a formalized system and all policy is distributed to the field staff and to the county offices.

IV. PURCHASE OF SERVICE REQUIREMENT

The State provides services directly to the refugee community through the Department of Human Services County offices, throughout the State. It may purchase services from public or private providers when necessary. The State must determine, prior to entering into a purchase of service agreement, that its total funding authorization is sufficient for that purpose.

V. UNACCOMPANIED MINORS

The State will administer services and benefits as provided in Subpart H-Child Welfare Services. As defined by the Refugee Act of 1980, a refugee unaccompanied minor is:

A. DEFINITION

- REPEAL-EO 23-02**
- person who has not yet attained his or her 18th birthday, of the age of majority in the state in which he is residing; and
 - who has no known immediate adult relatives in the United States; and
 - who has been lawfully admitted to the United States in parole status; and
 - who meets the general definition of a refugee.

B. Unaccompanied minors are not generally eligible for adoption because the goal for unaccompanied refugee children is reunification.

C. SCOPE OF SERVICES

1. Child welfare benefits and services available in foster care cases to other children in the state apply to lawfully admitted unaccompanied refugee minors.
2. Application policy includes preparation of a case plan for each child, implementation of the plan, payment of benefits, and periodic case review and reporting.

3. The state agency's child welfare standard practices and procedures should prevail in providing services to these children.
4. Scope of services provided is to include specialized services that are provided in a culturally and linguistically appropriate manner.

D. PROCEDURE

Voluntary resettlement agencies under contract with the State Department will facilitate the admission and placement of these children.

1. There shall be arrangements made whereby the State Agency establishes legal responsibility through a sponsor for the care and maintenance of the unaccompanied minor. The purpose of establishing legal responsibility is to ensure that the unaccompanied children receive the full range of assistance, care and services to which any child in the state is entitled, and to designate a legal authority to act in place of the child's unavailable parent(s). This action will follow the process normally required by state law to establish protective legal responsibility for a minor child. (However, in determining legal responsibility, it is inappropriate to initiate contact with the child's natural parents overseas because of potential danger to the parents.)
2. The State Agency will develop and implement a plan for care and services appropriate to the needs of an unaccompanied minor in the legal custody of a sponsor.

REPEAL-EO 23-02

VI. REPORTING

DHS/DCO shall submit the following reports as indicated to the Director of ORR.

1. Refugee and Entrant Unaccompanied Minor Placement Report (Form ORR-3)
2. Refugee and Entrant Unaccompanied Minor Progress Report (Form ORR-4)
3. Quarterly Reports (ORR-6)
4. Annual Services Plan (FSA-110)
5. State Estimate Report (ORR-I)
6. Annual Outcome Goals Report
7. State of Origin Report (ORR-11)

VII. PLAN FOR PROMOTION OF ECONOMIC SELF-SUFFICIENCY OF THE REFUGEE

A. CASH ASSISTANCE

In order for a person to be eligible for Refugee Cash Assistance, he/she must:

- Have one of the recognized statuses as defined in 45 CFR §400.43 or is the dependent child of, and part of the same family unit as individuals who meet identification requirements; and are within 8 months of date of entry into the United States.
- Be in financial/medical need according to the public assistance standard of TANF, known as Transitional Employment Assistance (TEA) in the State of Arkansas.
- Unable to meet the categorical eligibility requirements for TANF, SSI, OAA, AB, APTD, and AABD.
- Not be a full-time student in an institution of higher education.
- Not, for the purpose of receiving assistance, have voluntarily quit, or refused to apply for or accept, any appropriate offer of employment or employment-related training.

REPEAL-EO 23-02

The State of Arkansas has opted for a publicly administered RCA program. The State will notify promptly the local resettlement agency when a refugee applies for RCA and will contact the applicant's sponsor or local resettlement agency at the time of application for RCA concerning offers of employment. RCA policies/procedures will be consistent with the provisions of Arkansas' TANF program in regard to: (1) The determination of initial and on-going eligibility (treatment of income and resources, budgeting methods, needs standard); (2) the determination of benefit amounts (payment levels based on size of the assistance unit, income disregards) and (3) proration of shelter, utilities, and similar needs. TANF work requirements will not apply to RCA applicants or recipients. The following will not be counted as income or resources for RCA eligibility:

1. A refugee's resources remaining in his or her country of origin.
2. A sponsor's income and resources are not considered accessible to a refugee solely because the person is serving as a sponsor.
3. Any cash grant received by the applicant under the Department of State or Department of Justice Reception and Placement programs.

Other provisions for RCA include:

- Income available to the refugee on the date of application will be the basis for determining eligibility. Assistance will begin the month in which the refugee applies for cash assistance, so long as the person is within eight months of arrival into the country in the application month. The State will adhere to Federal regulations applicable to publicly administered programs as contained in 45CFR Part 400-Refugee Resettlement Program.
- The county DHS enrolls refugees in whatever mainstream cash assistance program is deemed appropriate for the applicant/unit. This includes TANF, for families with dependent children, and RCA. The blind, elderly, and disabled may be referred to Social Security to apply for SSI.
- Refugees receiving cash assistance will have a family self-sufficiency plan developed for the purpose of enabling the family to become self-supporting through employment of one or more family members. The DHS staff person will develop the plan in collaboration with the refugee.
- Within thirty days, non-exempt refugees who are aide recipients, are enrolled in an employment services program. The work registration referral is made to the local Employment Security Department. Arkansas chooses not to change the employment exemptions allowed previously, in 45 CFR 400.76. The State adheres to 45 CFR 400.81 criteria for appropriate employability services and employment. For example, no refugee is placed in a work site, which is in violation of applicable Federal, State, or local health and safety standards.
- Failure or refusal to accept employability services or employment will result in termination of cash assistance or sanctioning in accordance with 45 CFR 400.82. A conciliation period and fair hearings are provided refugees as outlined in 45 CFR 400.83.

B. MEDICAL ASSISTANCE

As with cash assistance, medical assistance applications will be taken and maintained through the county DHS offices. Arkansas provides the same services in the same manner and to the same extent as under the State's Title XIX Medicaid program as delineated in 42 CFR Part 400.

1. Each individual member of the assistance unit is assessed separately for eligibility for medical assistance.
2. If qualified for the State's Medicaid or CHIP program, a refugee is enrolled in these instead of RMA.

3. Maximum eligibility for RMA is eight months, beginning the month of arrival in the United States.
4. All other provisions of 45 CFR Subpart G-Refugee Medical Assistance will be followed regarding continued coverage of recipients who receive increased earnings from employment.
 - a. Increased earnings from employment will not affect a refugee's continued medical assistance eligibility for RMA throughout the remainder of the eight-month eligibility period.
 - b. Where a refugee on Family and Children's Medicaid loses eligibility during the first eight months of residency, due to increased earnings, the case will be transferred to RMA for the remaining months of eligibility.
 - c. A refugee who obtains private medical coverage may remain on RMA as supplement to the insurance. RMA may be used to pay that which is not covered by the third party payment.

Medical Screening

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In the absence of a contracted provider, the local VOLAG representatives assist new arrivals in obtaining health screenings. There is no charge for elementary health screening at the Department of Health. Health Department facilities are encouraged to work with the resettlement agencies to coordinate transportation and interpreter services necessary for the health assessment screening and any required follow-up. Refugee Health Assessment will include:

Screening and treatment for health conditions of public health concern; health status evaluation and diagnosis of problems; follow-up for conditions identified prior to entry in U.S.; referral for any follow-up care needed; and education regarding the availability of health services.

VIII. PLAN FOR IDENTIFYING REFUGEES IN NEED OF MEDICAL TREATMENT

The American Council of Voluntary Agencies for Foreign Services, Inc. (ACFA) provides identifying information about all new arrivals to the State. Refugees are contacted, by the service provider or by personnel from the State Department of Health, for screening in accordance with 45 CFR 400.107(a)(1).

Local Health Departments in Arkansas serve, to the extent possible, the health needs of newly arriving refugees. As part of the RMA program, application for RMA and assistance for follow-up treatment and health monitoring is provided through the providers as prescribed in 45 CFR 400.5(f) and 400.107(a)(1). Screenings are performed as soon after arrival as possible, within 30-90 days.

A refugee will be assessed for RMA eligibility only after being determined ineligible for Medicaid and or SCHIP.

IX. NONDISCRIMINATION PRACTICES

Assistance and services funded under this plan will be provided to refugees without regard to race, religion, nationality, sex, or political opinion.

X. POLICIES AND REGULATIONS COMPLIANCE

The State of Arkansas will comply with the provisions of Title IV of the Act, official issuances of the Director, and all applicable regulations, and will amend the plan as needed to comply with standards, goals and priorities established by the Director.

The State has complied with the new rules regarding the eligibility of refugees for ORR funded program services that took effect April 1, 2000. The State will base RMA on the applicant's income and resources on the date of application. (~~§400.102(d)~~). The State will use the 200% of poverty opinion as the eligibility standard for RMA as prescribed in (~~§400.101(a)(2)~~ and (~~§400.101(b)(2)~~)).

The State will not count R&P, MG, or RCA assistance on the date of application. Refugees, who lose eligibility for Medicaid due to employment during the first eight months, will be transferred to RMA for the duration of the eight-month eligibility period without an eligibility determination. (~~§400.104(b)~~).

Whether a refugee has been denied or terminated from RCA will not be used as criterion for determining that an applicant is ineligible for RMA. (~~400.100(a)~~). A refugee may continue to receive refugee medical assistance (RMA) for the full eight-month eligibility period, regardless of income, or whether the recipient obtains private medical coverage, as long as the RMA payment is reduced by the amount of the third party payment.

The State of Arkansas is in compliance with the rule that limits eligibility for Refugee Social Services and targeted assistance services to refugees who have been in the U. S. for five years or less.

X. POLICIES ON SERVING LEP REFUGEES

In accordance with the Office of Civil Rights policy guidelines and following the four "Keys to Compliance," (FR, vol. 65, no. 169) the Arkansas State Refugee Office will monitor programs to ensure linguistic and culturally accessible services are being provided to refugees. The State Refugee Office will maintain up-to-date information on the demographics of the refugee population within the state and include this information in the ongoing development of a comprehensive written policy on language access. All Grantees and contractors receiving funds through the Arkansas Refugee Office will be advised of the need for adequate language accessibility services. Language accessibility will include oral language interpreters, the translation of written materials in regularly encountered languages within their service areas and an effective method of providing notices advising Limited English Proficient persons of their right to language assistance. The Refugee Office will also sponsor ongoing staff development training to ensure that employees working with Limited English Proficient persons are both knowledgeable and aware of LEP policies and procedures. Written information concerning the RCA program, including eligibility standards, duration and amount of cash assistance payments, the requirements for participation in services, the penalties for non-compliance and client rights and responsibilities are will be provided, in appropriate languages, as required by numbers of any group (as per ORR 400.55).

At this time the program consists of groups numbering less than twenty-five persons and written materials will not be feasible financially. To comply with Title VI, the following (not limited to) method will be used to convey to the LEP population their right to language assistance:

1. Signs in appropriate public places (right to free translation/interpretation) as deemed necessary by numbers of persons accessing assistance.
2. Messages in the monthly newsletter, published in four languages, sent to the refugee community by the service provider.
3. Verbal notification through staff at the service provider center, Social Services Offices and the general refugee population.

XI. STATE PLAN FOR CUBAN /HAITIAN ENTRANT PROGRAM

Under title V of the Refugee Education Assistance Act of 1980 (P. L. 96-422) and supporting regulations of the Office of Refugee resettlement (ORR) at 45 CFR part 401, Cuban and Haitian entrants (as defined in ORR State Letter #94-22, published September 9, 1994) will be eligible for services on the same basis as refugees.

In accordance with title V of the Refugee Education Assistance Act of 1980 (P.L. 96-422), the President "shall exercise authorities with respect to Cuban and

Haitian entrants which are identical to the authorities which are exercised under Chapter 2 of title IV of the Immigration and Nationality Act”

Section 412(a)(6) of chapter 2 of title IV of the Immigration and Nationality Act provides that, as a condition for receiving assistance under that chapter, a State must submit to the Director of the Office of Refugee Resettlement, Department of Health and Human Services, a plan which satisfies listed requirements, see 8 U.S.C 1522-(a)(6)(A) and 45 CFR 400, Subpart B Fed. Reg. 59323 (September 9, 1980). Similarly, as a condition for receiving assistance under section 501 (a) of the Refugee Education Assistance Act of 1980, States must submit plans for their Cuban/Haitian Entrant Program.


