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

**201.000 Arkansas Medicaid Program Participation Requirements for DDS
CES Waiver Program**

7-1-17

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

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

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

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

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

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

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

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

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

201.200 Organized Health Care Delivery System Provider 7-1-17

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

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

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

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

202.000 Documentation Requirements 7-1-17

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

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

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

- A. A copy of the beneficiary's person centered service plan, including any amendments thereto
- B. The specific services rendered
- C. The date, and actual time, the services were rendered
- D. The name of the individual who provided the service

- E. The relationship of the service to the treatment regimen of the beneficiary's person centered service plan
- F. Updates describing the beneficiary's progress or lack thereof. Updates should be maintained on a daily basis or at each contact with or on behalf of the beneficiary. Progress notes must be signed and dated by the provider of the service.
- G. Certification statements, narratives and proofs that support the cost effectiveness and medical necessity of the service to be provided

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

202.200 HCBS Settings Requirements

7-1-17

Home and Community-Based Services (HCBS) Settings

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

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

HCBS settings must have the following characteristics:

- A. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
 - 1. Choice must be included in the person-centered service plan.
 - 2. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.
- B. Ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.
- C. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- D. Facilitates individual choice regarding services and supports and who provides them.
- E. The setting is integrated in and supports full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.
- F. In a provider-owned or controlled residential setting (e.g., Group Homes), in addition to the qualities specified above, the following additional conditions must be met:
 - 1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or

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

210.000 PROGRAM COVERAGE

211.000 Scope

7-1-17

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

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

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

The objectives are as follows:

- A. To transition eligible persons who choose the waiver option from residential facilities into the community;
- B. To provide priority services to persons who meet criteria for the third tier of service (requiring supports 24 hours a day, seven days a week); and
- C. To enhance and maintain community living for all persons participating in the waiver program.

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

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

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

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

- A. The need for absence must be for the purposes of treatment in a licensed or certified program or facility for the purposes of behavior stabilization, physical or mental health treatment.
- B. The loss of home or loss of the primary non-paid caregiver.
- C. The request must be in writing with supporting evidence included.
- D. The request must be prior approved by DDS.
- E. A minimum of one visit or one contact each month is required.

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

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

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

- A. It must be demonstrated that a beneficiary needs case management and at least one other service as documented in their person centered service plan.
- B. Beneficiaries must receive monthly monitoring of waiver services.

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

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

- B. Wilderness camps and boot camps are considered a public institution if a governmental unit has any degree of administrative control.
- C. Inmate status will continue until the indictment against the individual is dismissed or until he or she is released from custody either as “not guilty” or for some other reason (bail, parole, pardon, suspended sentence, home release program, probation, etc.)

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

211.200 Risk Assessment

7-1-17

- A. DDS will not authorize or continue waiver services under the following conditions:
 - 1. The health and safety of the beneficiary, the beneficiary’s caregivers, workers or others are not assured;
 - 2. The beneficiary or legally responsible person has refused or refuses to participate in the plan of care development or to permit implementation of the plan of care or any part thereof that is deemed necessary to assure health and safety;
 - 3. The beneficiary or legally responsible person refuses to permit the on-site entry of: case manager to conduct required visits, caregivers to provide scheduled care, DDS, DMS, DHS or CMS officials acting in their role as oversight authority for compliance or audit purposes;
 - 4. The beneficiary applying for, or receiving, waiver services requires 24 hour nursing care on a continuous basis as prescribed by a physician;
 - 5. The beneficiary participating in the waiver program is incarcerated, adjudicated as guilty or is an inmate in a state or local correctional facility;
 - 6. The person is deemed ineligible based on DDS Psychological Team assessment or reassessment for meeting ICF/IID level of care;
 - 7. The beneficiary is deemed ineligible based on not meeting or not complying with requirements for determining continued Medicaid income eligibility.
 - 8. The beneficiary does not undergo an independent assessment by a third-party vendor.
- B. Safeguards concerning the use of Restraints or Seclusion:
 - 1. Physical restraints (use of a staff member’s body to prevent injury to the consumer or another person) are allowed in cases of emergency. An emergency exists when:
 - a. The individual has not responded to de-escalation techniques and continues to escalate behavior,
 - b. The individual is a danger to self or others, or
 - c. The safety of the individual and those nearby cannot be assured through positive reinforcers.

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

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

1. Use of mechanical or chemical restraint is not allowed. Seclusion is not allowed.
 2. DDS standards require that providers will not allow maltreatment or corporal punishment (the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior) of individuals. Provider's policies and procedures must state that corporal punishment is prohibited.
- C. Safeguards Concerning the Use of Restrictive Intervention
1. Restrictive interventions may be used.
 2. DDS standards require the use of a behavior management plan for all individuals whose behavior may warrant intervention. The behavior management plan must specify what will constitute the use of restrictive interventions, the length of time to be used, who will authorize the use of restrictive intervention and the methods for monitoring the individual.

When the behavior plan is implemented, all use of restrictive interventions must be documented in the individual's case record and should include the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.
 3. Restrictive interventions include:
 - a. Absence from a specific social activity,
 - b. Temporary loss of a personal possession, or
 - c. Time out or separation.
 4. Restrictive interventions cannot include:
 - a. Aversion techniques,
 - b. Restrictions to an individual's rights, including the right to physically leave,
 - c. Mechanical or chemical restraints, or
 - d. Seclusion.

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

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

1. All personnel who are involved in the use of restrictive interventions must receive training in behavior management techniques, as well as, training in abuse and neglect laws, rules and regulations and policies. The personnel must be qualified to perform, develop, implement and monitor or provide direction intervention as applicable.
2. Use of restrictive interventions requires submission of an incident report that must be submitted no later than the end of the second business day following the incident. The DDS Quality Assurance staff investigates each incident and monitors use of restrictive interventions for possible overuse or inappropriate use. DDS Quality Assurance staff will notify entities involved with the complaint or service concern the results of their review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Failure to complete corrective action measures may result in the provider being placed on provisional status or revocation of certification.

D. Behavior Management Plans

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

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

1. Be designed so that the rights of the individual are protected,
2. Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or puts the individual at medical risk,
3. Identify the behavior to be decreased,
4. Identify the behavior to be increased.
5. Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior,
6. Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person.
7. Identify the event that likely occurs right before a behavior of concern.
8. Identify what staff should do if the event occurs.
9. Identify what staff should do if the behavior to be increased or decreased occurs, and
10. Involve the fewest interventions or strategies as possible.

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

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

E. Reports of Use of Restraints or Restrictive Intervention

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

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

212.000 Description of Services

7-1-17

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

Services provided under this program are as follows:

- A. Supportive Living
- B. Respite Services
- C. Supported Employment
- D. Adaptive Equipment
- E. Environmental Modifications
- F. Specialized Medical Supplies
- G. Supplemental Support Service
- H. Case Management Services
- I. Consultation Services
- J. Crisis Intervention Services
- K. Community Transition Services

213.000 Supportive Living**7-1-17**

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

A. Residential Habilitation Supports

Supports to assist the beneficiary to acquire, retain or improve skills in a wide variety of areas that directly affect the person's ability to reside as independently as possible in the community. The supports that may be provided to a beneficiary include the following:

1. Decision making including the identification of and response to dangerously threatening situations, making decisions and choices affecting the person's life and initiating changes in living arrangement or life activities;
2. Money management including training, assistance or both in handling personal finances, making purchases and meeting personal financial obligations;
3. Daily living skills including habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medications (to the extent permitted under state law) and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid and emergency procedures;
4. Socialization, including training, assistance or both, in participation in general community activities, and establishing relationships with peers. Activity training includes assisting the person to continue to participate on an ongoing basis;
5. Community integration experiences including activities intended to instruct the person in daily living and community living skills in an integrated setting. Included

are such activities as shopping, church attendance, sports, participation in clubs, etc. Community experiences include activities and supports to accomplish individual goals or learning areas including recreation and specific training or leisure activities. Each activity is then adapted according to the beneficiary's individual needs.

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

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

7. Mobility including training, assistance or both aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel or movement within the community;
8. Communication including training in vocabulary building, use of augmentative communication devices and receptive and expressive language;
9. Behavior shaping and management including training, assistance or both in appropriate expressions of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors;
10. Reinforcement of therapeutic services, including conducting exercises or reinforcing physical, occupational, speech and other therapeutic programs;
11. Health maintenance activities may be provided by a (supportive living worker). All health maintenance activities, except injections and IV's, can be done in the home by a designated care aide, such as a supportive living worker. With the exception of injectable medication administration, tasks that beneficiaries would otherwise do for themselves, or have a family member do, can be performed by a paid designated care aide at their direction, as long as the criteria specified in the Arkansas Nurse Practices Consumer Directed Care Act has been met. Health maintenance activities are available in the Arkansas Medicaid State Plan as self-directed services. State plan services must be exhausted before accessing waiver funding for health maintenance activities.

B. Companion and Activities Therapy

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

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

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

C. Direct Care Supervision

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

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

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

- a. Staff, at all times, are aware of the medications being used by the beneficiary.
- b. Staff are knowledgeable of potential side effects of the medications being used by the person through the prescribing physician, nurse and pharmacist at the time medications are ordered.
- c. All medications consumed are prescribed or approved by the beneficiary's physician or other health care practitioner.
- d. The beneficiary or legally responsible person is informed by the prescribing physician about the nature and effect of medication being consumed and consent to the consumption of those medications prior to consumption.
- e. Staff are implementing the service provider's policies and procedures as to medication management, appropriate to the beneficiary's needs as monitored by the direct care supervisor in accordance with acceptable personnel policies and practices and by the case manager at least monthly.
- f. If psychotropic medications are being used for behavior, the direct care supervisor and case manager are responsible to assure appropriate positive behavior programming is present and in use with programming reviews at least monthly.
- g. The consumption of medications is monitored at least monthly by the direct care supervisor to ensure that they are accurately consumed as prescribed.
- h. Toxicology screenings are conducted on a frequency determined by the prescribing physician with case manager oversight.
- i. Any administration of medication or other nursing tasks or activities are

- performed in accordance with the Nurse Practice and Consumer Directed Care Acts and are monitored by the direct care supervisor in accordance with acceptable personnel practices and by the case manager at least monthly.
- j. Medications are regularly reviewed to monitor their effectiveness, to address the reason for which they were prescribed and for possible side effects.
- k. Medication errors are effectively detected by the direct care supervisor by review of the medication log and with appropriate response up to and inclusive of incident reporting and reporting to the Nursing Board.
- l. Frequency of monitoring is based on the physician's prescription for administration of medication.
- m. The physician approving the service level of support and the person centered service plan is responsible for monitoring and determining contraindications when multiple medications are prescribed. A minimum review is at the annual continued stay review of the person centered service plan for approval and recertification.

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

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

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

Controls in place to assure payments are only made for services rendered include requirement by assigned staff to complete daily activity logs for activities that occurred during the work timeframe with such activities linked to the person-centered case plan objectives; supervision of staff by the direct care supervisor with sign-off on timesheets maintained weekly; audits and reviews conducted by DDS Quality Assurance annually and at random; DDS Waiver Services annual retrospective reviews, random attendance at planning meetings and visits to the home; DMS random audits; and oversight by the chosen and assigned case manager. Retainer payments may be made to providers of habilitation while the waiver participant is hospitalized or absent from his/her home.

213.300 Benefit Limits for Supportive Living

7-1-17

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

Tier 3: Maximum Daily Rate is \$391.95 with a maximum of \$143, 061.75 annually.

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

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

See Section 260.000 for billing information.

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

214.000 Respite Services

7-1-17

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

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

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

Respite services may be provided through a combination of basic child care and support services required to meet the needs of a child. Respite may be provided in the following locations:

- A. Beneficiary's home or private place of residence.
- B. The private residence of a respite care provider.
- C. Foster home.
- D. Licensed respite facility.
- E. Other community residential facility approved by the state, not a private residence.
- F. Licensed or accredited residential mental health facility.

214.100 Benefit Limits for Respite Services

7-1-17

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

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

Tier 2 – maximum daily rate is \$184.80 with a maximum annual rate of \$67,452.00.

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

See Section 260.000 for billing information.

215.000 Supported Employment

7-1-17

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

- A. **Discovery Career Planning:** Information is gathered about a beneficiary's interests, strengths, skills, the types of supports that are the most effective, and the types of environments and activities where the participant is at his or her best. These services should result in the development of the Individual Career Profile which includes specific recommendations regarding the beneficiary's employment support needs, preferences, abilities and characteristics of optimal work environment. The following activities may be a component of Discovery/Career Planning: review of the beneficiary's work history, interest and skills; job exploration; job shadowing; informational interviewing, including mock interview; job and task analysis activities; situational assessments to assess the beneficiary's interest and aptitude in a particular type of job; employment preparation (i.e. resume development); benefits counseling; business plan development for self-employment; and volunteerism.
- B. **Employment Path:** Beneficiary receiving these services must have goals related to employment in integrated community settings in their person-center service plan. Activities must be designed and developed to support the employment goals outlined in the person-centered service plan. Such activities should develop and teach soft skills utilized in integrated employment including, but not limited to, following directions, attending to tasks, problem-solving skills and strategies, mobility training, effective and appropriate communication (verbal and nonverbal) and time management.

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

- C. **Employment Supports.**
 - 1. **Job Development:** Individualized services that are specific in nature to obtaining a certain employment opportunity. The initial outcome of Job Development is the Job Development Plan. The Job Development Plan must be created and incorporated with the individual Career Profile no later than 30 days after Job Development services begin. The Job Development Plan must, at a minimum, specify:
 - a. The short- and long-term employment goals
 - b. Target wages
 - c. Task hours
 - d. Special conditions that apply to the worksite for the beneficiary
 - e. Jobs that will be developed or tasks that will be customized through negotiations with potential employers
 - f. Initial list of employer contacts
 - g. The plan for how many employers will be contacted each week, and
 - h. The conditions for use of on-site job coaching.
 - 2. **Job Coaching:** On-site activities that may be provided to a beneficiary once employment is obtained. Activities provided under this service may include, but are not limited to, completing job duty and task analysis; assisting the beneficiary to learn to do the job by the least intrusive method available; developing compensatory

strategies if needed to cue beneficiary to complete the job; analyzing the work environment during initial training/learning of the job and making determinations regarding modifications or assistive technology. Services are authorized for twelve months. A fading plan must be developed for Job Coaching Services that show how the goals of this service will be achieved in 12 months. Additional authorizations of Job Coaching with no additional fading gains will require additional documentation of level of need for service.

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

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

215.100 Supported Employment Exclusions

7-1-17

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

Payment for employment services excludes:

- A. Incentive payments made to an employer of waiver beneficiaries to encourage or subsidize an employer's participation in the program.
- B. Payments that are passed through to waiver beneficiaries.
- C. Payments for training that are not directly related to the waiver beneficiary's employment.
- D. Reimbursement if the beneficiary is not able to perform the essential functions of the job. The functions of a job coach are to "coach," not to do the work for the person.
- E. CES waiver supported employment services when the same services are otherwise funded under the Rehabilitation Act of 1973 or Public Law 94-142. This means that such services must be exhausted before waiver-supported employment services can be approved or reimbursement can be claimed.
- F. Services provided in a sheltered workshop or other similar type of vocational service furnished in a specialized facility.

215.200 Documentation Requirements for Supported Employment

3-1-10

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

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

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

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

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

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

215.300 Benefit Limits for Supported Employment

3-1-10

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

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

- A. 60% at the end of the beneficiary's first pay period.
- B. 25% when the beneficiary has completed four (4) weeks on the job.
- C. 15% when the beneficiary has completed eight (8) weeks on the job.

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

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

See Section 260.000 for billing information.

216.000 Adaptive Equipment

7-1-17

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

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

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

be provided, it must be documented that an assessment was conducted and a plan was created to show how the enabling technology will meet those requirements.

Equipment may only be covered if not available to the beneficiary from any other source. Professional consultation must be accessed to ensure that the equipment will meet the needs of the beneficiary when the purchase will at a minimum, but not necessarily, exceed \$500.00. Consultation must be conducted by a medical professional as determined by the beneficiary's condition for which the equipment is needed. All items must meet applicable standards of manufacture, design and installation.

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

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

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

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

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

Exclusions:

- A. Swimming pools (in-ground or above ground) and hot tubs are not allowable as either an environmental modification or adaptive equipment.
- B. Therapeutic tools similar to those therapists employ during the course of therapy are not included.
- C. Educational aids are not included.
- D. Computer supplies.
- E. Computer desk or other furniture items are not covered.
- F. Medicaid purchased equipment cannot be donated if the equipment being donated is needed by another waiver beneficiary residing in the residence.

216.100 Adaptive Equipment: Vehicle Modifications

7-1-17

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

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

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

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

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

Exclusions:

- A. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the beneficiary
- B. Purchase, down payment, monthly car payment, or lease cost of a vehicle
- C. Regularly scheduled upkeep and maintenance of a vehicle.

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

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

216.300 Benefit Limits for Adaptive Equipment 7-1-17

The maximum annual expenditure for adaptive equipment, including vehicle modifications and PERS, and environmental modifications is \$7,687.50 per person per year.

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

216.400 Required Documentation for Adaptive Equipment 7-1-17

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

217.000 Environmental Modifications 7-1-17

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

Environmental modification may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, installation of specialized electric and plumbing

systems to accommodate medical equipment, installation of sidewalks or pads to accommodate ambulatory impairments, and home property fencing when medically necessary to assure non-elopement, wandering or straying of persons who have dementia, Alzheimer's disease or other causes of memory loss or confusion as to location or decreased mental capacity or aberrant behaviors.

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

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

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

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

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

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

217.100 Environmental Modifications Exclusions

7-1-17

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

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

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

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

Environmental modifications may not be used to adapt living arrangements that are owned or leased by providers of waiver services.

Swimming pools (both in and out of ground) and hot tubs (spas) are not allowable.

The moving of modifications, such as fencing or ceiling tracks and adaptive equipment that may be permanently affixed to the structure or outside premises is not allowable.

217.200 Benefit Limits for Environmental Modifications

7-1-17

A beneficiary's annual expenditure for environmental modifications and adaptive equipment cannot exceed \$7,687.50 per person per year.

218.000 Specialized Medical Supplies

7-1-17

A physician must order or document the need for all specialized medical equipment. All items must be included in the person-centered service plan. Specialized medical equipment and supplies include:

- A. Items necessary for life support or to address physical conditions along with the ancillary supplies and equipment necessary for the proper functioning of such items.
- B. Durable and non-durable medical equipment not available under the Arkansas Medicaid State Plan that is necessary to address beneficiary functional limitations.
- C. Necessary medical supplies not available under the Arkansas Medicaid State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design and installation. The most cost-effective item will be considered first.

Additional supply items are covered as a waiver service when they are considered essential and medically necessary for home and community care. Covered items include:

- A. Nutritional supplements
- B. Non-Prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage.
- C. Prescription drugs, minus the cost of drugs covered by Medicare Part D, when extended benefits are available under the Arkansas Medicaid State Plan.

When the items are included in Arkansas Medicaid State Plan services, a denial of extension of benefits by DMS Utilization Review will be required prior to approval for waiver funding by DDS.

218.100 Benefit Limits for Specialized Medical Supplies

7-1-17

The maximum annual allowance for specialized medical supplies, supplemental supports and community transition services is \$3690.00 per year.

When a non-prescription or prescription medication is necessary to maintain or avoid health deterioration, the \$3,690.00 limit may be increased with the difference in the specialized medical supplies maximum allowance and the required amount deducted from the supportive living maximum daily allowance. All such requests must be prior approved by the DDS Assistant Director of Waiver Services.

See Section 260.000 for billing information.

219.000 Supplemental Support Service

7-1-17

The supplemental support service helps improve or enable the continuance of community living. Supplemental support service will be based on demonstrated needs as identified in a beneficiary's person centered service plan as unforeseen problems arise that, unless remedied,

could cause disruptions in the beneficiary's services, placement, or place him or her at risk of institutionalization. Waiver funds will be used as the payer of last resort.

219.100 Reserved 7-1-17

219.200 Supplemental Support Service Benefit Limits 7-1-17

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

The maximum annual allowance for supplemental support, community transition services, and specialized medical supplies is \$3,690.00 per year.

220.000 Case Management Services 7-1-17

Case management services assist beneficiaries in gaining access to needed waiver services and other Arkansas Medicaid State Plan services, as well as medical, social, educational and other generic services, regardless of the funding source to which access is available.

Case management services include responsibility for guidance and support in all life activities. The intent of case management services is to enable waiver beneficiaries to receive a full range of appropriate services in a planned, coordinated, efficient and effective manner.