Therefore, the State of Arkansas hereby submits its plan for a program to provide assistance to Cuban and Haitian Entrants under the following terms and conditions.

- (a) The State agency responsible for administering or supervising the administration of the Refugee Resettlement plan under title IV of the Immigration and Nationality Act will be responsible for administering or supervising the administration of the Cuban/Haitian Entrant Program.
- (b) The State will encourage the effective resettlement of Cuban and Haitian Entrants and promote economic self-sufficiency as quickly as possible through the effective use of cash assistance and medical assistance through the methods described in the State Plan for Refugee Resettlement.
- (c) The State Coordinator (as defined in 45 CFR 400.2, 45 Fed. Reg. 59323, September 9, 1980) who is responsible for ensuring coordination of public and private resources in refugee resettlement, will be responsible for insuring coordination of public and private resources in Cuban and Haitian Entrant resettlement.
- (d) The State will provide for the care and supervision of, and insure that legal responsibility is arranged for, unaccompanied Cuban and Haitian Entrant children in the State. The State will also be required to submit a statement subsequent to the issuance of an Action Transmittal regarding unaccompanied Cuban/Haitian Entrant minors indicating the procedures to be observed in arranging for the legal responsibility of unaccompanied Cuban and Haitian Entrant children as well as describing programs and services to be undertaken in behalf of these children pursuant to the requirements of the Refugee Act of 1980. This statement shall conform to Federal policies, regulations, Action Transmittals and other issuances pertaining to the responsibility of States under the Refugee Act of 1980.

- (e) The State will use those procedures described in its State Plan for Refugee Resettlement for the identification of Cuban and Haitian Entrants who, at the time of resettlement in the State, are determined to have medical conditions requiring, or medical histories indicating a need for, treatment or observation and for the monitoring of any necessary treatment or observation.
- (f) The State will provide assistance and services to the eligible Cuban and Haitian Entrants without regard to race, religion, nationality, sex, or political opinion.
- (g) The State will comply with: (1) the provisions of Title IV, chapter 2, of the Immigration and Nationality Act, as applicable to the provision of assistance to Cuban and Haitian Entrants under section 501(a) of the Refugee Education Assistance Act of 1980; (2) all applicable regulations; and (4) the provisions of this State Plan. The State will amend this plan as required to comply with standards, goals, and priorities established by the Director.
- (h) The State will administer its Cuban/Haitian Entrant Program in accordance with the regulatory requirements regarding plan amendments, submittal of plans for Governor's review, maintenance of records and reports, and confidentiality of records applicable to the Refugee Resettlement Program under 45 CFR 400.6, 400.7, 400.10 and 400.11, Federal Register 59324, September 9, 1980.
- (i) The State acknowledges and agrees that all Federal reimbursements for assistance provided Cuban and Haitian Entrants after November 1, 1980, is conditioned upon submission of this plan, duly signed with all of its provisions.

January 31, 2003

Date


Governor, or Designated State
Agency Official, or State
Coordinator

6000 REFUGEE RESETTLEMENT PROGRAM

INTRODUCTION

The Refugee Resettlement Program (RRP) is a federally funded program to provide cash assistance, medical assistance and social services to refugees. It is authorized by the Refugee Act of 1980 (Public Law 96-212) and amended by the Refugee Assistance Amendments of 1982 (Public Law 97-363) and the Refugee Assistance Extension Act of 1986 (Public Law 99-605).

The Division of County Operations of the Department of Human Services (DHS) has the responsibility for administering the Refugee Resettlement Program.

6100 PURPOSE

The purpose of RRP is to provide Refugee Cash Assistance (RCA), Refugee Medical Assistance (RMA), and Social Services to eligible refugees.

This policy will correlate RRP regulations as closely as possible to existing DHS programs. Similarities and differences will be noted accordingly.

6200 DEFINITION

A refugee is defined by law as "any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. The term "refugee" does not include any person who ordered, incited, assisted, or otherwise participated in the persecution of any person on account of race, religion, nationality, membership in a particular social group, or political opinion".

6201 ELIGIBLES

Individuals admitted to the United States under the criteria listed in FA 6501 meet the definition of a refugee. Each refugee will have his/her refugee status determined individually. It is possible that not all members of a family will have entered the United States with refugee status. Some family members may have been admitted as immigrants or parolees. Only those individuals with a documented refugee status are eligible. Programs available to eligible individuals include cash and medical assistance, and social services under the Refugee Resettlement Program.

6202 IDENTIFICATION NUMBER

This number appears on the INS Forms I-94 and I-551. It will be used in every instance to identify each refugee. The number will have the prefix A (e.g., A24-478-475).

Amerasians will have a unique identifier. A-numbers (beginning with 4) will appear in block 20 on the back of the I-94. Block 26 (Comment Section) will contain a stamp showing the word "Admitted" and the code AM1, AM2, or AM3 next to the word "Class" on the stamp. Above "Class" will be an abbreviation for the port of entry and the handwritten date of arrival.

If an Amerasian presents an I-551, the codes AM6, AM7, or AM8 will appear.

6300 DETERMINATION OF ELIGIBILITY UNDER OTHER PROGRAMS

Any refugee or refugee family group potentially eligible for AFDC or SSI must be referred for a determination of eligibility in those programs.

If it is determined that the refugee applicant is not eligible under the AFDC or SSI program, eligibility for refugee cash assistance must be determined.

If a refugee requests only medical assistance, then eligibility for Medicaid will be explored. If the refugee client is not eligible for Medicaid, then eligibility will be determined for Refugee Medical Assistance (RMA).

6400 INITIAL APPLICATION PROCESS.

6401 PERSONS TO BE INCLUDED IN RRP ASSISTANCE APPLICATIONS

Each individual refugee age 18 or over will have his application processed as an individual unless he has a spouse or is the parent of minor children. One application will be processed for parents and minor children. A married couple with no children will be processed as one application. A minor child who was born to a refugee parent or parents after the parent or parents entered the U.S. can be included in the refugee assistance group of the parent although the child is actually a citizen of the United States. One application will be processed for a group of minor siblings.

For example, a refugee household group consisting of a man and his wife, two minor sons, ~~the 18 year old daughter, two minor nephews and the man's elderly parents, would involve four refugee assistance applications. One application for the 18 year old daughter and one for his elderly parents is required. One family application for the man, his wife, and two minor sons.~~ A separate application is needed for the two minor nephews with the payee on this application being whichever of the adults in the home is assuming the responsibility for the care of these children. Each of the budget groups would be subject to the maximum grant for the number of individuals in the budget group. This means that the maximum grant for the family application of a man, his wife, and two minor sons would be the maximum grant for four. The maximum grant for the 18 year old daughter would be the maximum grant for one, and the same principle would apply to other budget groups of RRP refugees.

6402 ACCEPTING AND REGISTERING RRP ASSISTANCE APPLICATIONS

When a refugee requests financial assistance for himself or for a group of minor children for whom he is responsible, accept and process the application in the usual way. Seek social security numbers through the local Social Security Office when needed. (See FA 2280).

Application and Certification Procedure for RRP:

1. Determine whether the client wants cash assistance or medical assistance only.

2. If cash assistance is requested, evaluate for AFDC eligibility. If eligible, proceed according to FA 2201. If there are aged, blind or disabled adults or disabled children in the family group, refer them to the local Social Security Office for SSI determination at the time of application.
3. When it has been determined that the RCA category is to be used, proceed with the application process as outlined in FA 2130.1-2150.2.
4. Contact the applicant's sponsor/resettlement agency to determine the following:
 - a. The amount of financial assistance which may have been provided to the applicant;
 - b. Verify offers of employment and inquire if the applicant has voluntarily quit employment or has refused to accept an offer of employment within 30 consecutive days immediately prior to the date of application.

Resettlement in Arkansas is primarily handled by one voluntary agency. The address is:

United States Catholic Charities
Mr. Dutch Dortch
2500 North Tyler Street
Little Rock, AR 72207
Telephone 664-0340

6500

ELIGIBILITY REQUIREMENTS

Eligibility for Refugee Cash Assistance (RCA) is limited to those who -----

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1. Are ineligible for cash assistance under the AFDC(S) programs;
 2. Meet immigration status requirement;
 3. Meet AFDC need standards in FA 2300;
 4. Provide the name of the sponsor/resettlement agency;
 5. Meet Social Security Enumeration;
 6. Meet relationship requirement;
 7. Meet age requirement;
 8. Meet residence requirements;
 9. Are not full-time students in institutions of higher education unless such attendance is part of an individual employability plan;
 10. Meet requirements for Employment Services
 - * 11. Have resided in the United States 8 months or less. The 8 month period begins the month the refugee enters the U.S.

6501

IMMIGRATION STATUS

An applicant for assistance must provide proof, in the form of documentation issued by INS, of one of the following statuses, as a condition of eligibility:

1. Paroled as a refugee or asylee under section 212(d)(5); (this does not include paroled immigrants)
2. Admitted as a conditional entrant under section 203(a)(7);
3. Admitted as a refugee under section 207;
4. Granted asylum under section 208;
5. Admitted for permanent residence, provided the individual previously held one of the statuses identified above;

6. A child born to refugee parents, after their entrance into the United States, who were in a status as described above;
7. Amerasians admitted through the Orderly Departure Program as indicated on form I-94 or I-551;
8. Cuban/Haitian Entrants as specified below:
 - a. has an I-94 stamped "Cuban/Haitian Entrant" or "paroled or granted voluntary departure".
 - b. has an I-551 with date of entry identified as date parole status granted or date I-94 was issued.

Restrictions: An applicant for asylum is not eligible for assistance under these guidelines. Public Interest Parolees (PIP) and Humanitarian Parolees are not eligible for assistance under these guidelines. An individual who entered the United States as an Immigrant is not eligible for assistance under these guidelines. A refugee who marries an American citizen permanently loses refugee status.

6502 NEED STANDARDS

All income and resources available to the refugee family group must be considered and measured against the standards for financial need which are applicable to the AFDC program.

NOTE: EXCEPTION

Do not apply the earned income disregard of \$30 plus one-third of the remainder of the earnings or the disregard of \$30.

Do not consider any resources remaining in the applicant's country of origin to be accessible to an applicant or recipient. Do not consider a sponsor's income and resources to be accessible to a refugee solely because the person is serving as a sponsor.

Inkind support and services are not considered in figuring income.

6503 SOCIAL SECURITY ENUMERATION

See FA 2280.

6504 RELATIONSHIP

See FA 2250.

6505 AGE

(See FA 2210-2211). The agency will accept whatever evidence the Immigration and Naturalization Service used when the refugee was admitted into the United States. Dates of birth should be contained in the INS papers the refugee client presents during eligibility determination. When a refugee is married, divorced, etc. in the United States, the appropriate legal documents will be used (See FA 2211).

Refugee Resettlement Program

6506 RESIDENCE

See FA 2230.

6507 EMPLOYMENT SERVICES

Participation in employment services is an eligibility requirement for cash assistance in the RRP category. All RCA applicants and recipients must be referred to the local Employment Security Division office at the time of initial application. Referral for employment services is a mandatory condition of eligibility unless good cause can be established.

Those individuals who are exempt from participation, but wish to volunteer, may do so and shall receive the same services as a mandatory participant.

EXCEPTION: For RCA recipients who live in Sebastian or Crawford Counties written referrals for employment and other services will be made to the RRP services provider located at the Fort Smith Adult Education Center. For RCA recipients who live in Pulaski North/South and Saline Counties written referrals for employment and other services will be made to the RRP Unit located at the Pulaski South DHS office.

NOTE: Inability to communicate in English does not exempt a refugee from a referral for employment services. English-as-a-Second-Language Training is available through both providers.

6507.1 EXEMPTIONS

The agency must consider an applicant for or recipient of RCA to be employable and require him or her to register for employment and follow through with the requirements of ESD or the Services providers unless the applicant or recipient is:

1. Under age 16
2. Under age 18 and a full time student as defined in FA 2273.1#7
3. Ill or injured serious enough to temporarily prevent entry into employment or training. Medical evidence or other sound evidence must be presented. (For example, an applicant with a cast on his leg with a doctor's statement regarding estimated date cast will be removed).
4. Incapacitated by physical or mental impairment, by itself or in conjunction with age, that is determined by a physician or licensed or certified psychologist and verified by the agency to prevent the individual from engaging in employment or training.
5. 65 years of age or older
6. Caring for another member of the household who has a physical or mental impairment which requires, as determined by a physician or licensed or certified psychologist and verified by the agency, care in the home on a substantially continuous basis, and no other appropriate member of the household is available.
7. A parent or other caregiver relative of a child under age six (6) who personally provides full time care of the child with only very brief and infrequent absences from the child.

8. Working at least 30 hours per week in unsubsidized employment expected to last a minimum of 30 days. This exemption continues to apply if there is a temporary break in full time employment expected to last no longer than 10 working days.
9. Medically verified pregnancy in at least the sixth month.

6507.2 VOLUNTARY TERMINATION OF EMPLOYMENT

As a condition of eligibility for RCA, an employable applicant may not, without good cause, within 30 consecutive calendar days immediately prior to the application for assistance, have voluntarily quit employment or have refused to accept an offer of employment.

As a condition of continued receipt of RCA, an employable recipient may not, without good cause, voluntarily quit employment or refuse or fail to follow through with job referrals, interviews, etc., as required by ESD or the RRP Social Services provider.

6507.3 FAILURE/REFUSAL TO PARTICIPATE IN EMPLOYMENT SERVICES

In those counties where RRP services providers are located, the case manager will contact the county office and advise of the participant's refusal to participate without good cause in the employment services or other services such as English as a Second Language Training when such services are part of the employability plan.

Voluntary Participant - When a voluntary participant has failed or refused to participate in employment services as made available through ESD or the Services providers, the information shall be noted in the case record. The individual's cash assistance will not be affected.

Mandatory Participant - When, without good cause, a mandatory participant has failed or refused to meet the requirements of ESD, the Services providers or has voluntarily quit a job, sanctions will occur. (Refer to FA 6508.1).

6507.4 GOOD CAUSE FOR FAILURE TO PARTICIPATE IN EMPLOYMENT SERVICES

Good cause for failure to participate in employment services will be determined to exist if the following criteria are met:

1. The position is vacant due to a strike, lockout, or other bona fide labor dispute; or
2. The client would be required to work for an employer contrary to the conditions of existing union rules governing that occupation. The client may or may not be a member of the union for this to apply.

6508 ADMINISTRATIVE HEARING - REFUSAL TO PARTICIPATE

See Fa 2274.2.

6508.1 SANCTIONS

Once it has been verified that a mandatory participant has refused to participate, without good cause, the Service Representative will apply the sanctions as follows:

1. A 10 day notice will be sent to the client advising that benefits will be reduced or terminated (whichever is appropriate) unless he/she cooperates with employment services. If the client responds, he/she will be re-referred to either ESD or to the local services provider.
2. If the client fails to respond and the sanctioned individual is the only member of the filing unit, the assistance shall be terminated. This sanction shall remain in effect for three (3) payment months for the first such failure and 6 payment months for any subsequent such failure.
3. If the filing unit includes other members, the sanctioned individual's needs will not be included in determining the filing unit's need for assistance.

6509 8 MONTH REQUIREMENT

A refugee may be eligible for RCA during the 8 month period beginning with the first month the refugee entered the United States. For example, a refugee client provides INS documentation showing a date of entry into the United States of October 1991. His first month of RCA eligibility is October 1991 and ends May 31, 1992. This is provided he remains eligible regarding all other eligibility criteria.

6600 DETERMINING RCA GRANT AMOUNT

See FA 2385-2410.

6700 DISPOSITION OF APPLICATION

See FA 2510-2542.

6701 EXTENDED MEDICAL BENEFITS WHEN AN RCA CASE IS CLOSED SOLELY DUE TO EARNINGS FROM EMPLOYMENT

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If a refugee client who is receiving RCA becomes ineligible solely by reason of increased earnings from employment, the client's medical assistance eligibility shall be extended. The extension period will begin with the first month following the last month of RCA eligibility and continue until the refugee reaches the end of his or her 8 month time eligibility period.

6701.1 AUTHORIZATION PROCEDURE

When it is determined that the family is ineligible for RCA, but eligible for the extended medical benefits, (RMA) the Service Representative will authorize the extended coverage period by submitting the EMS-56. Transaction type "C" with the appropriate action reason will be entered on the EMS-56. An "N" will be entered in the client notice field so that a system notice will not be sent. An entry will be made in the Medicaid End Date field, showing the last month of medical eligibility. This will apply to any size household as long as all currently eligible household members entered the United States in the same month. If individual household members have different entry dates, the entries must be made in the Medicaid End Date fields on WASM indicating the appropriate end dates for each person.

The Services Representative will manually issue an EMS-1 to the client indicating who in the household will be eligible for the extended coverage and the last month of eligibility.

Example 1: Do Thi Long entered the United States as a refugee in October 1991. He applied and was approved for RCA in November 1991. His 8 month time eligibility period begins October 1, 1991 and ends May 31, 1992. He begins and reports employment in December 1991 with earnings that make him ineligible for continued RCA beginning in January 1992. This is the sole reason for his ineligibility. The extended coverage will be effective January 1, 1992 and run through April 30, 1992. The end of the four months of extended eligibility comes before the end of his 8 month period of time eligibility.

Example 2: Tran Van Son and family entered the United States as refugees in October 1991. They applied and were approved for RCA in October 1991. Their 8 month period of time eligibility begins October 1, 1991 and ends May 31, 1992. Mr. Tran begins and reports employment in March 1992 with earnings that make the family ineligible for continued RCA beginning in April 1992. The extended coverage will begin April 1, 1992 and end May 31, 1992. In this case the family's time eligibility period ends before the entire four months of extended coverage could be granted, therefore only two months of extended coverage were authorized.

Under no circumstances can medical eligibility in an RCA category extend past the end of the 8 month time eligibility period that begins with a refugee's month of entry into the United States.

6800

RRP SOCIAL SERVICES

The Refugee Resettlement Program currently funds the provision of social services in the Sebastian/Crawford County area and in the Pulaski County area for refugees who live in those areas.

Social services and targeted assistance services are limited to eligible refugees who have been in the U.S. for 5 years or less. Referral and interpreter services will be provided with no time limits imposed.

The following services are provided to all eligible refugees:

Employment Services

This is defined as services which support job placement and/or continuation of employment. Activities may include:

- a. Assessment services from the standpoint of employability and includes identification of familiar or environmental obstacles to employment.
- b. Manpower employment services, which include career counseling, development of an individual employability plan, job orientation, job development, job placement and follow-up. These services are available at both locations.

Education/Training

These are defined as services which provide knowledge and skills to prepare the individual to enter the mainstream of society. Services may be provided through classroom instruction, vocational education, or on the job training.

- a. English as a Second Language (ESL) is emphasized, particularly survival English as it relates to obtaining and retaining a job. This service is limited to persons 16 years of age and older and not full time students in elementary or secondary school. The target population is heads of households receiving cash assistance. This is available through both providers.

b. Vocational training, includes driver education and training when provided as part of an individual employability plan. This is available only at the Fort Smith location.

c. Skills recertification, including short term preparation for the General Education Diploma (GED) when the diploma is required by an employer for employment or for advancement or by a State Licensing board for registration for a licensing examination. This is available only at the Fort Smith location.

Clients who reside in the Little Rock area may obtain their GED through the local Adult Education Center.

Social Adjustment Services

This is defined as services which provide advice and/or direction to help the refugee become self-sufficient.

Activities may include:

- a. Information and referral such as advice or direction or making arrangements for necessary services.
- b. Home management instructions to individuals or families in home maintenance, nutrition, housing standards, tenant's rights, and other topics of consumer education.
- c. Emergency services as follows: assessment and short term counseling to persons in a perceived crisis, referral to appropriate resources, and the making of arrangements for necessary services.
- d. Services which assist the new arrival to become socially adjusted. The new arrival refers to the refugee who has been in the United States for six months or less. Services are usually more intensive in the areas of social adjustment and health related services. Some transportation services are included when deemed necessary to reach a refugee's goal of self-sufficiency. These services are available at both locations.

Health Related Services

These are defined as services to assist individuals and families to attain and maintain a favorable condition of health, secure and utilize necessary medical treatment as well as preventive and health maintenance and includes arranging for emergency medical care. These services are available at both locations.

Interpreter Services

This is defined as services which enable the refugee to communicate with others for the purpose of meeting basic needs and are usually provided in conjunction with another service (employment, education/training). This is a supportive service and linked to another service. This service is available in both locations.

3007.0.0 OPTIONS COUNSELING AND MDS REFERRALS TO THE DEPARTMENT OF HUMAN SERVICES (DHS)

3007.1.0 Authority

Options Counseling: Ark. Code Ann. § 20-10-2101 through 2107.

Minimum Data Set Section Q: 42 U.S.C. § 1395i-3 and 42 C.F.R. § 483.20.

3007.2.0 Purpose: This rule implements both the long-term care Options Counseling and the Minimum Data Set (MDS) Section Q referral processes that are made to the Department of Human Services (DHS). In both programs, long-term care facilities are required to refer to DHS residents who are interested in other care alternatives. State law requires that referrals be made for Options Counseling by the day after admission. Federal law and regulations require facilities to refer those interested within ten days of completion of the MDS.

3007.3.0 The Options Counseling Program provides information regarding long-term care options to an individual (or the individual’s representative) who:

- A. Seeks an Options Counseling consultation
- B. Seeks admission to a long-term care facility, regardless of payment source
- C. Resides in a long-term care facility and applies for Medicaid reimbursement

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3007.3.1 For the purposes of Options Counseling, “Long-Term Care Facility” means a nursing facility or a licensed level II assisted living facility. For the purposes of the referral through Section Q, “Long-Term Care Facility” means any nursing facility required by federal law to complete an MDS on residents.

3007.3.2 When completing Section Q of the MDS, the long-term care facility shall be required to refer the individual to the “local contact agency” (DHS) if the care plan process determines that it is feasible that the individual may be able to return to the community, or if the individual or representative responds positively to the question, “Do you want to talk with someone about the possibility of returning to the community?”

3007.4.0 Long-Term Care Options Counseling Consultation

3007.4.1 Regardless whether the individual is referred to DHS through the Options Counseling Program or through the MDS, for administrative ease, the individual will be referred in the same manner and will receive the same type of consultation. For the purposes of this policy, the consultation for both programs will be referred to as Options Counseling.

- 3007.4.2 Each long-term care Options Counseling consultation shall include information about:
- A. Factors to consider when arranging for care, including methods for maximizing independence and self-reliance;
 - B. Available options;
 - C. Costs and potential payment sources;

3007.4.3 Each long-term care Options Counseling consultation may include an assessment of the individual's functional capabilities.

3007.5.0 Division of Aging and Adult Services Responsibilities

3007.5.1 Overall Responsibilities:

The Division of Aging and Adult Services (DAAS) is responsible for providing Options Counseling to residents who indicate interest. The response to a resident may be in the form of mailing community resource information to the resident or it may include a face-to-face consultation with the resident/representative by a DAAS employee in the facility. DAAS employees may include Home and Community-Based Services (HCBS) Nurses, Transition Coordinators and Eligibility Facilitators.

3007.5.2 Assistance to Medicaid Recipients/Applicants

Residents who are on Medicaid or who have applied for Medicaid may receive assistance from DAAS with meeting the resident's transition and community service goals, if the resident is interested in transitioning to a community setting.