These activities include locating, coordinating, assuring the implementation of and monitoring:

- A. All proposed waiver services
- B. Other Medicaid state plan services
- C. Needed medical, social, educational and other publically funded services, regardless of the funding source
- D. Informal community supports needed by beneficiaries and their families

Case management services consist of the following activities:

- A. Arranging for the provision of services and additional supports
- B. Monitoring and reviewing beneficiary services included in the person-centered service plan
- C. Facilitating crisis intervention
- D. Guidance and support to obtain generic services and supports
- E. Case planning
- F. Needs assessment and referral for resources
- G. Monitoring to assure quality of care and case reviews that focus on the beneficiary's progress in meeting goals and objectives established through the case plan
- H. Providing assistance relative to obtaining Waiver Medicaid eligibility and ICF/ID/DD level of care eligibility determinations
- I. Assuring the integrity of all case management Medicaid Waiver billing in that the service delivered must have prior authorization and meet required waiver service definitions and must be delivered before billing can occur

- J. Assuring submission of timely (advance) and comprehensive behavior and/or assessment reports, continued person-centered service plans, revisions as needs change, and information and documentation required for ICF/IID level of care and waiver Medicaid eligibility determinations
- K. Arranging for access to advocacy services as requested by the beneficiary
- L. Monitoring and reviewing services to assure health and safety of the beneficiary
- M. Upon receipt of DDS approvals or denials of requested services, ensure that a copy is provided to the beneficiary or legal representative
- N. Provides assistance with the appeals process when the appeal option is chosen by the beneficiary or legal representative
- O. Planning meetings are scheduled by the case manager on behalf of the beneficiary, at a time and in a location that is convenient for the beneficiary or legal representative. The planning meeting will only include the case, the beneficiary or legal representative and other persons invited by the beneficiary.

Case Management will be provided up to a maximum of a 90 day transition period for all persons who seek to voluntarily withdraw from waiver services unless the individual does not want to continue to receive the service. The transition period will allow for follow up to assure that the person is referred to other available services and to assure that the person's needs can be met through optional services. It also serves to assure that the person understands the effects and outcomes of withdrawal and to ascertain if the person was coerced or otherwise was unduly influenced to withdraw. During this 90 day timeframe, the person remains enrolled in the waiver, the case remains open, and waiver services will continue to be available until the beneficiary finalizes their intent to withdraw.

The State of Arkansas adheres to CMS regulation as it relates to conflict-free case management. Case Management services may not include the provision of direct services to the beneficiary that are typically or otherwise covered as service under CES Waiver of State Plan. The organization may not provide case management services to any person to whom they provide any direct services without adhering to the following firewalls and protections:

- A. The individual who performs the annual needs-based assessment may not be a provider of services on the person-centered service plan and may not provide direct care
- B. Participant should be encouraged to advocate or have an advocate present during all planning meetings
- C. Providers will administratively separate case management functions and staff and direct-care functions and staff

Case management services are available at two tiers of support. They are:

A. Tier 3: Requiring care 24 hours per day, seven (7) days per week
 B. Tier 2: Requiring care of less than 24 hours per day, seven (7) days per week
 The minimum requirement for service contacts is as follows:

- A. At least one contact monthly
- B. At least one face-to-face contact per quarter

Abeyance: It is sometimes necessary to place a case in abeyance to allow the case to remain open while the beneficiary is temporarily placed in a licensed or certified treatment program for the purpose of behavior, physical, or health treatment of stabilization. On a monthly basis, the case manager must conduct a monitoring contact and report the status to DDS.

See Section 260.000 for billing information.

220.100 Transitional Case Management

3-1-10

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

220.200 Benefit Limits for Case Management

3-1-10

The maximum reimbursement limit per beneficiary is \$117.70 per month and \$1,412.40 per year.

Abeyance will be approved in three-month increments when the beneficiary will be out of service for at least one month. Abeyance cannot exceed one year.

Case management is provided only through the Waiver to beneficiaries who are age 21 and over. All medically necessary case management services are provided to children under the age of 21 through the Medicaid State Plan EPSDT benefit.

221.000 Consultation Services

7-1-17

Consultation services are clinical and therapeutic services which assist waiver beneficiaries, parents, guardians, legally responsible individuals, and service providers in carrying out the beneficiary's person centered service plan.

A. Consultation activities may be provided by professionals who are licensed as:

1. Psychologists
2. Psychological examiners
3. Mastered social workers
4. Professional counselors
5. Speech pathologists
6. Occupational therapists
7. Physical therapists
8. Registered nurses
9. Certified parent educators or provider trainer
10. Certified communication and environmental control specialists
11. Dieticians
12. Rehabilitation counselors
13. Recreational therapists
14. Qualified Developmental Disabilities Professional (QDDP)
15. Positive Behavioral Supports (PBS) Specialist
16. Behavior Analyst

These services are indirect in nature. The parent educator or provider trainer is authorized to provide the activities identified below in items 2, 3, 4, 5, 7, and 13. The provider agency will be responsible for maintaining the necessary information to document staff qualifications. Staff who meet the certification criteria necessary for other consultation functions may also provide these activities. Selected staff or contract individuals may not provide training in other categories unless they possess the specific qualifications required

to perform the other consultation activities. Use of this service for provider training cannot be used to supplant provider trainer responsibilities included in provider indirect costs.

B. Activities involved in consultation services include:

1. Provision of updated psychological and adaptive behavior assessments
2. Screening, assessing and developing therapeutic treatment plans
3. Assisting in the design and integration of individual objectives as part of the overall individualized service planning process as applicable to the consultation specialty
4. Training of direct services staff or family members in carrying out special community living services strategies identified in the person centered service plan as applicable to the consultation specialty
5. Providing information and assistance to the individuals responsible for developing the beneficiary's person centered service plan as applicable to the consultation specialty
6. Participating on the interdisciplinary team, when appropriate to the consultant's specialty
7. Consulting with and providing information and technical assistance with other service providers or with direct service staff and/or family members in carrying out a beneficiary's person centered service plan specific to the consultant's specialty
8. Assisting direct services staff or family members in making necessary program adjustments in accordance with the beneficiary's person-centered service plan as applicable to the consultation specialty
9. Determining the appropriateness and selection of adaptive equipment to include communication devices, computers and software consistent with the consultant's specialty
10. Training and/or assisting beneficiaries, direct services staff or family members in the set up and use of communication devices, computers and software consistent with the consultant's specialty
11. Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment and modification of the positive behavior support plan consistent with the consultant's specialty
12. Training of direct services staff and/or family members by a professional consultant in:
 - a. Activities to maintain specific behavioral management programs applicable to the beneficiary
 - b. Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the beneficiary
 - c. The provision of medical procedures not previously prescribed but now necessary to sustain the beneficiary in the community
13. Training or assisting by advocacy to beneficiaries and family members on how to self-advocate
14. Rehabilitation counseling for the purposes of supported employment supports that do not supplant the Federal Rehabilitation Act of 1973 and PL 94-142 and the supports provided through Arkansas Rehabilitation Services
15. Training and assisting beneficiaries, direct services staff or family members in proper nutrition and special dietary needs.

The maximum amount payable per year for consultation services, per person is \$1,320.00. It is reimbursable at no more than \$136.40 per hour.

See Section 260.000 for billing information.

222.000 Crisis Intervention Services

7-1-17

Crisis intervention services are defined as services delivered in the beneficiary's place of residence or other local community site by a mobile intervention team or professional.

Intervention services must be available 24 hours a day, 365 days a year and must be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geographic area conducive to rapid intervention as defined by the provider responsible to deploy the team or professional. Services may be provided in a setting as determined by the nature of the crisis, i.e., residence where behavior is happening, neutral ground, local clinic or school setting, etc. The following criteria must be met:

- A. The beneficiary is receiving waiver services
- B. The beneficiary needs non-physical intervention to maintain or re-establish behavior management or positive programming plan
- C. Intervention is on-site in the community

The maximum rate of reimbursement for this service is \$127.10 per hour. The annual maximum is \$2,640.00.

Crisis intervention services are only provided as a waiver service to individuals who are age 21 and over. All medically necessary crisis intervention services for children under age 13 are covered as part of the Medicaid State Plan EPSDT benefit.

See Section 260.000 for billing information.

223.000 Community Transition Services

7-1-17

Community transition services are non-recurring set-up expenses for beneficiaries who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the beneficiary or his or her guardian is directly responsible for his or her own living expenses. Waiver funds can be accessed once it has been determined that the waiver is the payer of last resort.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- A. Security deposits that are required to obtain a lease on an apartment or home
- B. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens
- C. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water
- D. Services necessary for the beneficiary's health and safety such as pest eradication and one-time cleaning prior to occupancy
- E. Moving expenses

Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the person-centered service plan development process,

clearly identified in the person centered service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Duplication of environmental modifications will be prevented through DDS control of prior authorizations for approvals.

Costs for community transition services furnished to beneficiaries returning to the community from a Medicaid institutional setting through entrance to the waiver, are considered to be incurred and billable when the person is determined to be eligible for the waiver services. The beneficiary must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the beneficiary does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid.

Exclusions: Community transition services may not include payment for room and board; monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional or recreational purposes. Community transition services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Diversionary or recreational items such as televisions, cable TV access, VCRs or DVD players are not allowable.

223.100 Benefit Limits for Community Transition Services

7-1-17

The maximum annual allowance for supplemental support, community transition services, and specialized medical supplies is \$3,690.00.

See Section 260.000 for billing information.

230.000 ELIGIBILITY ASSESSMENT

7-1-17

The intake and assessment process for the DDS CES Waiver Program includes:

- A. Determination of categorical eligibility
- B. Level of care determination
- C. Comprehensive diagnosis and evaluation, including an independent assessment
- D. Development of a person-centered service plan
- E. Cost comparison to determine cost-effectiveness
- F. Notification of a choice between home and community-based services and institutional services

230.100 Categorical Eligibility Determination

3-1-10

Current eligibility for the Arkansas Medicaid Program must be verified as part of the intake and assessment process for admission into the CES Waiver Program. Medicaid eligibility is determined by the Division of Developmental Disabilities Services or by the Social Security Administration for SSI Medicaid eligibles.

Failure to obtain any required eligibility determination, whether initial or subsequent (time bound) reassessments, will result in the beneficiary's case being closed. Once closure has occurred, and the appeals processes are exhausted, the affected person will have to make a new request for services through the waiver program intake process.

For the supportive living arrangements, the Medicaid eligibility date is retroactive to the date the Medicaid application is received at the DDS Medicaid Unit or no more than three months prior to the receipt of the Medicaid application, whichever is less.

230.200 Level of Care Determination

7-1-17

Based on intellectual and behavioral assessment submitted by the provider, the ICF/ID/DD level of care determination is performed by the Division of Developmental Disabilities. The ICF/ID/DD level of care criteria provides an objective and consistent method for evaluating the need for institutional placement in the absence of community alternatives. The level of care determination must be completed and the beneficiary determined to:

- A. Require the level of care provided in an ICF/ID/DD, and
- B. Need institutionalization in an ICF/ID/DD in the near future (in a month or less) but for the provision of waiver services.

Recertification, based on intellectual and behavioral assessments submitted by the provider at appropriate age milestones, will be performed by DDS to determine the beneficiary's continuing need for an ICF/ID/DD level of care.

The annual level of care determination is made by a QDDP (physician).

230.210 Tiers of Support

7-1-17

Coverage is provided within two tiers of support. The two tiers are as follows:

Tier 3: Institutional Level of Care; 24/7

Tier 2: Institutional Level of Care; less than 24/7

Tiers will be determined through an independent assessment conducted by a third-party vendor that will assess the participant in the following areas:

1. Individual areas, including
 - a. Medical history, current medical conditions, or conditions observed by the assessor or self-reported by the individual
 - b. Behavioral
 - c. Home living activities
 - d. Community activities
 - e. Employment
 - f. Health and safety assessment
 - g. Social functioning
2. Caregiver (natural supports) areas, including
 - a. Physical/behavioral (health)
 - b. Involvement
 - c. Social resources
 - d. Family stress
 - e. Safety

3. Current Risk Assessment Review, including
 - a. Safety Plan, if available
 - b. Behavior Plan
 - c. Physical Plan
 - d. Medical Plan

The independent assessment must be used in conjunction with the application packets and other applicable functional assessments to create the person centered service plan.

230.300 Comprehensive Diagnosis and Evaluation

7-1-17

A comprehensive diagnosis and evaluation (D&E) must be administered in order to determine that applicants are persons with a developmental disability prior to receiving CES Waiver services from the DDS.

The comprehensive diagnosis and evaluation includes a series of examinations and observations performed or validated and approved by professionals leading to conclusions and findings.

The examinations and/or assessments include, but are not limited to:

- A. A thorough medical examination and other evaluations deemed necessary by the physician
- B. A psychological assessment
- C. A social history/sociological examination
- D. An educational assessment, if applicable
- E. An appraisal of adaptive behavior
- F. All other examinations, assessments and evaluations necessary to describe the beneficiary's needs
- G. Areas of Need form

Failure to submit the reassessments in advance of eligibility expiration date will result in the denial of case management reimbursement for the period the determination is overdue. Failure to obtain any required eligibility determination, whether initial or subsequent time-bound reassessments, may result in the beneficiary's case being closed.

When a beneficiary's case has been closed, the affected person must make a new request for services through the waiver program intake process in order for services to continue. This will be considered a new application to the waiver program.

230.400 Person-Centered Service Plan

7-1-17

During the initial sixty (60) days of DDS CES waiver services, a beneficiary receives services based on a DDS pre-approved initial person-centered service plan that provides for case management at the prevailing rate, up to sixty (60) days; and supportive living services for direct-care supervision up to sixty (60) days. It may include transitional funding when the person is transitioning from an institution to the community. Persons residing in a Medicaid-reimbursed facility may receive case management the last 180 consecutive days of the institutional stay.

NOTE: The fully-developed person-centered service plan may be submitted, approved and implemented prior to the expiration of the initial person-centered service plan. The initial plan period is simply the maximum time frame for developing, submitting, obtaining approval from DDS and implementing the person-centered service plan. An extension may be granted when there is supporting documentation justifying the delay.

Prior to expiration of the interim service plan, each beneficiary eligible for CES waiver services must have an individualized, specific, written person-centered service plan developed by a multi-agency team and approved by the DDS authority. The members of the team will determine services to be provided, frequency of service provision, number of units of service and cost for those services while ensuring that the beneficiary's desired outcomes, needs and preferences are addressed. Team members and a physician, via the DDS 703 form, certify the beneficiary's condition (level of care) and appropriateness of services initially and at the annual continued-stay review. The person-centered service plan development is conducted once every 12 months in accordance with the continued stay review date or as changes in the beneficiary's condition require a revision to the person-centered service plan.

The person-centered service plan must be designed with consideration given to the independent assessment results and to assure that services provided will be:

- A. Specific to the beneficiary's unique circumstances and potential for personal growth.
- B. Provided in the least restrictive environment possible.
- C. Developed within a process assuring participation of those concerned with the beneficiary's welfare. Participants of the multi-agency team included the beneficiary's chosen case manager, the beneficiary or legal representative and additional persons whom the beneficiary chooses to invite to the planning meeting, as long as all rules pertaining to confidentiality and conflict of interest are met. If invited, the DDS Waiver Specialist attends the planning meetings randomly, in an effort to assure an annual 10% attendance ratio. Mandatory attendance by the case manager is required to assure the written person-centered service plan meets the requirements of regulations, the desires of the beneficiary or legal representative, is submitted timely, and is approved by DDS prior to service delivery.
- D. Monitored and adjusted to reflect changes in the beneficiary's needs. A person-centered service plan revision may be requested at any time the beneficiary's needs change.
- E. Provided within a system which safeguards the beneficiary's rights.
- F. Documented carefully, with assurance that appropriate records will be maintained.
- G. Will assure the beneficiary's and others' health and safety. The person-centered service plan development process identifies risks and makes sure that they are addressed through backup plans and risk management agreements, including how and who will be responsible for ongoing monitoring of risk level and risk management strategies, and how staff will be trained regarding those risks. A complete description of backup arrangements must be included in the person-centered service plan. All strategies must be designed to respect the needs and preferences of the beneficiary. All risk management strategies must be analyzed by the team at least quarterly as part of the PCSP review.
- H. Consider cost-efficient options that foster independence, such as shared staffing and other adaptations. When such options are not utilized in the PCSP for a Tier 3 participant, it must be documented that the participant's health and safety require one-on-one staffing, 24 hours a day.

Identification information must include:

1. Beneficiary's full name and address
2. Beneficiary's Medicaid number
3. Guardian or Power of Attorney with an address (when applicable)
4. Number of individuals with MR/DD residing in home of waiver beneficiary and type of residence
5. Physician Level of Care Certification
6. Names, titles and signatures of the multi-agency team members responsible for the development of the beneficiary's person centered service plan
7. Results of the independent assessment and any other functional assessments used to develop the person-centered service plan

B. Budget Sheet, Worksheets and Provider Information

Information must include:

1. Identification of the type of waiver services to be provided
2. The name of the provider delivering the service
3. Total amount by service
4. Total plan amount authorized
5. Beginning and ending date for each service
6. Supported Living Array worksheet listing units and total cost by service and level of support
7. Adaptive Equipment, Environmental Modifications, Specialized Medical Supplies, Supplemental Support, and Community Transition worksheets listing units and total cost by service
8. Provider Information sheet showing case management provider, case manager, supportive living provider, and direct care supervisor

C. Narrative justification for the revision to the initial plan of care must, at a minimum justify the need for requested services. Narrative justification for annual continued stay reviews must address utilization of services used or unused within the past year, justify new services requested and address risk assessment.

D. The person-centered service plan must include:

1. Identification of individual objectives
2. Frequency of review of the objectives
3. List of medical and other services, including waiver and non-waiver services necessary to obtain expected objectives
4. Expected outcomes including any service barriers

E. Product and service cost effectiveness certification statement, with supporting documentation certifying that products, goods and services to be purchased meet applicable codes and standards and are cost-competitive for comparable quality.

CES waiver services require prior authorization by the Division of Developmental Disabilities Services. **In the absence of prior authorization, reimbursement will be denied and will not be approved retroactively.**

241.000 Approval Authority

7-1-17

For the purpose of person centered service plan approvals, DDS is the Medicaid authority.

- A. The DDS prior authorization process requires that all pervasive level of support service plans, problematic service plans, or plans not clearly based on documented need must have approval by DDS Plan of Care Review Team.
 1. Problematic is based on individual circumstances, a change in condition, or a new service request as determined by the DDS Waiver Specialist or by request of the case manager.
 2. The DDS Plan of Care Review Team consists of the DDS Waiver Program director or designee, DDS Waiver Area Managers, DDS Psychology Team member and other expert professionals such as nurses, physicians or therapists. The DDS Waiver Specialist is responsible for presenting the case to the team. The waiver participant or legal representative is permitted to attend the meeting and present supporting evidence why the services requested should be approved, as long as all rules pertaining to confidentiality and conflict of interest are met.
 3. The DDS Waiver Specialist must conduct an in-home visit for all Tier 3 service plans and may conduct an in-home visit for problematic service plans or plans that are not based on documented need. Failure of the beneficiary or legal representative to permit DDS from conducting the in-home visit may result in the denial of service request and may result in case closure.
- B. Tier 2 service plans will be subject to a local-level approval process.
- C. All waiver services must be needed to prevent institutionalization.
- D. All beneficiaries receiving medications must also receive appropriate support in the management of medication(s). The use of psychotropic medications for behavior will require the development, implementation and monitoring of a written positive behavior plan.
- E. Service requests that will supplant Department of Education responsibilities WILL NOT be approved. This includes voluntary decisions to withdraw from, or never enter the Department of Education, public school system. The waiver does not provide educational services, including educational materials, equipment supplies or aids.
- F. All person centered service plans are subject to review by a qualified physician and random audit scrutiny by DDS Specialists, DDS Area Managers, DDS Licensure staff or DMS Quality Assurance staff. In addition, the following activities will occur:
 1. Review of provider standards and actions that provide for the assurance of a beneficiary's health and welfare
 2. Monitoring of compliance with standards for any state licensure or certification requirement for persons furnishing services provided under this waiver
 3. Assurance that the requirements are met on the date that the service is furnished
 4. Quality assurance reviews by DDS staff include announced and unannounced quarterly on-site home visits.
 5. Random review equal to a percent as prescribed by DDS Licensure Unit's certification policy.