3007.5.3 Responsibilities of DAAS Employees:

DAAS employees will have an active presence in facilities throughout Arkansas to help ensure that Medicaid recipients are aware of community options and are able to make informed decisions about how the resident receives long-term services and supports. The DAAS employee will seek to develop a working relationship with members of the facility's staff. As appropriate for the needs of the resident, DAAS employee's duties will include:

- A. Assuring residents have information about community long-term services and supports options;
- B. Screening residents for potential transition;
- C. Requesting and gathering copies of resident information from the facility, such as MDS, care plan, etc., once permission from the resident/authorized representative is secured, in order to fully screen the resident and plan for transition;

- D. Identifying barriers to transition and working with the resident, his/her family, facility staff and others to remove or address the barriers to transition;
- E. Conducting appropriate assessment, care planning and coordinating the authorization of services;
- F. Referring residents to available transition resources;
- G. Facilitating the transition of enrollment to the appropriate waiver with the Division of County Operations (DCO) local office.

3007.6.0 Offering Long-Term Care Options Counseling Consultations

3007.6.1 Long-Term Care Facility Responsibilities

A. Long-Term Care Facility Admissions

- 1. Long-term care facilities must inform new admissions of the opportunity for a long-term care Options Counseling consultation at admission regardless of the individual’s payment source.
- 2. When admitting a resident, the long-term care facility must:

a. Complete and obtain the signature of each resident or the resident’s representative on a separate Form DHS-9571;

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- b. Transmit the form to the Arkansas Department of Human Services (DHS) via online submission at <https://dhs.arkansas.gov/daas/NursingHome/> no later than 5:00 p.m. of the next business day following the admission. Due to the one-day timeline for submission that is required by law, if the facility is having connectivity problems, it may fax the form to the Office of Long Term Care in order to meet the timeline; but once connectivity returns, the facility must follow-up and enter the information that had previously been faxed, via the website;

Note: There are two methods for obtaining a signed DHS-9571. The long-term care facility may complete the form manually, obtain the signature of the individual or representative, and then key the information into the website; or, key the information into the website, print the completed form from the website, and then obtain the signature of the individual or representative.

- c. Maintain the original DHS-9571 in the resident’s file at the long-term care facility until completion of the next standard survey or for 18 months, whichever is longer; and
- d. Make these records available for audit purposes as requested by DHS, its representatives, or designees.

B. Previously Admitted Long-Term Care Facility Residents Who Apply For Long-Term Care Medicaid

Each long-term care facility must:

1. Offer the opportunity for an Options Counseling consultation to previously admitted residents who apply for long-term care Medicaid reimbursement;
2. Offer the opportunity for an Options Counseling consultation to each resident before the Medicaid application is filed if possible; and
3. Transmit the form to DHS via online submission at <https://dhs.arkansas.gov/daas/NursingHome/> no later than 5:00 p.m. of the next business day following the offer;
4. When a person or the person's representative declines an offer for an Options Counseling consultation, the long-term care facility must complete Form DHS-9571 documenting that the individual refused an Options Counseling consultation.
5. Maintain the original DHS-9571 in the resident's patient file at the long-term care facility until completion of the next standard survey (for nursing homes) or licensure survey (for Level II Assisted Living Facilities), or for 18 months, whichever is longer; and

6. Make these records available for audit purposes as requested by DHS, its representatives, or designees.

C. For Long-Term Care Facilities completing an MDS either at admission or at reassessment, the facility shall:

1. Complete section Q of the MDS. The long-term care facility shall be required to refer the individual to the "local contact agency" (DHS) if the care plan process determines that it is feasible that the individual may be able to return to the community, or if the individual or representative responds positively to the question, "Do you want to talk with someone about the possibility of returning to the community?";
2. If a referral is appropriate, the long-term care facility will transmit the information on the individual via the same online submission as Options Counseling at <https://dhs.arkansas.gov/daas/NursingHome/> no later than 10 days from the time the MDS is completed;

3005.6.2 DHS, Division of County Operations, (DCO), Responsibilities.

DCO will offer information on Options Counseling to each long-term care Medicaid applicant.

3007.7.0 OLTC shall:

3007.7.1 Deliver to Division of Aging and Adult Services (DAAS) all DHS-9571 forms received from long-term care facilities.

3007.7.2 After the first three failures of a long-term care facility to complete the form required under § 20-10-2106 in any calendar year, the Department of Human Services, through the Office of Long Term Care, shall assess a fee against the long-term care facility of twenty-five dollars for each failure beyond three, with an annual maximum fee of one thousand two hundred dollars (\$1,200).

- A. OLTC shall provide written notice to long-term care facilities that a fee is imposed.
- B. Notice shall:
 - 1. State or list the specific failures leading to the imposition of the fine, including the dates on or about which the failure occurred, the names of residents for whom the failure occurred, and the amount of the fine imposed; and,
 - 2. Set forth the long-term care facility's appeal rights.

3007.7.3 While state level penalties are not applicable to a failure to refer under MDS Section C, federal deficiencies and penalties may be applicable.

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3007.8.0 Appeal

- A. A long-term care facility may appeal a fee by sending a written request for a hearing to the Director of the Department of Human Services ("Director")
- B. The Director must receive the appeal within sixty calendar days after OLTC mails the notice of fee to the long-term care facility by regular mail to the most recent address provided by the facility in facility license records.
- C. The Director shall assign the appeal to a fair and impartial hearing officer who shall not be a full-time DHS employee. The hearing officer shall preside over the hearing and make findings of fact and conclusions of law in the form of a recommendation to the Director.
- D. DHS shall commence each hearing within forty-five days of receipt of a timely request for hearing. The hearing officer shall notify the OLTC Director of the date, time, and place of the hearing. Such notification shall be in writing sent by regular mail to the appealing long-term care facility at least twenty days before the hearing date.
- E. The appealing facility may agree in writing to resolve the appeal without a hearing.

- F. If the facility waives the time limit under subdivision (D) of this section, the hearing officer shall begin the hearing at a time agreed to by the parties.
- G. Hearing Officers shall conduct the appeal hearing in accordance with the Administrative Procedure Act and DHS Policy 1098.
- H. Upon written request of a facility, OLTC shall provide copies of all documents, papers, reports, and other information that relate to the appeal. OLTC must make such disclosure within ten working days of receipt of the written request unless the hearing officer specifies a different date.
- I. Upon failure of a person without lawful excuse to obey a subpoena or to give testimony, the aggrieved party may apply to the circuit court in the county where the hearing will be held for a court order compelling compliance.

3007.9.0 Appeal Decision

- A. The Hearing Officer shall issue a recommended decision within 10 working days after the close of the hearing, the receipt of the transcript, or the submission of post-trial briefs requested or approved by the hearing officer, whichever is latest.
- B. The Director shall review each recommendation. He or she may:
 1. Approve the recommendation, or
 2. Modify the recommendation in whole or in part; or
 3. Remand the appeal to the hearing officer for further proceedings. On remand the hearing officer shall conduct further proceedings as set forth in the Notice of Remand and shall submit a new recommended decision to the Director.
- C. If the Director modifies a recommendation, in whole or in part, or remands the decision, the Director shall state in writing the reasons for the remand or modification, including statutory, regulatory, factual, or other grounds.
- D. If the Director takes no action on the hearing officer's recommendation within 60 calendar days of receiving the recommendation, the recommendation shall be the final agency disposition as defined at Ark. Code Ann. § 25-15-202(5).
- E. The Director's modification or approval of a hearing officer's recommendation is the final agency disposition as defined at Ark. Code Ann. § 25-15-202(5).

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3007.10.0 Payment of Fees

- A. Unless the Director denies a stay, a written request for a hearing shall stay any fee pending the hearing and the final decision of the Director of the Department of Human Services.
- B. Long-term care facilities must pay fees to OLTC within thirty working days of receipt of the notice of fee, or if stayed pending appeal, within thirty working days of receipt of the final agency disposition unless the disposition has been timely appealed to circuit court.

3007.11.0 Originating Section/Department Contact:

DHS has designated the following entity as the Local Contact Agency:

Aging and Disability Resource Center
700 Donaghey Plaza South
P. O. Box 1437, Slot S-530
Little Rock, AR 72203-1437
Contact: 501-682-8509

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DHS Responses to Public Comments Regarding Rule 253 Community and Employment Supports (CES) Agency Standards

Kathy Weatherl

Bost

Comment:

Bost - Comments on proposed CES waiver standards.

1) 302 Employee Qualifications:

(3)(2 & 3) Still states employee must have high school diploma or GED or equivalent.

We do not believe this is a necessary requirement and would like to see it removed. A high school diploma or GED does not qualify a person as a good support staff.

2) 313 Behavior Plans

(2)(a)(III) Positive behavior support specialist – under consultation they expanded to say certified through Cetner of Excellence university of Arkansas Partners for Inclusive communities OR any other entity that offers a similar certification curriculum. **How can we find out what must be required in the certification curriculum if we choose not to use Partners? Will the state provide this information to us? Will the state have to approve a different certification curriculum?**

(3)(A-G) Still lists the specifics of what must be in the PBSP. **It does not make sense that we as non-licensed providers, tell a licensed professional what they need to put in a PBSP. They are licensed professionals and know what should be addressed in a plan. We can share with them what you are requesting to be in the plan, but if they do not address all those items what will be the ramifications for the provider?**

3) 403 Transitions from 1 waiver provider to another

1(f) requires signatures of both providers on the plan. **Not realistic as this will likely be done via technology or phone, especially if the individual is moving to a new area. Can we just document who was part of the meeting?**

2((b) Requires current provider to be at transition conference. **What if the individual/guardian does not want the current provider at the transition meeting? That situation will occur because the individual/guardian is mad at the current provider and that's why they are transitioning. What is the expectation around this?**

2€ States current provider remains responsible for delivery of services until such time as beneficiary's transition to the new provider is complete, which shall not exceed 90 days from the date of transition conference. **What will occur in a situation where a family fires the current provider but has not yet transitioned to a new provider. What will the expectation be**

for the current, but fired by the family, provider? If we are not allowed in their home and they refuse to work with us we cannot provide services during that transition period.

Response: Thank you for your comment

- The current CES Waiver application approved by CMS requires a high school diploma or GED for direct support staff, so this is unable to be changed until the requirement is changed within the CES Waiver.
- The state is not developing any additional curriculum or new certifications at this time.
- A certified as a CES Agency Consultation provider would be subject to the requirements of Section 313(3) for any positive behavior support plan they developed. If it was not compliance with Section 313(3), then it would not be an acceptable plan and they would not be able to be paid for performing a CES Agency Consulting service.
- The state will change Section 403(1)(f) to read “Documentation or other evidence that demonstrated both the current and new provider’s consent to the transition plan (i.e. signatures on plan, email approval, etc.)” to expand the ways agreement can be demonstrated beyond signatures. DHS believes it should be required to show that all parties agreed to the transition plan and not just that they attended the meeting.
- Both the current and new provider must attend the transition meeting to ensure a safe transition from the current to the new provider. If a parent refuses to attend the transition meeting after reasonable attempts, that fact should be documented.
- A new Section 403(e)(3) will be added to the CES Agency which states, “If a current provider is denied access to deliver services by the beneficiary or the beneficiary’s family/guardian before transition to the new provider is complete, then the current provider must specifically document its attempts and the family/guardian’s denial of access to provide services.”

Josh Wilson

ICM

Comment:

TO: Thomas Tarpley, Director, Division of Developmental Disability Services
FROM: Josh Wilson, PhD., CEO, ICM
DATE: 2-7-2024
SUBJ: Public Comment-Community and Employment Supports Agency Standards

- 403(d). We request that only the newly selected provider be required to participate in the transition conference and clarifying who is responsible for inviting other parties. There will be instances when all parties cannot attend the conference at the scheduled date and time.

- 403(e)(1). We request a timeframe be set for when a transition conference must be held following a new provider being notified of their selection. The addition of a timeframe will help avoid a delayed transition.
- 404(a)(1). We request that a provider be allowed to issue a refusal to serve when a conflict of interest arises that could hinder the provider from effectively supporting the beneficiary.
- 404(a)(2). We request clarity on how and who should be notified at DDS of a refusal to serve.
- 404(d). We request that a provider be allowed to immediately cease supports if there is a threat of immediate harm. For instance, a provider cannot enter a setting where a person is assaulting or threatening to assault the provider. Proposed language: "A provider may immediately cease serving an individual when a significant threat to provider's safety exists."
- 404(c). We request that a timeline be provided for when DDS will determine that a refusal to serve is based on legitimate health, safety, and welfare concerns.
- 404(d). We request that a provider only be required to continue serving a beneficiary for 30 days following the refusal to serve notice unless it is an immediate refusal due to the presence of a significant threat to the provider.