- G. All service requests are subject to review by DDS and may necessitate the gathering and submission of additional justification, information and clarification before prior approval is made. In this event, it is the primary responsibility of the case management provider, with cooperation from the procurement source, to satisfy the request(s) within the prescribed time frames.
- H. It is the responsibility of the case management services provider with cooperation from the direct services providers to ensure that all requests for services are submitted in a timely manner to allow for DDS prior authorization activities prior to the expiration of existing plans or expected implementation of revisions.
- I. Initially, a beneficiary receives up to three months of DDS CES waiver services based on a DDS pre-approved interim service plan. The pre-approved interim plan will include case management and supportive living service for direct care supervision and may include community transition services when the person is transitioning from an institution to the community. For transitional case management, the three month interim plan begins with the date of discharge.
 - 1. At any time during the initial three months or transitional case management period, the case manager will complete the planning process and submit a detailed person centered service plan that identifies all needed, medically necessary services for the remainder of the plan of care year. Once approval is obtained, these services may be implemented.
 - 2. Waiver services will not be reimbursed for any date of service that occurs prior to the date the beneficiary's person centered service plan is approved, the date the beneficiary is determined to be ICF/IID eligible, or the date the beneficiary is deemed Medicaid waiver eligible, whichever date is last.
 - 3. All changes of service or tier revisions must have prior authorization. Services that are not prior authorized will not be reimbursed.
- J. Emergency approvals may be obtained via telephone, facsimile or e-mail, with retroactive reimbursement permitted as long as the notice of emergency, with request for service change, is received by DDS within 24 hours from the time the emergency situation was known. All electronically transmitted requests for emergency services must be followed with written notification and requests must be supported with documented proof of emergency. Failure to properly document proof of emergency shall result in approval being rescinded.

251.000 Method of Reimbursement

7-1-17

The reimbursement rates for DDS CES waiver services will be according to the lesser of the billed amount or the Title XIX (Medicaid) maximum for each procedure.

The maximum supportive living daily rate is inclusive of administration costs that cannot in any event exceed 20% of the total supportive living array for a beneficiary.

If fringe benefits exceed 25%, documentation must be submitted with person centered service plan and budget request. Fringe benefits cannot exceed 32%.

The administration and fringe costs are subject to audit and must be documented to support the rate charged.

261.000 Introduction to Billing

7-1-17

DDS CES waiver providers use the CMS-1500 claim form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim should contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

262.000 DDS CES Waiver Procedure Codes

7-1-17

The following procedure codes and any associated modifier(s) must be billed for DDS CES Waiver Services. Prior authorization is required for all services.

Procedure Code	M1	M2	PA	Description	Unit of Service	National POS Codes
H2016			Y	Supportive Living	1 Day	12, 99, 14
H2023			Y	Supported Employment	15 Minutes	99
S5151			Y	Respite Services	1 Day	12, 99, 14, 54
T2020	UA		Y	Supplemental Support Services	1 Package	12, 99, 14
T2022			Y	Case Management Services	1 Month	12, 99, 14
T2025			Y	Consultation Services	1 Hour	12, 99, 14
T2028			Y	Specialized Medical Supplies	1 Package	12, 99, 14
T2020	UA	U1	Y	Community Transition Services	1 Package	99, 14, 54
T2022	U2		Y	Transitional Case Management	1 Month	99, 14, 54
T2034	U1	UA	Y	Crisis Intervention Services	1 Hour	99, 12
K0108			Y	CES environmental modifications	1 Package	12
S5160			Y	Adaptive equipment, personal emergency response system (PERS), installation and testing,	1 Package	12, 14
S5161			Y	Adaptive equipment, personal emergency response system (PERS), service fee, per month, excludes installation and testing	1 Package	12, 14
S5162			Y	Adaptive equipment, personal emergency response system (PERS), purchase only	1 Package	12, 14
S5165	U1		Y	CES adaptive equipment, per service	1 Package	12, 14

262.210

Completion of CMS-1500 Claim Form

7-1-17

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's date of birth as given on the Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary resides.
STATE	Two-letter postal code for the state in which the beneficiary resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's telephone number or the number of a reliable message/contact/emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured beneficiary.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.
	Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	<p>Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.</p> <p>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:</p> <p>454 Initial Treatment</p> <p>304 Latest Visit or Consultation</p> <p>453 Acute Manifestation of a Chronic Condition</p> <p>439 Accident</p> <p>455 Last X-Ray</p> <p>471 Prescription</p> <p>090 Report Start (Assumed Care Date)</p> <p>091 Report End (Relinquished Care Date)</p> <p>444 First Visit or Consultation</p>
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for DDS Community and Employment Supports (CES) Waiver services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's inpatient hospitalization, enter the beneficiary's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.
20. OUTSIDE LAB?	Not required.
\$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use "9" for ICD-9-CM.</p> <p>Use "0" for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>
22. RESUBMISSION CODE ORIGINAL REF. NO.	<p>Reserved for future use.</p> <p>Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.</p>
23. PRIOR AUTHORIZATION NUMBER	<p>The prior authorization or benefit extension control number if applicable.</p>
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	<p>Two-digit national standard place of service code. See Section 262.100 for codes.</p>
C. EMG	<p>Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.</p>
D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	<p>Enter the correct CPT or HCPCS procedure code from Section 262.000.</p>
MODIFIER	<p>Modifier(s) if applicable.</p>

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
NPI	Not required.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

PROPOSED

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Includes Changes Implemented through November 2014

Submitted by:

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Submission Date:	
------------------	--

CMS Receipt Date (CMS Use)	
----------------------------	--

PROPOSED

RECEIVED

MAR 17 2014

BUREAU OF
LEGISLATIVE RESEARCH

State:	
Effective Date	

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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors.

State:	
Effective Date	

Application: 1

1. Request Information

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

B. Program Title (optional – this title will be used to locate this waiver in the finder):

Community and Employment Support Waiver

C. Type of Request: Amendment

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

<input type="radio"/>	3 years
<input checked="" type="radio"/>	5 years

<input type="checkbox"/>	New to replace waiver Replacing Waiver Number: <input type="text"/>		
<input type="checkbox"/>	Migration Waiver – this is an existing approved waiver Provide the information about the original waiver being migrated		
	Base Waiver Number:	AR.0188	
	Draft ID:	AR.	
<input checked="" type="checkbox"/>	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)	07/01/17	

D. Type of Waiver (select only one):

<input type="radio"/>	Model Waiver
<input checked="" type="radio"/>	Regular Waiver

E. Proposed Effective Date:

Approved Effective Date (CMS Use):

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

<input type="checkbox"/>	Hospital (select applicable level of care)
<input checked="" type="checkbox"/>	Hospital as defined in 42 CFR §440.10 If applicable, specify whether the State additionally limits the waiver to subcategories of the

State:	
Effective Date	

	hospital level of care:
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input type="checkbox"/>	Nursing Facility <i>(select applicable level of care)</i>
<input type="radio"/>	Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155 If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input checked="" type="checkbox"/>	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150) If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID facility level of care:

State:	
Effective Date	

Application: 3

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

<input checked="" type="radio"/>	Not applicable	
<input type="radio"/>	Applicable	
Check the applicable authority or authorities:		
<input type="checkbox"/>	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I	
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:	
Specify the §1915(b) authorities under which this program operates (check each that applies):		
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/> §1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/> §1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program operated under §1932(a) of the Act. Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:	
<input type="checkbox"/>	A program authorized under §1915(i) of the Act.	
<input type="checkbox"/>	A program authorized under §1915(j) of the Act.	
<input type="checkbox"/>	A program authorized under §1115 of the Act. Specify the program:	

H. Dual Eligibility for Medicaid and Medicare.
Check if applicable:

<input checked="" type="checkbox"/>	This waiver provides services for individuals who are eligible for both Medicare and Medicaid.
-------------------------------------	---

State:	
Effective Date	

2. Brief Waiver Description

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

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

The goals of the Waiver are to:

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

Support of the person includes:

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

The objectives are as follows:

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

Under the organizational structure of the Department of Human Services (DHS), the Division of Medical Services (DMS) is the state Medicaid agency. DMS has administrative authority for the HCBS Waiver including the items as outlined in the Interagency Agreement (See Appendix A-2-b). The Division of Developmental Disabilities Services (DDS), also within DHS, is responsible for operation of the HCBS Waiver, including the items as outlined in the Interagency Agreement. Waiver services are delivered through private providers who are certified by the DDS Quality Assurance Section. The providers must first meet DDS certification requirements and then enroll with Medicaid as HCBS Waiver providers before the provider can deliver services.

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

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

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

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

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

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

i. Individual Areas

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

ii. Caregiver (natural supports) areas

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

iii. Current Risk Assessment Review

- a. Safety Plan, if available;
- b. Behavior Plan;
- c. Physical Plan; and

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d. Medical Plan

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

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

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

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

3. Components of the Waiver Request

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

- A. **Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. **Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. **Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. **Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. **Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one):*

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

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<input checked="" type="radio"/>	No. This waiver does not provide participant direction opportunities. Appendix E is not required.
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- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

<input checked="" type="radio"/>	Not Applicable
<input type="radio"/>	No
<input type="radio"/>	Yes

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

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

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

<input type="checkbox"/>	<p>Geographic Limitation. A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.</p> <p><i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>
<input type="checkbox"/>	<p>Limited Implementation of Participant-Direction. A waiver of statewide is requested in order to make <i>participant direction of services</i> as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere</p>

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	in the State. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i>

5. Assurances

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

- A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
 1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. **Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
 1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed

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100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

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6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity

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and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

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

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

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

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

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

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

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

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

7. Contact Person(s)

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

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

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

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

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8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

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

Last Name:	Stehle			
First Name:	Dawn			
Title:	Director			
Agency:	Division of Medical Services, Arkansas Department of Human Services			
Address:	P.O. Box 1437, Slot S-401			
Address 2:				
City:	Little Rock			
State:	Arkansas			
Zip:	72203-1437			
Phone:	(501) 683-0173	Ext:	<input type="checkbox"/>	TTY
Fax:	(501) 682-6836			
E-mail:	Dawn.stehle@dhs.arkansas.gov			

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Attachment #1: Transition Plan

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

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

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

i. Individual Areas

- a. Medical history, current medical conditions, or conditions observed by the assessor or self-reported by the individual;
- b. Behavioral;
- c. Home living activities;
- d. Community activities;
- e. Employment;

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- f. Health and safety assessment; and
- g. Social functioning
- ii. Caregiver (natural supports) areas
 - a. Physical/behavioral (health);
 - b. Involvement;
 - c. Social resources;
 - d. Family Stress; and
 - e. Safety
- iii. Current Risk Assessment Review
 - a. Safety Plan, if available;
 - b. Behavior Plan;
 - c. Physical Plan; and
 - d. Medical Plan

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

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

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

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

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

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

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and

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that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

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

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

The State of Arkansas submitted a statewide transition plan for review to CMS in accordance with requirements found at 42 CFR 441.301(c) & 441.710. AR.01888-DDS Community and Employment Support Waiver was identified as being affected by the new requirements, and was therefore included in the Arkansas Statewide Transition Plan. This Plan can be found at <http://dds-hcbs.herokuapp.com/>.

Arkansas assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Arkansas will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment.