Response: Thank you for your comment.

- All parties currently listed in Section 403(d)(2) must attend the transition meeting to ensure a safe transition from the current to the new provider. If any party refuses to attend the transition meeting after reasonable attempts, that fact should be documented.
- Section 403(c) will be amended to read, "The new Provider must hold a transition conference to develop a transition plan for the beneficiary within fourteen (14) business days of issuing the notification required in subsection (b) above. If the new Provider is unable to hold the a transition conference within the required timeframe, reasonable justification for the delay must be documented."
- Section 404(d) will be amended to read, "If a Provider is currently serving a beneficiary when declaring a refusal to serve, the Provider shall remain responsible for the delivery of CES Waiver Services until the beneficiary transitions to their new Provider or other placement unless there is an immediate health or safety risk to Provider employees. A detailed description of any health and safety risk justifying the ceasing of service delivery prior to a completed transition of beneficiary to a new Provider must be documented."

Summit Compliance

Comment:

Summit would like to submit the below comments or questions for the proposed changes to the CES Agency Standards:

311. Restraints and Other Restrictive Interventions: There are some adaptive equipment items that providers view as mechanical restraints such as an enclosed bed, and buckle guards. Are items used for therapeutic or non-behavioral purposes still classified as mechanical restraints? If not, can more information be added for section 2?

- (1) A Provider cannot use a restraint on a beneficiary unless the restraint is required as an emergency safety intervention.
- (2) An emergency safety intervention is required when:
 - (A) An immediate response with a restraint is required to address an unanticipated beneficiary behavior; and
 - (B) The beneficiary's behavior places the beneficiary or others at serious threat of harm if no intervention occurs.
- (3) The use of seclusion for a beneficiary is strictly prohibited.
- (4) The use of the following types of restraints on a beneficiary are strictly prohibited:
 - (A) Mechanical restraint; and
 - (B) Chemical restraint.

402. Exits: Item (3) is very vague and might be up to interpretation. It would be helpful to have clear guidelines in this section.

- 402. Exits.**
- (a) A Provider may exit a beneficiary:
 - (1) If the beneficiary becomes ineligible for CES Waiver as provided in section 405;
 - (2) If the beneficiary chooses to use another Provider; or
 - (3) For any other lawful reason.

601: Supportive Living: The new health maintenance language found in the 1915(c) HCBS regarding Supportive Living services in the clinical setting is missing from this section.

601. Supportive Living.

- (a) Supporting living services are individually tailored rehabilitative services and activities to enable a beneficiary to reside successfully in their own home, with family, or in an alternative living setting.
- (b)
 - (1) Supportive living services must be provided in an integrated community setting.
 - (2) Supportive living services must directly relate to goals and objectives in the beneficiary's non-clinical treatment plan.
 - (3) Providers must ensure that a sufficient number of direct care staff are scheduled during the performance of supportive living services to guarantee the health, safety, and welfare of each beneficiary.
 - (4) Providers must have backup plans in place to address contingencies if direct care staff are unable, fail, or refuse to provide scheduled supportive living services.
- (b) A Provider of supportive living services must maintain the following documentation in the

604. Supported Employment: Can service definitions be added to the below supported employment services?

- (1) Supported employment services may include any combination of the following services:
 - (A) Job assessment and discovery;
 - (B) Person centered employment planning;
 - (C) Job placement;
 - (D) Job development;
 - (E) Job coaching;
 - (F) Benefits support;
 - (G) Training and planning;

Response: Thank you for your comment.

- The definition of a "Mechanical Restraint" is found in Section 103(p).

Lindsey Lauritzen

Disability Rights Arkansas

Comment:

Please see my attached comment on the new rule for community providers delivering services to beneficiaries enrolled in the CES Waiver.



Lauritzen comment
on rule for 1915c pr

My name is Lindsey Lauritzen, and I am requesting that the Division of Developmental Services (DDS) make the following changes to increase the quality of services that individuals with disabilities receive who are enrolled in the Community and Employment Support (CES) Waiver.

1. Section 303a: All employees must receive training on specific topics. Items a.1 thru a.6 are straightforward, but topics a.7, Verbal intervention and a.8 De-escalation techniques are vague. Providers could develop training materials for their employees that are not thorough and do not prepare them well for working with beneficiaries. If training in these topics is required, DDS should create the training materials for verbal intervention and de-escalation techniques and distribute to providers so that employees will be well-prepared and equipped with the right skills before having any beneficiary direct contact.
2. Section 601: The section on Supportive Living should be more detailed. B.1 Supportive living services must be provided in an integrated community setting, which is a necessity for providers on the CES Waiver so they are in compliance with the Home and Community-based Services (HCBS) Settings Rule. But the term "integrated community setting" is not defined in section 103 and there is no mention of the Settings Rule. Please define integrated community setting and incorporate the Settings Rule into this proposed rule for CES waiver providers.
 - a. The ways that beneficiaries experience their home and community help determine whether their home is an integrated community setting. Beneficiaries should feel they have independence, and feel they have a rich community life (CMS document 79 FR 2948).
 - b. It is important to mention in this rule that beneficiaries have a right to privacy, dignity, respect, and freedom as a recipient of CES waiver services, as this is specifically mentioned in the Settings Rule.
 - c. Mention that providers should prioritize autonomy and independence for beneficiaries.

Please consider these comments and others that you may receive from interested individuals in finalizing the proposed rules.

Response: Thank you for your comment.

- Providers are much more qualified to develop and utilize existing appropriate training materials on these topics than the State.

- Section 502(a) requires each Provider owned, leased, or controlled CES Waiver Service residential setting to meet the home and community-based services setting regulations as established by 42 CFR 441.301(c) (4)-(5).

Sherice Smith

Comment:



Sherice Smith
Public Comments.pc

As a person with a disability, I have personally experienced restraints and seclusion. It was not helpful, and it did not change my behavior. What it did do was leave me afraid of teachers in school and of tight spaces. Now, as a self-advocate and an advocate for others, I think the agency should be careful and clear when allowing use of restraints and seclusion so as not to traumatize another generation. The directives on restraints do not specify what should be done before resorting to restraints. Please consider the following.

1. How are "unanticipated" behaviors defined?
2. How will these rules be implemented and compliance monitored to ensure consistent application across all direct-service providers?
3. What exact forms of restraints can be used?
4. What is the maximum amount of time that a restraint can be used?

Many direct-service providers have worked in their jobs for a long time, and they are used to doing things the "old way," which we now know to be unsafe and ineffective.

I would also like to voice some concerns related to crisis response. How are providers supposed to develop crisis response plans? Are the plans required to be developed with guidance from someone who works in the mental health field? What if a provider does not have a clinical director on staff?

Please consider these concerns and others that you may get from concerned individuals.

Response: Thank you for your comment. Seclusion is strictly prohibited regardless of circumstances in Section 311(a)(3). Section 311 and Section 313 limit any restraints and restrictive interventions to an emergency safety intervention only. Section 311(a)(2) very specifically defines what constitutes an emergency safety intervention. Any time a restraint or restrictive intervention is administered (whether appropriate/permitted or not) is required to be specifically documented as provided in Section 311(c).

Derek Henderson

Disability Rights Arkansas

Comment:

Please see the attached comments regarding proposed CES Agency Standards.



Comments re CES
Agency Standards.p

I wish to offer public comments concerning the proposed CES Agency Standards. I generally support the adoption of such standards to inform PASSEs and providers of their obligations, to inform beneficiaries of their rights and obligations, and to create a culture of accountability that implements waiver services with fidelity. I offer the following specific comments in their order of occurrence within the proposed rules.

- Section 103(h): Please clarify how the “pass-through” process will continue with certain requests for services, or what will replace it. Home modifications, for example, can only be completed by a contractor. The pass-through process requires a waiver provider to make the request and essentially serve as a middleman to the contractor.
- Section 103(i)(3): Please clarify whether “not a standard treatment” refers to not being standard for the condition or not being a regularly administered treatment to the particular beneficiary.
- Section 103(l): Please consider adding a requirement that the plan specifies who will provide the training and what their credentials are to be.
- Section 103(l)(5): Please clarify whether the plan is to be developed and approved by DDS or developed by another party and then approved by DDS.
- Section 103(m): Please clarify persons who are not to be considered employees. The current definition states that an independent contractor is not an employee if the contractor does not assist in day-to-day operations and has no beneficiary contact. The conjunctive here could mean that a contracted accountant, for example, is considered to be an employee.
- Section 103(o)(2)(E): Please clarify “informational gatherings.” A provider could, for example, hold a recreational event open to all members of the community at which services are described. If any mention of services is only ancillary to the main purpose of the event, does that constitute marketing?
- Section 103(t): Clarify whether there may be CES waiver recipients who are not PASSE members. The PASSE manual still mentions Tier 1 beneficiaries as voluntary enrollees. The ARIA manual does not mention Tier 1 CES beneficiaries.
- Section 103(v)(3): Please clarify whether DDS is to develop and approve the plan or whether another party will develop the plan.
- Section 103(y)(1): Please clarify that the application of force means only the application of force with one’s body. Mechanical and chemical restraints are prohibited, and objects presumably are prohibited as well.
- Section 103(z): Please clarify whether PASSEs are to develop risk mitigation plans for all beneficiaries. Please modify this definition to have a member’s “care coordination team”

complete the plan, as care coordinators generally will not have appropriate knowledge and resources to complete this alone.

- Section 103(aa): Please clarify situations that are considered to be seclusion and therefore are prohibited. Forcing a person into a closet is obviously seclusion. Physically preventing elopement from one's home may also be seclusion by this definition.
- Section 103(bb)(4)(C): Consider adding "acute psychiatric treatment facility" or similar language to account for the fact that a beneficiary can suffer serious psychological or emotional trauma.
- Section 103(cc)(2)(F): Clarify whether intent on the provider's part is necessary to constitute a violation.
- Section 201: Consider adding a requirement that providers must consent to having their credentials and records of any adverse actions available for a public electronic search feature.
- Section 202(b)(3): Consider adding a requirement that providers periodically update the list of employees it submitted. Ideally, there would be an electronic system in which providers would enter updates within days.
- Section 203(c): Consider adding expirations so that renewals will be required. Without renewal, there is no review cycle to ensure compliance.
- Section 302(b)(3): Consider requiring licensed professionals to periodically submit proof of good standing with their licensing agencies. Consider adding a requirement that licensed professionals report any actions against their licenses within 72 hours.
- Section 303: Consider providing additional guidance on specific training topics like trauma-informed care. DDS should consider creating a model training curriculum to serve as a minimum.
- Section 303(a)(8): Clarify the meaning of "de-escalation techniques. Since this term is used separately from "verbal intervention," it implies that de-escalation refers to a physical intervention. Non-physical de-escalation should be emphasized, but the current language muddles this.
- Section 303(b)(1): Consider adding a minimum amount of training in this area, and clarify whether activities like record review constitute training. Add a requirement that this training include information on the beneficiary's preferences. While not all clients are under guardianship, the Ward's Bill of Rights at Ark. Code Ann. § 28-65-106 offers some ideas about what preferences a caretaker might need to know about a client.
- Section 303(c): Consider placing minimum numbers on yearly refresher training.
- Section 303(e): Consider changing to "a licensed professional who has received substantially similar training as a condition of licensure." I believe it is extremely dangerous to bypass this requirement altogether.
- Section 305(a)(1): Clarify that service records must be available to a beneficiary or guardian at any time upon request.
- Section 305(b)(5): Consider adding a requirement that the service record include a list of the five nearest in-network emergency service providers and urgent care providers.
- Section 305(c)(1): Consider adding a requirement that the documentation of requesting the PCSP must be no older than 30 days. Providers must request this until they receive it.
- Section 305(d)(1)(A): Clarify that potential fill-in staff are "need to know."
- Section 305(d)(1)(B): Consider the effect of DHS Policy 1094 and whether this warrants clarifying this section regarding DRA's access to records.
- Section 305(d)(2)(B)(ii): Clarify that electronic records must employ sufficient security measures to safeguard personal information.

- Section 307(b): Clarify that providers assume responsibility for third-party compliance.
- Section 308(a)(1): Clarify that beneficiaries must be given reasonable opportunity to make use of their funds, namely intentional community integration and engagement.
- Section 308(b): Clarify that providers cannot disclaim criminal or civil liability under federal or state law.
- Section 308(d): Consider defining “account.” Subsection (2) seems to indicate that a provider keeping clear records of deposits and withdrawals into an aggregate account is sufficient, but that does not comport with an ordinary understanding of what an account is. It would also be nearly impossible to calculate interest using the aggregate approach.
- Section 311(a)(2)(A): Consider removing this subsection. Subsection (B) is sufficient because it limits these interventions to serious safety threats. Subsection (A) is confusing because it seems to allow broad use of restrictive interventions for anything that is “unanticipated.” If the section is read to require that subsections (A) and (B) both are met, it may not be clear whether a behavior should have been anticipated.
- Section 311(b)(1): Consider adding a requirement that a provider can only use a behavior de-escalation and management system if the system is approved by DHS (and situational requirements are met). At any rate, providers should not be creating their own interventions.
- Section 311(b)(2): Consider adding that the monitoring must include the client’s physical and emotional conditions. Consider adding a requirement that providers debrief with staff concerning antecedents to the restraint and what steps will be taken to avoid the need for future restraints.
- Section 311(c)(1): Consider having DHS draft a reporting form to be used by all providers.
- Section 311(c)(2)(D): Consider requiring that all individuals involved compose independent narratives. It is very important that individuals not “get their stories straight” by composing one agreed narrative.
- Section 312(c)(2): Consider having DHS draft forms for medication plans and logs.
- Section 313(a)(3)(D): Consider adding a requirement that the plan include specific information about a beneficiary’s history of restraint and seclusion and any anticipated adverse effects from continued application of restrictive interventions.
- Section 313(b)(1): Clarify who is to receive a risk mitigation plan and the form it should take. The risk mitigation plan is obviously very important. To use this section as an example, a consultation provider seems required for high-risk clients. If so, that would affect how services for such a beneficiary are to be considered and approved by the PASSE.
- Section 313(b)(2)(A): Clarify whether a psychiatrist can perform this task.
- Section 313(b)(3): Clarify how often the professional must review the plan.
- Section 401(a): Consider requiring providers to inform beneficiaries that enrollment with them is not a guarantee of coverage. Consider requiring providers to assume financial responsibility for any services they provide for which they did not follow normal procedures for requesting prior authorization.
- Section 402(a): Clarify what an “exit” is as opposed to “refusal to serve.” Providers should inform PASSEs of exits.
- Section 402(b): Consider requiring steps to ensure that clients do not experience any gaps in services.
- Section 403(c): Consider placing a timeframe on when the new provider must hold the transition conference.

- Section 403(d)(2)(C): Consider adding “and other PASSE representatives necessary to ensure transition without a lapse in services.”
- Section 403(e)(1): Consider adding “complete as determined by the PASSE and recorded in a written notification sent to the client.”
- Section 404: This section and the concept of refusal to serve present challenges. If a provider is allowed to drop a beneficiary because the provider asserts it is unable to ensure health, safety, or welfare, this will undoubtedly have the greatest impact on clients with serious health needs. That could constitute discrimination on the basis of one’s perceived or actual disabilities. Since PASSEs receive capitated rates for members, one way to increase cost savings (and with it profits) is to pay for as few services as possible. If clients with the most serious needs are dropped due to those needs, they will likely be institutionalized. If this happens to clients who could live in their communities with proper supports, that could violate federal laws against discrimination on the basis of disability.
- Section 404(d): Clarify whether this is subject to a 90-day timeframe.
- Section 405: This section concerns me most. I think there is great potential for abuse and coercion. Stripping waiver eligibility is an extreme measure, and this section seems to allow it without due process for beneficiaries. My chief concern is who will decide whether a condition has been met and whether conditions overall are sufficient to warrant such a drastic penalty. Please clarify that a single event recorded by a provider will not be sufficient to strip waiver eligibility, and please clarify that beneficiaries will have normal due process protections of notice and opportunity to contest the action.
- Section 501: Emergency weather plans should be required and clearly defined. It is not sufficient for a provider to tell a client that he or she must rely on “natural supports.” Pursuant to federal regulations, natural supports must be voluntary, and they cannot supplant needed paid supports. Providers must have contingency plans in the event that weather prevents normal staffing. For example, a provider could have a contingency plan to rent sufficient space for temporary lodging for multiple individuals if staff cannot get to them in their homes and the clients have no natural supports. Clients who can temporarily stay with family can document that the temporary arrangement does not constitute a natural support as defined in regulations. I am not endorsing this option above any other, but I provide it to illustrate a range of approaches to weather planning.
- Section 502(g): Consider whether this complies with the International Residential Code. My understanding is that a bedroom must be at least 70 square feet with no dimension less than seven feet, and that at least half of the area of the room must have a minimum of seven foot ceiling clearance.
- Section 502(g)(2): Consider requiring a minimum of a twin bed, which is 38 inches wide.
- Section 502(g)(5)-(6): Clarify what constitutes “reasonable” furnishing. This could vary widely between providers without some guidance. Consider a comfortable chair among other minimum requirements, and consider whether a television or any other appliances is to be required.
- Section 503(b)(5): Consider requiring a minimum period of review, perhaps every three months. Also, DDS should have the final say (subject to client appeal rights) to approve or deny a variation.
- Section 601: Consider additional guidance on what is “sufficient.” Network adequacy guidelines on this are quite thin, only requiring that the service be “available” in all counties.
- Section 601(b): Consider requiring a minim period of review for goals, perhaps every

three months.

- Section 602(h)(3)(B): Define “mental health professional.”
- Section 604: Consider explaining each of the services listed for supported employment.
- Section 608: Consider explaining how consultation can work in conjunction with other services, specifically how it can be used to provide better training for direct care staff. Nutrition training is especially pertinent, as I receive frequent reports from clients that they do not receive sufficient support from their providers in this area.
- Section 610: For supplemental support and other services, consider giving the PASSEs more direction on when these services should be approved. The DMS manual defines medical necessity, but PASSEs currently use criteria of their choosing for most medical necessity decisions. Please address this to ensure more consistent results across all the PASSEs.
- Section 702: Consider adding Disability Rights Arkansas as a recipient of reports pursuant to Rule 1094 and other sources of authority.
- Section 801: The PASSE manual requires PASSEs to proactively monitor implementation of services. Consider addressing the role of PASSEs in this section. Consider intervals at which DDS should monitor.
- Section 802: Consider addressing situations in which a PASSE knew or should have known of a violation and failed to report it or require corrective action.
- Section 803(a)(1)(B): Clarify that “public health” includes beneficiary health.
- Section 803(b)(3): Current policy presumes a provider’s right to take on new clients. I think the presumption should be against taking on new clients. PASSEs are required to maintain sufficient provider networks. PASSEs should evaluate providers’ current staffing and provision of services before providers are allowed to take on more clients.
- Section 806: Consider defining “violation.” The definition seems to allow for a lot of subjective judgment, and that could lead to different interpretations that favor or punish specific providers. It is important to know how many events are being addressed, especially when monetary penalties are a possibility. Consider whether \$500 per violation is a sufficient deterrent to achieve desired results.

Thank you for your consideration in this matter. Please contact my office with questions.

Response: Thank you for your comment.

- All beneficiaries in a CES Waiver slot are members of a PASSE.
- While certifications are not reissued, individual site visits are still performed as required.
- Providers are much more qualified to develop and utilize existing appropriate training materials on these topics than the State.
- Refreshers are required every other year pursuant to Section 303(c)
- Section 305(a)(3) will be added which states, “A beneficiary service record must be made immediately available to a beneficiary and their legal guardian upon request.”
- Section 307(b) requires that Providers ensure third-party compliance.
- Section 403(c) will be amended to read, “The new Provider must hold a transition conference to develop a transition plan for the beneficiary within fourteen (14) business days of issuing the notification required in subsection (b) above. If the new Provider is unable to hold a transition

conference within the required timeframe, reasonable justification for the delay must be documented.”

- Section 404(d) will be amended to read, “If a Provider is currently serving a beneficiary when declaring a refusal to serve, the Provider shall remain responsible for the delivery of CES Waiver Services until the beneficiary transitions to their new Provider or other placement unless there is an immediate health or safety risk to Provider employees. A detailed description of any health and safety risk justifying the ceasing of service delivery prior to a completed transition of beneficiary to a new Provider must be documented.”
- Disenrollment of a beneficiary from CES Waiver only occurs as a last resort unless disenrollment is otherwise required by law.
- The definition of mental health professional can be found in Section 103(r).
- Providers must have a residential setting (if applicable) and staffing in place that meets these CES Agency Waiver standards prior to accepting a beneficiary.

Michelle Neece

Guardian to Paul Keller

Comment:

This letter is in response to the January 12, 2024 memo entitled “Community and Employment Supports (CES) Agency Standards. The following will outline the comments you requested from “Interested Persons and Providers”.

As the Guardian for beneficiary, Paul Keller, of the Arkansas CES Waiver Program, I most certainly consider myself to be an “Interested Person”. It was a disappointment to see that this memo was not distributed to all other Guardians, parents and Direct Care Staff who are impacted by the PASSE and Providers, as they have a very unique and vastly comprehensive understanding of how these standards directly affect the beneficiaries DDS is attempting to serve on a daily basis. I was fortunate enough to be able to have access to this memo, as I have witnessed not only the Waiver program in operation for the last 25 years, but I have been directly involved in the day-in and day-out issues that have plagued my beneficiary and many other beneficiaries since the PASSE program came into existence. These Agency Standards are desperately needed and have been a long time coming.

The initial and most glaring concern after digesting this memorandum would be who SPECIFICALLY at DDS is responsible for enforcing these said standards? Although there is a **Subchapter 8. Enforcement**, that addresses the monitoring of Providers and enforcement of actions, etc., there MUST BE a specific department and specific personnel within the Division of DDS that is set up to be responsible for receiving, investigating, monitoring, enforcing and reporting on all complaints that come in from ANYONE, be it a Direct Care Staff of a Provider company, an employee of a PASSE organization, a Guardian, a Direct Care Staff, a parent, a legal representative, a social worker or any other individual with a personal interest, who believes that these standards are being violated.

This contact information needs to be distributed state-wide to ALL interested parties (i.e., Providers and their employees, PASSE and their employees, any subcontractors associated with DDS, Guardians, parents, family members, direct care staff, etc.). This contact information should include the direct phone number to this department, the individuals' names and titles to whom the calls should be directed, the email addresses to which complaints or concerns should be sent and a physical address to send follow-up and official correspondence. To take it one-step further, a 24-hour hotline should be established for individuals to leave information anonymously or for people to leave concerns during non-business hours.

To simply provide a set of guidelines without the appropriate infrastructure set up to receive and process these complaints and concerns, and without universally distributing the contact information to report infractions of these standards is absolutely ineffective and unreasonable.

So let us begin with page 1, **Subchapter 1. General, 102. Purpose:**

The purpose of these standards is to:

- (1) *Serve as the minimum standards for community Providers delivering services to...*

Although we understand it is part and parcel of legal jargon, it is an insult to our disabilities community to use the word "minimum" when we are referring to the "purpose" of these standards. **These should simply be "standards" that Providers must adhere to, period.** Our beneficiaries deserve more than simply the "minimum". Perhaps if DDS expected more than simply the "minimum" from their Providers, the beneficiaries that the Providers and DDS are tasked with serving would have the opportunity to receive better services. And isn't that the purpose of this memo to begin with?

Continuing on under page 1, **Subchapter 1. General, 102. Purpose:**

- (2) *Ensure the health and safety of beneficiaries who are enrolled in the CES Waiver.*

This is such a broad and wide net to cast when listing this as a purpose. It is the single MOST important thing CES Waiver has to ensure the Providers are handling, and yet it is one of the things that currently suffers the most.

HEALTH AND SAFETY comes in all forms, shapes and sizes when referring to our beneficiaries, as most all of them require so much more than simply having a meal and a roof over their head to be considered as healthy and safe.