The Division of Developmental Disabilities Services (DDS) is the operating agency for one 1915(c) waiver impacted by the HCBS Settings Rule: AR.0188 DDS – the Community and Employment Support Waiver. The purpose of this waiver is to support individuals of all ages who have a developmental disability and choose to receive services within their community. The person-centered service plan (PCSP) offers an array of services that allow flexibility and choice for the participant. Services are provided in the person's home and community.

Individuals served by the Waiver can choose to reside in a private home in the community and receive HCBS services in their home. The home may be the person's home, or the home of a family member or friend. The remainder live in either a group home, a provider owned or controlled apartment, or in the home of a staff person who is employed by the HCBS provider. It is expected that people who live in their own home or the home of a family member or friend who is not paid staff receive services in a setting that complies with requirements found at 42 CFR 441.301(c)(4).

DDS staff offers each person a choice of both case management and direct service providers. The chosen case management provider assesses the person's needs and wants and facilitates the development of the PCSP, which is approved by DDS staff. DDS Waiver staff will monitor services through random home visits (minimum 10% per staff caseload). In addition, as part of the DDS certification process, DDS Licensure and Certification staff monitors services in the person's home. DDS Waiver staff and DDS Licensure and Certification staff have been trained on the CMS Final Rule.

DDS is proposing to achieve and maintain full compliance with HCBS requirements, as indicated by this statewide transition plan. A transition plan chart is attached which outlines the processes and timeline which DDS and stakeholders will follow to identify and assess at-risk providers, remediate any areas of non-compliance, and conduct outreach to engage providers and other stakeholders [see AR HCBS STP–Timeline Chart (12-15-2015)].

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Description of State Assessment of Current Level of Compliance

Review of State Policies and Procedures

DDS has revised its HCBS Standards to include the characteristics of Settings which will guide DDS providers as they transition provider settings to those which fully include all the necessary characteristics and traits of a fully compliant HCBS setting. New providers are expected to be compliant with the Final Rule at the time of application.

Assessment of Provider Compliance with Residential and Non-Residential Settings Requirements

As part of the Statewide Transition Plan, the state of Arkansas has developed an inter-agency HCBS Settings working group. The group discusses assessment activities, including provider self-assessment surveys, site visits, and ongoing compliance with the HCBS Settings rule. An inter-agency site review Team is being developed that will review the provider self-assessment surveys, conduct an on-site assessment tool to validate provider self-assessments, and analyze compliance over the coming months.

Provider self-assessment.

DDS is conducting the assessment process outlined in CMS guidance. DDS is analyzing both its residential and day service systems. Residential providers include Group Homes, Apartments, and provider staff homes in which consumers live. Each residential provider has completed and returned a self-study to DDS. The self-study is based on the "Exploratory Questions" document included in the toolkit developed by CMS. It will serve as a baseline "snapshot" of the residential provider's existing self-assessed compliance with the HCBS Settings rule. All DDS providers participated in the self-assessment process. Survey responses are being validated through on-site visits.

Validation of self-assessment (site visits).

As stated in a previous section, an inter-agency team composed of staff employed by the Division of Aging and Adult Services, DDS, and the Division of Medical Services will be identified and assigned to an inter-agency site visit team. This team will conduct the initial review of settings for compliance with CMS setting regulations. DDS Certification staff have conducted an on-site technical support visit to each group home and provider owned or controlled apartment and are in the process of conducting technical support site visits to each provider who uses staff homes as settings. Of the 151 Residential Settings, 123 settings received an on-site technical support visit. An analysis of the information is being provided to the inter-agency site review team as part of the State provider assessment process.

Ongoing Assessment of Settings

Licensed and certified settings are subject to periodic compliance site-visits by DDS. HCBS settings requirements will be enforced during those visits. Settings found to have deficiencies are required to implement corrective actions and can lose their license or certification when noncompliance continues or is egregious. New providers will also be subject to an assessment of compliance with the HCBS settings requirements prior to licensure and certification.

Remediation

DDS has developed and will promulgate standards that support and promote the belief that individuals must have full access to the benefits of community living and have the opportunity to receive services in the most integrated setting appropriate. The standards specify how services must be offered in settings that are

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designed specifically for people with disabilities when the individuals in the setting are primarily people with disabilities and on-site staff providing services to them; and the setting may have the effect of isolating the individuals who live there from the broader community of individuals not receiving Medicaid-funded HCBS.

The standards require that organizations that own or operate a residential service setting or a day service setting which may be presumed to have institutional qualities offer services in such a way as to ensure that the characteristics required of an HCBS setting are present. The standards: 1) require assurance of specific individual rights; 2) prescribe certain characteristics of the ~~physical plant residential setting~~; and 3) specify steps which must be taken if any of the required conditions must be modified based on a specific assessed need of an individual.

DDS issues a report to each Organization that owns, operates, or otherwise controls a residential setting of any characteristics at each location that do not appear to be in compliance with the current HCBS Settings rule. Each Organization that receives a report identifying practices that require improvement from DDS, responds with an improvement plan and submits relevant policies to assure best practice.

DDS will issue a recommendation of approval to the Site Development Review Subcommittee (the "Subcommittee") for each residential setting that is in compliance with the HCBS Settings requirements. If a residential setting is not recommended for approval as complying with HCBS Settings requirements, DDS will defer to the Subcommittee for final determination. If the Subcommittee and the HCBS Settings working group do not feel that a provider is progressing towards compliance, the State will implement relocation strategies. The HCBS Settings working group will develop a relocation plan in the coming months as we work through the on-site assessment process. The relocation remediation strategy will include a detailed relocation plan that provides reasonable notice and due process for residents. The relocation plan will also include a timeframe, a description of the state's process to ensure sufficient services and supports are in place prior to the transition, and assurances that affected residents will receive sufficient information, opportunity, and supports to make an informed choice regarding transition to a new compliant setting.

Heightened Scrutiny

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

Following the provider self-assessment and on-site assessment(s), settings that meet any of the above criteria will be published in a public notice in the statewide newspaper, Arkansas Democrat-Gazette, to allow for public comment. The public notice will list the affected settings by name and location, and will identify the number of individuals served at each setting. The public notice will include all justifications as to how and why the setting meets HCBS requirements and will specifically note that the public has an opportunity to comment on the state's evidence. The state will provide responses to these public comments in a subsequent version of the STP.

In cases where DDS asks for heightened scrutiny by CMS for certain settings, the same process as

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described in the DAAS section will be utilized by DDS.

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Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Will Put comments received here.

Appendix A: Waiver Administration and Operation

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

<input checked="" type="radio"/>	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (<i>select one</i>):
<input type="radio"/>	The Medical Assistance Unit (<i>specify the unit name</i>) (<i>Do not complete Item A-2</i>)
<input checked="" type="radio"/>	<div style="display: flex;"> <div style="flex: 1; padding-right: 10px;"> Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (<i>Complete item A-2-a</i>) </div> <div style="flex: 1; border: 1px solid black; height: 100px;"></div> </div>
<input type="radio"/>	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. Specify the division/unit name:
	Division of Developmental Disabilities Services (DDS)
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (<i>Complete item A-2-b</i>).

- 2. Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated

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State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities.

The Division of Medical Services (DMS), within the Department of Human Services (DHS), is the State Medicaid agency and has administrative authority for the Waiver including the following:

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

The Division of Developmental Disabilities Services (DDS), also within DHS, is responsible for operation of the Waiver including the following:

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

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- 9) Provide to DMS the results of monitoring activities;
- 10) Develop and implement a Quality Assurance protocol that meets criteria as specified in the Interagency Agreement.

DDS is also responsible for:

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

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

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

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

<input checked="" type="radio"/>	<p>Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i></p> <p>DMS and DDS contracts with a Third Party Vendor to conduct Independent Assessments that are used to determine the participants' service tier and create his or her PCSP.</p>
<input type="radio"/>	<p>No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).</p>

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

<input checked="" type="radio"/>	Not applicable
<input type="radio"/>	Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
<input type="checkbox"/>	Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i>
<input type="checkbox"/>	Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i>

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

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

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Third Party Contractor must submit monthly contractor reports to DMS and DDS that include:

1. Demographics about the Participants who were assessed;
2. An activities summary, including the volume, timeliness and outcomes of all Assessments and Reassessments; and
3. A running total of the activities completed.

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

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

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

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:	AA1: Number and percent of unduplicated participants served within approved limits specified in the approved HCBS Waiver. Numerator: Number of unduplicated participants served within approved limits specified in the HCBS Waiver. Denominator: Number of approved unduplicated participants.		
Data Source (Select one): Other			
If 'Other' is selected, specify: MMIS			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

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			Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	AA2: Number and percentage of applicants who had an initial LOC determination completed before receipt of services. Numerator: Number of applicants who had an initial LOC determination completed before receipt of services. Denominator: Number of LOC determinations reviewed.		
Data Source (Select one): Other			
If 'Other' is selected, specify: LOC Determination Report			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	

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	<i>Specify:</i>		
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Source (Select one): Other

If 'Other' is selected, specify: **DDS Quarterly QA Report**

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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Performance Measure:	AA3: Number and percentage of participants for whom the appropriate process and instruments were used to determine initial eligibility. Numerator: Number of participants' packets with appropriate process and instruments used to determine initial eligibility; Denominator: Number of participants' packets reviewed.
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Data Source (Select one): Other

If 'Other' is selected, specify: **DDS Quarterly QA Report**

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified; Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	AA4: Number and percentage of PCSPs completed in the time frame specified in the agreement with the Medicaid Agency. Numerator: Number of PCSPs completed in the time frame specified; Denominator: Number of PCSPs reviewed.
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Data Source (Select one): Other

If 'Other' is selected, specify: **Medicaid Quarterly QA Report (Validation Chart Reviews)**

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	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input checked="" type="checkbox"/> Other Specify:
			DMS reviews 20% of the charts reviewed by DDS during Individual File Reviews, as a validation review.

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	AA5: Number and percentage of participants with delivery of at least two HCBS Waiver services on their PCSP. Numerator: Number of participants with delivery of at least two HCBS Waiver services on their PCSP; Denominator: Number of participants served.
Data Source (Select one): Other	
If 'Other' is selected, specify: No Waiver Service Report	

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	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified; Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	AA6: Number and percentage of providers certified by DDS. Numerator: Number of provider agencies that obtained annual recertification in accordance with promulgated standards. Denominator: Number of provider agencies reviewed.		
Data Source (Select one): Other			
If 'Other' is selected, specify: DDS Quarterly QA Report (Validation reviews of Provider Certification Files)			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Source (Select one): Other

If 'Other' is selected, specify: **Provider Certification File Review**

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	95% with +/-5% margin of error
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

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Specify:	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	AA7: Number and percentage of policies developed by DDS that are reviewed and approved by the Medicaid Agency prior to implementation. Numerator: Number of policies and procedures by DDS reviewed by Medicaid before implementation; Denominator: Number of policies and procedures developed.
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Data Source (Select one): Other
If 'Other' is selected, specify: PD/QA Request Forms

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis	
Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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Performance Measure:	AA8: Number and percent of waiver claims on the Overlapping Services Report (OSR) having the same date of service as a claim for institutional services, which correctly paid only for the date of discharge or date of admission according to policy. Numerator: Number of waiver claims on the OSR which correctly paid according to policy; Denominator: Number of waiver claims reviewed from the OSR.		
Data Source (Select one): Other			
If 'Other' is selected, specify: Overlapping Service Reports (OSR)			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	AA9: Number and percent of waiver claims that were paid using the correct rate as specified in the waiver application. Numerator: Number of claims paid at correct rate; Denominator: Number of claims.
Data Source (Select one): Other	

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If 'Other' is selected, specify: **Recipient Claims History Profile (Validation Reviews)**

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

AA10: Number and percent of reviewed claims with services specified in the PCSP.
Numerator: Number of claims with services specified in the PCSP; **Denominator:** Number of claims reviewed.

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

If 'Other' is selected, specify: **Recipient Claims History Profile (Validation Reviews)**

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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	<i>applies)</i>		
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input checked="" type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample; Confidence Interval =</i>
	<input type="checkbox"/> <i>Other Specify:</i>	<input type="checkbox"/> <i>Annually</i>	<i>95% with +/-5% margin of error</i>
		<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Group:</i>
		<input type="checkbox"/> <i>Other Specify:</i>	
			<input type="checkbox"/> <i>Other Specify:</i>

Data Aggregation and Analysis

<i>Responsible Party for data aggregation and analysis (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (check each that applies)</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input checked="" type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other Specify:</i>	<input type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other Specify:</i>

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Developmental Disabilities Services (DDS, the operating agency) and the Division of Medical Services (DMS, the State Medicaid agency) participate in quarterly team meetings to discuss

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and address individual problems associated with administrative authority, as well as problem correction and remediation. DDS and DMS have measures related to administrative authority of the HCBS Waiver.

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

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

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

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

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
		<input checked="" type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other Specify:

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c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input type="checkbox"/>	Aged or Disabled, or Both - General			
	<input type="checkbox"/> Aged (age 65 and older)			<input type="checkbox"/>
	<input type="checkbox"/> Disabled (Physical)			
	<input type="checkbox"/> Disabled (Other)			
<input type="checkbox"/>	Aged or Disabled, or Both - Specific Recognized Subgroups			
	<input type="checkbox"/> Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/> HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/> Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/> Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/>	Intellectual Disability or Developmental Disability, or Both			
	<input checked="" type="checkbox"/> Autism	0		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/> Developmental Disability	0		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/> Mental Retardation	0		<input checked="" type="checkbox"/>
<input type="checkbox"/>	Mental Illness (check each that applies)			
	<input type="checkbox"/> Mental Illness			<input type="checkbox"/>

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<input type="checkbox"/>	Serious Emotional Disturbance		
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b. Additional Criteria. The State further specifies its target group(s) as follows:

Both persons with intellectual disability and persons with developmental disability are recognized as target groups. Developmental disability diagnoses include Cerebral Palsy, Epilepsy, Autism, Down Syndrome, and Spina Bifida as categorically qualified diagnoses. Onset must occur before the person is 22 years old and must be expected to continue indefinitely. Other diagnoses will be considered if the condition causes the person to function as though they have an intellectual disability.

DDS eligibility is established by Arkansas Code Annotated, Section 20-48-101. The statute applies to Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID) and the HCBS Waiver. DDS interprets a developmental disability to be (1) a categorically qualifying diagnosis and (2) significant adaptive behavior deficits related to this diagnosis. Following are the categorically qualifying diagnoses:

Cerebral Palsy as established by the results of a medical examination provided by a licensed physician. Epilepsy as established by the results of a neurological examination provided by a licensed physician.

Autism as established as a result of a team evaluation by at a minimum a licensed physician, a psychologist or psychological examiner, and speech pathologist.

Down syndrome as established by the results of a medical examination provided by a licensed physician. Spina Bifida as established by the results of a medical examination provided by a licensed physician.

Intellectual Disability as established by significant intellectual limitations that exist concurrently with deficits in adaptive behavior that are manifested before the age of 22. "Significant intellectual limitations" are defined as a full scale intelligence score of approximately 70 or below as measured by a standard test designed for individual administration. Group methods of testing are unacceptable.

The qualifying disability must constitute a substantial handicap to the person's ability to function without appropriate support services including, but not limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment. When the age of onset of the qualifying disability is indeterminate, the Assistant Director or the Director for Developmental Disabilities Services will review evidence and determine if the disability was present before age 22.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

<input checked="" type="radio"/>	Not applicable. There is no maximum age limit
<input type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit. <i>Specify:</i>

Appendix B-2: Individual Cost Limit

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- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

<input checked="" type="radio"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>		
<input type="radio"/>	Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
	<input type="radio"/>	%	A level higher than 100% of the institutional average Specify the percentage:
	<input type="radio"/>	Other (<i>specify</i>):	
<input type="radio"/>	Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. <i>Complete Items B-2-b and B-2-c.</i>		
<input type="radio"/>	Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. <i>Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.</i>		
	The cost limit specified by the State is (<i>select one</i>):		
	<input type="radio"/>	The following dollar amount: Specify dollar amount:	
		The dollar amount (<i>select one</i>):	
	<input type="radio"/>	Is adjusted each year that the waiver is in effect by applying the following formula: Specify the formula:	
	<input type="radio"/>	May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.	
	<input type="radio"/>	The following percentage that is less than 100% of the institutional average:	
	<input type="radio"/>	Other: <i>Specify:</i>	

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- b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

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- c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input type="checkbox"/>	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
<input type="checkbox"/>	Other safeguard(s) <i>(Specify):</i>

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Appendix B-3: Number of Individuals Served

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	4803
Year 2	4843
Year 3	4863
Year 4	4883
Year 5	4903

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

<input type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input checked="" type="radio"/>	The State limits the number of participants that it serves at any point in time during a waiver year.

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

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	4683
Year 2	4723
Year 3	4743
Year 4	4763
Year 5	4783

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- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

<input checked="" type="radio"/>	Not applicable. The state does not reserve capacity.	
<input type="radio"/>	The State reserves capacity for the following purpose(s). Purpose(s) the State reserves capacity for: Community Transition of children in foster care.	
	Table B-3-c	
		Purpose
	Waiver Year	Capacity Reserved
	Year 1	
	Year 2	
	Year 3	
	Year 4	
	Year 5	

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

<input checked="" type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="radio"/>	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an <i>intra-year</i> limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.**

Select one:

<input checked="" type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="radio"/>	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and

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	<p>how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:</p>

- f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

<p>1) General Requirements: DDS policy requirements for information release, choice of community versus institution (102 choice form), and social history documents are executed.</p> <p>2) Selection for participation is as follows:</p> <p>a) In order of Waiver application eligibility determination date for persons determined to have successfully applied for the Waiver, but who through administrative error were or are inadvertently omitted from the Waiver wait list.</p> <p>b) In order of Waiver application eligibility determination date of persons for whom Waiver services are necessary to permit discharge from an institution, e.g. persons who reside in ICFs/IID, Nursing Facilities, and Arkansas State Hospital patients; or admission to or residing in a Supported Living Arrangement (group homes and apartments).</p> <p>c) In order of date of Department of Human Services (DHS) custodian choice of Waiver services for eligible persons in the custody of the DHS Division of Children and Family Services or DHS Adult Protective Services.</p> <p>d) In order of Waiver application determination date for all other persons.</p>
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B-3: Number of Individuals Served - Attachment #1

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

- a. 1. **State Classification.** The State is a *(select one)*:

<input checked="" type="radio"/>	§1634 State
<input type="radio"/>	SSI Criteria State
<input type="radio"/>	209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State *(select one)*.

<input type="radio"/>	No
<input checked="" type="radio"/>	Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
<input checked="" type="checkbox"/>	Low income families with children as provided in §1931 of the Act		
<input checked="" type="checkbox"/>	SSI recipients		
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
<input type="checkbox"/>	Optional State supplement recipients		
<input checked="" type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: <i>(select one)</i>		
	<input checked="" type="radio"/>	100% of the Federal poverty level (FPL)	
	<input type="radio"/>	%	of FPL, which is lower than 100% of FPL Specify percentage:
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)		
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
<input type="checkbox"/>	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
<input type="checkbox"/>	Medically needy in 209(b) States (42 CFR §435.330)		
<input type="checkbox"/>	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		

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<input checked="" type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :		
	Adults newly eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.		
	Children who are receiving Title IV-E subsidy services or funding.		
<i>Special home and community-based waiver group under 42 CFR §435.217</i> Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed			
<input type="radio"/>	No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.		
<input checked="" type="radio"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>		
<input type="radio"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217		
<input checked="" type="radio"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):		
<input checked="" type="checkbox"/>	A special income level equal to (select one):		
<input checked="" type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)		
<input type="radio"/>	%	A percentage of FBR, which is lower than 300% (42 CFR §435.236)	
		Specify percentage:	
<input type="radio"/>	\$	A dollar amount which is lower than 300%	
		Specify percentage:	
<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
<input type="checkbox"/>	Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
<input type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)		
<input type="radio"/>	100% of FPL		
<input type="radio"/>	%	of FPL, which is lower than 100%	
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :		

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Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217.

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

<input checked="" type="checkbox"/>	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.</i>
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Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

<input type="radio"/>	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (<i>select one</i>):
<input type="radio"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.</i>
<input type="radio"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>
<input checked="" type="radio"/>	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. <i>Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

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Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):		
<input type="radio"/>	The following standard included under the State plan (Select one):	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons (select one):	
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%	A percentage of the FBR, which is less than 300% Specify the percentage:
<input type="radio"/>	\$	A dollar amount which is less than 300%. Specify dollar amount:
<input type="radio"/>	%	A percentage of the Federal poverty level Specify percentage:
<input type="radio"/>	Other standard included under the State Plan Specify:	
<input type="radio"/>	The following dollar amount Specify dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance: Specify:	
<input checked="" type="radio"/>	Other Specify: The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process including income that is placed in a Miller Trust.	
ii. Allowance for the spouse only (select one):		
<input checked="" type="radio"/>	Not Applicable	
<input type="radio"/>	The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: Specify: The special income level for institutionalized person, 300% of the SSI Federal Benefit Rate.	