A great deal of our beneficiaries have the mentality of a child and as we all know, keeping a child "healthy" and "safe" requires much more than what an able-bodied adult requires. Many of our beneficiaries have specific and serious health issues, emotional issues and physical issues, which require staff that are able to identify and comprehend their needs, address their needs and attend to their needs, not just a warm body showing up at their home to sit on a couch and scroll through their phone, while randomly jotting down fake notes to turn in and not even conversating with their client. Providers must be willing and be given the resources to attract, hire and retain competent, qualified, engaged and competitively paid staff in order to help correct the current shortcomings in HEALTH AND SAFETY that are putting our beneficiaries at risk.

This is an area that will require a tremendous amount of change and monitoring if it is to become a truly successful purpose of the CES standards.

Moving on to page 11, **Section 303. Employee Training and Certifications:**

- (a) *All employees must receive training on the following topics prior to having any beneficiary direct contact that is unsupervised by another employee...*

First and foremost, Provider-lead standardized employee training materials should be approved and signed off by DDS. It has been brought to my attention recently that there are some very questionable training materials being presented to new-hire employees by a local provider that could (and is) ultimately jeopardizing the HEALTH AND SAFETY and safety of our beneficiaries. We would suggest that DHS seriously consider monitoring curriculum that is used for training purposes. **Verbiage in this section of the Standards should address this potentially dangerous issue.**

After reading through the list of eight items, we are struck by the fact that there is no curriculum that addresses broad-based training regarding working with adults who are developmentally disabled. The training in the standards memo addresses HIPAA, reporting, basic health and safety practices, verbal intervention, etc., but these employees need a comprehensive education on working with the intellectually, mentally and physically disabled, as there are many new hires who have never worked with our beneficiaries and they need to be educated on how to treat them with dignity and respect, while still accomplishing their individual goals.

We are also struck by something we have experienced countless times in our personal situation. Our beneficiary requires 24/7 pervasive care that includes meal preparation and housekeeping. We see that training is offered for basic health and safety practices, verbal interventions, de-escalation techniques, infection control practices, etc. However, you would be surprised at the number of Direct Care Staff that are sent to care for an individual who apparently have no knowledge of the simplest of food prep or of keeping a house (i.e., vacuuming, dusting, cleaning a bathroom, etc.), or perhaps they simply choose not to do it, even though it is listed as part of their duties. Employees need to be trained on the very basics of keeping a beneficiary's home clean, sanitary and comfortable for them, as well as how to prepare appropriate meals for them, including any special dietary needs.

On page 12, under this same section, the standards go on to state:

- (b)
- (1) *All employees must receive beneficiary-specific training in the amount necessary to safely meet the individualized needs of those beneficiaries prior to having any direct contact that is unsupervised by another employee.*
- (2) *Every employee's beneficiary-specific training must at a minimum include training on the beneficiary's...*

It has been our experience that any training our staff has received has come from other staff members and has been limited to four hours or less. This is simply not enough time to train a person on all of the intricacies that are involved with our beneficiary (and we're assuming many others). Not only does our

staff need a bare minimum of eight hours of on-site training, they also need at least eight hours of job shadowing to ensure that they are handling things appropriately.

We are also confused as to why other Direct Care Staff are tasked with training the newly hired staff members. Should it not be the job of the Providers to employ a trainer whose job it is to make sure that Direct Care employees are properly trained to work with a beneficiary? Or, in the alternative, should it not be the care coordinator's job to make sure they have trained a new Direct Care Staff to meet the HEALTH AND SAFETY requirements of a beneficiary before he/she places them in their home?

We cannot express to you the number of times that as a Guardian and as family members, we, ourselves, have trained staff over and over and over again when adequate training had not been provided. We have developed and provided job descriptions where there were none. We have developed and provided lists of job duties during shifts where there were none. We have developed information regarding our beneficiary and put it in print to hand out to staff where there was none.

Although we truly want to be involved in engaged developing the plan of care, the goals and the staffing of our beneficiary, we are aging and in poor health. What happens when we are no longer here to essentially step-in and do the job of our Provider when it is not being done properly? What happens when we are not able to constantly monitor our Provider and case management to make sure our beneficiary is receiving the proper services and care the waiver program and DDS is tasked with providing him? I will tell you what happens. Our beneficiary's HEALTH AND SAFETY will suffer. He will receive substandard care at the hand of DDS, our Providers and the PASSE, and that is NOT ACCEPTABLE.

And lastly, when a substitution staff person is sent in to a beneficiary's home, it is incumbent upon the Provider that the sub staff have been given beneficiary-specific training to that person, regardless of the circumstances under which they have been dispatched to that beneficiary. In other words, Providers need to be developing substitution staff pools in which the staff is trained and understands the needs of the beneficiaries. Otherwise, they are walking in blind and they have no idea what to expect or how to care for their beneficiary in a HEALTHY AND SAFE manner. They are currently being sent to residences with no training about the beneficiary, no contact sheets, no medicine sheets, no phone numbers, no information about the beneficiary, etc. This is ABSOLUTELY UNACCEPTABLE. It would be like pulling a stranger in off of the street and expecting them to know how to care for our developmentally disabled adult. **Verbiage must be added to this section to address this issue.**

On page 16, **Section 307. Third-Party Service Agreement:**

- (a) *A Provider may contract in writing with third-party vendors to provide services or otherwise satisfy requirements under these standards*

We, as well as many, many other families have been experiencing a shortage in staffing. It would be our suggestion that not only do we "allow" Providers to contract with third-party vendors to provide services, but we **change the verbiage** to "encourage" Providers to contract with third-party Providers when staffing becomes an issue, particularly in emergency situations such as bad weather. As families, we see this as an alternative to situations in which there are staffing shortages or emergencies that arise in which we are told they have no one to send and "emergency services" will have to be dispatched out to the

beneficiary, which would cause a great deal of harm and disruption to a beneficiary's mental health and well-being. Third-party Providers could include, but would not be limited to, other Providers than the one assigned to the beneficiary, nursing or health Provider services, and on-call elder / senior care services, etc.

On page 16, **Section 308. Financial Safeguards:**

Regarding this section, when a beneficiary's finances are handled by a Provider, who oversees and audits the finances and transactions made by the Providers on the beneficiaries behalf and how often are these audits conducted? **Verbiage should be added to this section** that addresses the oversight and compliance of a Provider to manage a beneficiary's finances, as well as the frequency of audits so that Providers will be on notice that DDS will be seeing to it that a beneficiary's money is being handled properly. To state as in section (b) (4) *A Provider may only use, manage, or access a beneficiary's funds or other assets to the extent permitted by law...* does not give the Provider any sense that they will be actively monitored, audited and reviewed by DDS and subject to fines and penalties by DDS if discrepancies or mishandling are identified, as well as subject to punishment to the fullest extent by law.

On page 19, **Section 311. Restraints and Other Restrictive Interventions:**

(a)

(3) *The use of seclusion for a beneficiary is strictly prohibited.*

Please note that we have experienced, Direct Care Staff using "seclusion", or choosing to not take our beneficiary out in public to participate in activities, as a way for them to not fully perform their job duties. (Unfortunately, once again, we are also aware of this happening with many other beneficiaries.) This is seclusion and quite frankly, a form of abuse. Waiver services are intended to be a form of "community-based" services and living. That means that if the beneficiary's PCSP and Guardian dictates that they are to be involved in community activities, a Direct Care Staff member's indifference or lack of motivation in performing these tasks is irrelevant and should be cause for discipline by a Provider.

On page 26, **Subchapter 4, Entries and Exits, 401. Entries:**

(a) *A Provider may enroll and provide those CES Waiver Services it is certified to deliver pursuant to its CES Waiver Service certification(s) to an eligible beneficiary.*

Considering the current state of staffing difficulties, does it seem prudent to allow Providers to continue to accept new beneficiaries when existing beneficiaries are not being staffed and served in a timely and consistent manner? If a Provider is unable to show that at least 90 to 95% of their beneficiaries are fully staffed, should they be allowed to continue to accept new beneficiaries and benefit from the monetary gains this provides them when they are unable to serve their current members?

This sets current beneficiaries up to have their HEALTH AND SAFETY compromised by untrained, ineffective and incompetent staffing and suffer with constant lapses in staffing. We know this because

we have experienced it and continue to experience it over and over again. Additionally, a Provider needs to show that they have an adequate “pool” of substitution staff that can be drawn on before being allowed to accept new beneficiaries. **This verbiage MUST be changed** in order to preserve the HEALTH AND SAFETY that DDS lists as their purpose.

On pages 28 and 29, **Section 404. Refusal to Serve:**

- (b) *If a Provider is unable to ensure a beneficiary’s health, safety, or welfare because qualified personnel are unavailable to deliver a CES Waiver Service included on the beneficiary’s PCSP, Provider must be able to demonstrate reasonable efforts to recruit and retain qualified personnel and the results of those efforts.*

DDS needs to **add verbiage that elaborates** on what is considered “reasonable efforts”, as we believe beneficiaries could be dismissed with a refusal to serve without reasonable efforts being made to recruit and retain staff. In the past many, many months, as Guardian, I have been doing the majority, if not all, of the active staff recruitment, as I have been unable to get my Provider to consider other alternatives to recruit staff or to “think outside of the box”, which is what is often required. We have been told they do the typical advertising on Indeed, etc, but that is not adequate or reasonable in today’s labor market. We’ve been told that they have “no one to hire in the Fort Smith area”, and yet we were advised that another Provider in our area just put 30 people through new-hire training in Fort Smith this week. The ball is being dropped somewhere, wouldn’t you agree?

The most important and pressing issue we have with attracting, hiring and retaining staff competent, qualified staff is the inadequate salaries they are being offered. I have written to my PASSE Provider requesting additional funds for staffing, and was turned down. We have utilized a personal care company to allow for more money in our “budget” to pay staff more, and yet our Direct Care Staff still only makes \$13.00 an hour.

Providers are expected to be able to hire staff and put our beneficiary’s life in their hands, to care for him, to meet his dietary needs, to take him out in the community and make sure he doesn’t fall while using an assistive device, to take him to doctors’ appointments (of which he has several) to bathe him, to perform his physical therapy exercises, to shave him, to wipe him, to monitor him at night with sleep issues, to give him his medicine, to make sure he doesn’t walk out in front of cars, to make sure he doesn’t try to cook for himself, to change the sheets on his bed, to keep his house, to keep up with his groceries, etc., this list goes on and on. His entire life, well-being, HEALTH AND SAFETY is in their hands and we only want to pay them \$13.00 an hour. They can go to Wal-mart or McDonald’s and make more per hour with none of the responsibility. How can Providers “*demonstrate a reasonable effort to recruit and retain qualified personnel*” when that is what they are up against?

Do you suppose that not paying a decent, competitive wage in today’s labor market could be an obstacle to the HEALTH AND SAFETY of our beneficiaries? And yet a PASSE company that has millions and millions of dollars at their discretion, won’t see to it that a Provider can offer a beneficiary’s Direct Care Staff enough money that they can afford to pay their rent when they have someone’s life in their hands? The Providers may attempt to make reasonable efforts to hire staff, but they MUST have the monies available

from the PASSES to be able and willing to pay qualified, competent employees so that the HEALTH AND SAFETY of the beneficiaries is put first, as DDS claims it is.

On page 30, **Subchapter 5., Settings Requirements, 501. Emergency Plans and Drills:**

Although not addressed in this section, there needs to be emergency plans in place regarding staffing policies during bad / inclement weather. We recently experienced an issue with being unable to have staffing provided to us (and there were no natural supports available) during a weather event and were told our Provider simply had no alternative but to send in “emergency services”, which would have caused tremendous mental turmoil to our beneficiary.

This situation can be avoided by care coordinators being proactive in addressing upcoming weather events and planning ahead, as well as there being an “inclement weather emergency plan” in place. In our situation, there were two full days to plan in advance and see to it that a plan for Direct Care Staff was in place to avoid a disruption in services, but our coordinator chose to just “wait and see what happens”, which created a tremendous amount of unnecessary drama for the Guardian, the family, the Direct Care Staff and the beneficiary.

If a Direct Care Staff is on duty during inclement weather and has no staff to relieve them, are they required to stay on duty until another staff member can arrive to relieve them? We would like some clarification on this matter, as we were advised by our Provider that they could not “make” a Direct Care Staff stay because it was against labor laws.

Some type of **verbiage needs to be added** to the Emergency Plans section that addresses inclement weather and how a Provider should make advanced plans (as we all know that Arkansas has plenty of advanced warning on weather events) to handle staffing in these instances to ensure no disruption of services.

On page 37, **Subchapter 6, Programs and Services. 601, Supportive Living:**

(b)

- (3) *Providers must ensure that a sufficient number of direct care staff are scheduled during the performance of supportive living services to guarantee the health, safety and welfare of each beneficiary.*
- (4) *Providers must have backup plans in place to address contingencies if direct care staff are unable, fail or refuse to provide scheduled supportive living services.*

As we have mentioned numerous times in this correspondence, Direct Care staffing and the quality of that Direct Care staffing continues to be an issue. We believe that adequate staffing can be accomplished with aggressive, proactive ad campaigns, collaboration with other vendors and providers such as healthcare agencies and senior care agencies, community outreach through churches, outreach through college campus organizations, reaching out to the United Way, active participation in job fairs, contacting hospitals, child care agencies and daycares, etc, as well as an increase in the availability of higher salaries for the workers who are hired. A sub staff pool must also be developed for when Direct Care Staff is sick,

on vacation or otherwise unavailable. This gives Direct Care Staff the ability to work normal, set schedules, without being stressed and overworked.

Once they are hired, better training and a more hands-on, involved and collaborative approach among the Direct Care staff, the Guardians, the PASSE and the Provider can result in a positive experience for our beneficiaries. But unfortunately, these things are not presently being done. My Provider case manager (who had been with us for six months) was setting up our annual meeting and did not even know the name or contact information for my PASSE care coordinator. Does this sound like collaboration to you? **Perhaps verbiage needs to be added** somewhere under the Supportive Living section that addresses the need for the Provider AND THE PASSE to work collaboratively with the Guardian and Direct Care Staff to assure that the beneficiary's goals are being worked on in a timely and consistent manner and that Direct Care Staff's job performance is being monitored in such a way that it meets the expectation of the job description and goals.

We would also **like to see verbiage that states** that a Guardian be offered to receive a copy of the daily progress notes as listed in number (b) (5) on a monthly basis.

Providers also need to be educated on the legal definition and appropriate use of the phrase "natural supports". In our situation, due to the age and health issues of our beneficiary's immediate family, he does not have any "natural supports". We are constantly being pressured and coerced, for lack of a better word, by our Provider to find and identify natural supports to make up for their lack of staffing. Providers **MUST BE EDUCATED** on what federal regulations define as "natural supports" and the fact that they are **VOLUNTARY**. We simply do not have natural supports in our situation, as we have no other family in the area.

In the case of a dire emergency, as Guardian, I would see to it that I would be taken to wherever my beneficiary was and provide whatever was needed, but due to my own health issues, that cannot occur unless it is a true emergency. Not being able to find Direct Care Staff because of poor planning on the part of a Provider or case manager does not constitute an emergency. **Verbiage MUST be added** which complies with federal law and clarifies the use of "natural supports" and the fact that it is voluntary when dealing with Guardians and family members.

On page 54, **Subchapter 7., 702. Reporting Requirements:**

*(b) A Provider must submit all reports to the beneficiary's assigned PASSE and to
DDS.*

Again, there needs to be specific entities, names, titles and contact information for these incidents to be reported. To simply say that this information should be reported to PASSE and DDS is not specific and clear enough. In the past, if an incident occurred which was reported to our PASSE care coordinator, nothing was generally done because they simply are not given the authority to handle any situation outside of the purview of developing plans of care and ordering supplies. To contact a PASSE 1-800 number was completely ineffective, as well as trying to deal with an "ombudsman". Providers, Guardians, families and Direct Care Staff **MUST** be provided with **SPECIFIC** and **ACCURATE** contact information for

both PASSE companies and DDS in the event that anything should occur that would impact the HEALTH AND SAFETY of a beneficiary as listed in Section 701.

Continuing on page 54, **Section 703, Notification to Legal Guardian:**

- (a) *If a beneficiary has a legal Guardian, then a Provider must notify the legal Guardian of any reportable incident involving the beneficiary.*

Verbiage should be added to this section which states the Guardian should be notified within 1 hour of the reportable incident, no exceptions.

On page 55, **Subchapter 8., Enforcement., Section 801, Monitoring:**

- (a) *DDS shall monitor a Provider to ensure compliance with these standards.*

And **Section 802, Written Notice of Enforcement Action**, goes on to state how a Provider will be notified of all enforcement actions taken against a Provider.

Verbiage should be added here that addresses that any enforcement actions taken against a Provider that directly involve a specific beneficiary should also involve immediate notification to the beneficiary's Guardian.

On page 57, **Section 804., Moratorium:**

We revisit the subject of prohibiting a Provider from accepting new beneficiaries, as discussed earlier in this correspondence. Although in this section of the memo, a Moratorium is being used as a penalty as a result of an enforcement action, we believe that a Moratorium should be used as a daily practice that prevents Providers from accepting new beneficiaries when they are unable to fully staff and provide sub staff to the current individuals they serve. (Please refer to my comments on page 6 of this document under "Entries and Exits".)

The Moratorium verbiage should be taken out of the Enforcement Actions section and used as a daily DDS policy to prevent Providers from jeopardizing the HEALTH AND SAFETY of the beneficiaries being served by allowing them to continue to accept new beneficiaries if they cannot effectively staff and serve at least 90 to 95% of their current beneficiaries.

In closing, I would like to comment on the role that the PASSE is playing in how we are able to effectively serve our beneficiaries. This memorandum developed specifically addressed the Providers and what is required of them. However, as we all know, the PASSE companies are contracted with the state and have a legal obligation to fulfill the rules and regulations of said contracts. When is DDS going to start holding the PASSE companies responsible for their contractual obligations and develop a set of Community Standards for PASSE organizations that must be followed?

There MUST BE a CLEARLY DEFINED set of roles and responsibilities among the PASSE companies, the Providers and DDS that has yet to be conveyed to those who are tasked with participating in this infrastructure. This set of roles and responsibilities needs to be set out in writing and distributed to all interested parties, including PASSE companies, Providers, Direct Care Staff, Guardians, families, beneficiaries, etc.

At the end of the day, the most important and vital thing that has to happen is that we diligently go above and beyond our very best to serve and protect these fragile individuals in our care that so desperately depend solely on us for their well-being. I take this task very seriously and I can only hope that those at DDS with the authority to initiate true policy and systemic change will, as well.

Response: Thank you for your comment.

- Providers are much more qualified to develop and utilize existing appropriate training materials on the required topics than the State.
- If there is any complaint or concern of a legal guardian relating to a CES Waiver provider's compliance with these standards, they should report it to their assigned PASSE care coordinator. If there is concern with how PASSE is handling the concern then there is the PASSE grievance process. The state is also in the process of setting up a citizens portal where a legal guardian (and the general public) would be able to submit complaints and concerns relating to CES Waiver services. Information regarding the citizen portal will be provided once it is established.
- Providers are required to maintain detailed emergency plans for each beneficiary which must specifically include weather related emergencies under Section 501(B).
- A beneficiary's legal guardian is entitled to receive a copy of the daily progress notes or any other documentation in a beneficiary's service record at any time. Section 305(a)(3) will be added to clarify this which states, "A beneficiary service record must be made immediately available to a beneficiary and their legal guardian upon request."
- Section 703(a) will be amended to read "If a beneficiary has a legal guardian, then a Provider must notify the legal guardian of any reportable incident involving the beneficiary within one (1) hour of discovery."

Sabrina Woodson

CEO

Focus, Inc.

Comment:

302 (2) Each individual eighteen (18) years of age or older residing in an alternative

living home that is not a family member of the beneficiary must successfully pass the checks, screens, and searches prescribed in subdivision (b)(1) of this part.

COMMENT: This remains an issue as providers cannot require non employees to do drug testing. Why would we do an excluded provider check on non-employees? That is not in statute. Is the expectation that a person receiving services will be expected to find a new home if someone living in the home can't pass an excluded provider check?

Suggestion: To be consistent with Ark. Code Ann. 20-38-101, Could we use the statutory language, see below, and then we work to get the statute amended next session on the issues being brought up here?

Each individual eighteen (18) years of age or older residing in an alternative living home who has unsupervised access to a beneficiary served by the provider must successfully pass the checks, screens, and searches prescribed in subdivision (b)(1) of this part. This provision does not apply if the individual living in the home with the beneficiary: (a) is a family member of the beneficiary; (b) is a volunteer; or (c) works in an administrative capacity and does not have unsupervised access to the beneficiary.

Lastly, can guardian be included too? Some people live with their guardians and we would not want to do checks on them?

Page 1, Definition Alternative Living Home

COMMENT: Referencing the above, the definition in the rules of, " ' Alternative living home' means beneficiary residential setting that is not owned leased or controlled by the beneficiary, the beneficiary's legal guardian, or a family member of the beneficiary" needs to be removed from the rules. 302 (2) is the only reference of "alternative living home" in the rules and again providers cannot require non employees to drug tests, provider checks, and searches.

313 Behavioral Management Plans (1) The selected provider for supportive living services must develop a behavioral prevention and intervention plan for a beneficiary if the beneficiary's risk mitigation plan identifies the beneficiary as a risk to display behaviors that can lead to harm to self or others but below a risk level requiring a positive behavior support plan. (b) (1) The selected Consultation Provider must develop and implement a positive behavior support plan if a beneficiary's risk mitigation plan identifies the beneficiary as a high behavioral risk that can lead to harm to self or others, as defined in the risk assessment and mitigation plan tool.

COMMENT: The risk mitigation tool has yet to be developed, presented, or trained with providers to have a start date of these rules for April 1, 2025. Providers will not be prepared or equipped to carry out the rules.

313 (b)(3) A positive behavior support plan must at minimum include all items listed in subsection(a)(3) of this part in addition to the following:.....

COMMENT: Licensed professionals are not receptive on mandates on how to write the PBSP, along with the shortage of licensed staff who are willing to do them for the consultation fee.

Subchapter 4. Entries and Exits

COMMENT: PASSE Open Enrollment also should be addressed.

403 (b) A newly selected Provider must notify the current Provider of its selection within fourteen (14) business days of receiving notification of its selection from the PASSE

(c) The new Provider must hold a transition conference to develop a transition plan for the beneficiary.

COMMENT: These should be in the Care Coordinators manual, not the CES manual. The Care Coordinator should be organizing and coordinating these tasks of which they have first access to the information. As of now, providers do not get notified to be able to initiate (b) and the care coordinators will be included in the transition conference and should coordinate the transition. If providers are to be responsible to develop a transition plan, it should be a billable service.

404 (d) If a Provider is currently serving beneficiary when declaring a refusal to serve, the Provider shall remain responsible for the delivery of CES Waiver Services until the beneficiary transitions to their new Provider or other placement.

COMMENT: Providers ask to have a timeframe for services to end with provider after a refusal to serve has been submitted. There are examples where a provider has submitted a refusal to serve and still are serving a client several years after declaring they cannot meet health and safety of the client.

Response: Thank you for your comment.

- Section 302(b)(2) will be changed to read, “Each individual eighteen (18) years of age or older residing in an alternative living home that is not a family member of the beneficiary must successfully pass the checks and searches required by Ark. Code Ann. §20-48-812(c)(1-4).”
- Section 302(b)(3) will be amended to read:

“(3) The checks, screens, and searches prescribed in subdivision (b)(1) of this part are not required for any:

(A) Licensed professional; or

(B) Legal guardian of a beneficiary.”

- Section 404(d) will be amended to read, “If a Provider is currently serving a beneficiary when declaring a refusal to serve, the Provider shall remain responsible for the delivery of CES Waiver Services until the beneficiary transitions to their new Provider or other placement unless there is an immediate health or safety risk to Provider employees. A detailed description of any health and safety risk justifying the ceasing of service delivery prior to a completed transition of beneficiary to a new Provider must be documented.”