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Specify the amount of the allowance (select one):		
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: Specify:	
iii. Allowance for the family (select one):		
<input checked="" type="radio"/>	Not Applicable (see instructions)	
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: Specify:	
<input type="radio"/>	Other Specify:	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:		
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. Select one:		
<input checked="" type="radio"/>	Not applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.	
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State establishes the following reasonable limits Specify:	

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Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c-2. Regular Post-Eligibility Treatment of Income: 209(B) State.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

Note: The following selections apply for the five-year period beginning January 1, 2014.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

e. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state – 2014 through 2018.

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility: 209(b) State – 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – 2014 through 2018

i. Allowance for the personal needs of the waiver participant (select one):		
<input type="radio"/>	The following standard included under the State plan (Select one):	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons (select one):	
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%	A percentage of the FBR, which is less than 300% Specify the percentage:
<input type="radio"/>	\$	A dollar amount which is less than 300%.

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			Specify dollar amount:
<input type="radio"/>	%	A percentage of the Federal poverty level Specify percentage:	
<input type="radio"/>	Other standard included under the State Plan Specify:		
<input type="radio"/>	The following dollar amount		\$ If this amount changes, this item will be revised.
	Specify dollar amount:		
<input type="radio"/>	The following formula is used to determine the needs allowance: Specify:		
<input checked="" type="radio"/>	Other Specify:		
	The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process including income that is placed in a Miller Trust.		
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. (select one):			
<input checked="" type="radio"/>	Allowance is the same		
<input type="radio"/>	Allowance is different Explanation of difference:		
Specify the amount of the allowance (select one):			
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:		\$ If this amount changes, this item will be revised.
	Specify dollar amount:		
<input type="radio"/>	The amount is determined using the following formula: Specify:		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:			
a. Health insurance premiums, deductibles and co-insurance charges			
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.			
Select one:			
<input checked="" type="radio"/>	Not applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.		

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<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits <i>Specify:</i>

Appendix B-6: Evaluation / Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	Minimum number of services. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: <div style="border: 1px solid black; padding: 2px; display: inline-block;">2</div>
ii.	Frequency of services. The State requires (select one):
	<input type="radio"/> The provision of waiver services at least monthly
	<input checked="" type="radio"/> Monthly monitoring of the individual when services are furnished on a less than monthly basis If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:
	A participant must receive case management and have authorized and delivered one other Waiver Service, as documented in the PCSP.
	Most participants receive waiver services on a monthly basis. Case managers are responsible for monthly monitoring of participant's health and safety.
	It is the intention of DDS to move from the current model of conflict free case management to case management through a contracted Managed Care Organization known as a Provider-owned Shared Savings Entity (PASSE). All participants will be enrolled with a PASSE and case management will be provided administratively, rather than as a service. The proposed date for beginning this transition is October 1, 2017.
	Therefore, DDS is requiring case management, plus one other waiver service to ensure all participants are receiving appropriate services to transition to a PASSE and remain eligible for the Waiver.

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

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By the operating agency specified in Appendix A
<input type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity:</i>
<input type="radio"/>	Other <i>Specify:</i>

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

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

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

The initial determination of eligibility for both the HCBS Waiver and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) requires the same type of evaluations. These include an evaluation of functional abilities that does not limit eligibility to persons with certain conditions, an evaluation of the areas of need for the person, a social history, and psychological evaluation applicable to the category of developmental disability, which are intellectual disability, cerebral palsy, epilepsy, autism, spina bifida, Down syndrome or other condition that causes a person to function as though they have an intellectual disability or developmental disability.

The DDS Psychology Team is responsible for determining initial eligibility for the Waiver. This eligibility process mirrors eligibility for ICF/IID institutional care. The same criteria as specified in "B1b" is applied for both HCBS Waiver and ICF/IID initial evaluations and reevaluations.

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

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

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

- (1) Verification of a categorically qualifying diagnosis;

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- (2) Age of onset is established to be prior to age 22;
- (3) Substantial functional limitations in activities of daily living (adaptive functioning deficits) are present and are as a result of the categorically qualifying diagnosis. Adaptive functioning deficits are defined as an individual's inability to function in three of the following six categories as consistently measured by standardized instruments administered by qualified professionals: Self-Care, Understanding and Use of Language, Learning, Mobility, Self-Direction, and Capacity for Independent Living; and
- (4) The disability and deficits are expected to continue indefinitely.

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

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

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

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

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

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

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

Eligibility for persons with co-occurring diagnoses of intellectual disability or developmental disability and mental illness is established when the DDS Psychology Team has determined that the primary disability for the person is the intellectual or developmental disability, not the mental illness.

DDS reserves the right to require an evaluation of eligibility at any time.

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

<input checked="" type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="radio"/>	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

DDS evaluates all applicants using the process described in B6d for the initial application for ICF/IID and waiver services. The completed application packet is sent to the DDS Psychology Team who reviews the information, makes a determination of eligibility and documents the determination on Form DHS 704.

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

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

For periodic reevaluations to confirm diagnosis and functional eligibility, the person receiving waiver services or their provider obtains and submits psychological and intelligence testing, and adaptive evaluations to DDS for a determination of eligibility by the DDS Psychological Team. The team reviews the documentation to determine whether the instruments used in the evaluation process were appropriate according to the age, mental, medical and physical condition of the individual. If the team determines the instruments are acceptable, they verify the age of onset and the corresponding functional deficit and make a determination of continued eligibility. This team may require additional evaluations, but will not conduct any testing or evaluations themselves.

If an individual disagrees with an eligibility determination, they may appeal to the Assistant Director for Quality Assurance for an administrative review of the findings. Individuals may also appeal

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directly to the DHS Office of Appeals and Hearing, in accordance with DDS Appeals Policy 1076.

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

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input checked="" type="radio"/>	Every twelve months
<input type="radio"/>	Other schedule <i>Specify the other schedule:</i>

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

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

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

DDS staff generate a monthly report identifying any person whose periodic functional assessment and annual institutional level of care packet are due. Periodic functional assessment are described in B.6. d. Packets include the reports and assessments noted in this section.

DDS sends the report to the person's case manager, who is responsible for ensuring timely evaluation. For quality assurance purposes, DDS managers also produce a monthly report identifying the same information sorted by DDS staff. Waiver managers follow up with staff, who notify case managers.

- j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All records are maintained in an electronic environment with protected security and access. This system includes level of care records. All electronic records are housed by the Department of

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Information Systems in the state designated storage medium. The responsibility for day to day operations will remain with DDS.

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-assurances:

a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

i. Performance Measures

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

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

Performance Measure:	LOC A1: Number and percentage of applicants for whom an application packet is completed and submitted timely to the DDS psychology team for an LOC initial determination. Numerator: Number of applicants for whom an application packet is completed and submitted timely to the DDS psychology team for an LOC initial determination; Denominator: Number of application packets submitted.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify: Intake and Referral Report of Timely Application Submissions			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

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<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
	<input type="checkbox"/> Other Specify:	
		<input type="checkbox"/> Other Specify:

Data Source (Select one) (Several options are listed in the on-line application): **Other**
If 'Other' is selected, specify: **DDS Quarterly QA Report**

Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
	<input type="checkbox"/> Other Specify:	
		<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

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	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	LOC A2: Number and percentage of applicants who had an initial LOC determination completed before receipt of services. Numerator: Number of applicants who had an initial LOC determination completed before receipt of services; Denominator: Number of initial LOC determinations reviewed.
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Data Source (Select one) (Several options are listed in the on-line application): Other

If 'Other' is selected, specify: Individual File Review

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	95% with a +/- 5% margin of error
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Source (Select one) (Several options are listed in the on-line application): Other

If 'Other' is selected, specify: DDS Quarterly QA Report

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	95% with a +/- 5%

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	Specify:		margin of error
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.**

i. Performance Measures

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

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

- c Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the initial participant level of care.**

i. Performance Measures

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

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

Performance Measure:	LOC C1: Number and percentage of participants for whom the appropriate process and instruments were used to determine initial eligibility. Numerator: Number of participants' packets with appropriate process and instruments used to determine initial eligibility; Denominator: Number of participant's packets reviewed.
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Data Source (Select one) (Several options are listed in the on-line application): Other

If 'Other' is selected, specify: DDS Quarterly QA Report

Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
	<input type="checkbox"/> Other Specify:	
		<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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b. Methods for Remediation/Fixing Individual Problems

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

(LOC A1) The Intake and Referral (I&R) Application Tracking system tracks all applications on an ongoing basis. At 45 days, the Intake Specialist sends a notice to families to notify them that the information is due. For applications over 90 days old, the Intake Manager reviews overdue applications for cause and then contacts Intake staff to develop a corrective action plan, which will be implemented within 10 days. The Intake Manager will submit an I&R Report of Timely Application submissions to the I&R administrator monthly for review to identify any systemic issues and to determine if there is a need for corrective action. The I&R administrator will submit a quarterly report to the QA Assistant Director and describes any corrective actions.

(LOC A2) The system in place for new applicants to enter the HCBS Waiver program does not allow for services to be delivered prior to an initial Level of Care Determination being made.

(LOC C1) The DDS Psychology Team manager reviews 100% of all initial waiver application determinations submitted within the previous month for process and instrumentation review. A Requirement Checklist form for each application in the sample is completed for procedural accuracy and appropriateness of testing instruments utilized in adjudications. Results are tracked. When problems are noted, the Psychology Supervisor contacts Psychology staff to develop a corrective action plan, which will be implemented within 10 days. The Psychology supervisor submits a quarterly report to the QA Assistant director and outlines corrective actions.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

<i>Remediation-related Data Aggregation and Analysis (including trend</i>	<i>Responsible Party (check each that applies)</i>	<i>Frequency of data aggregation and analysis: (check each that</i>
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<i>identification)</i>		<i>applies)</i>
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other: Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver intake and referral is the responsibility of DDS intake and referral staff. The DDS staff person explains the service options of the Waiver or ICF/IID to each person or their legal guardian by phone, personal visit, email, or mail. The individual or legal guardian completes the HCBS Choice Form and selects either the Community and Employment Supports Waiver program or ICF/IID placement. For persons residing in an ICF/IID, choice between the programs is offered annually at the time of their annual PCSP review. Anyone residing in an ICF/IID can request Waiver services at any time by contacting DDS. Transition Coordinators work with the Waiver Applications Unit Administrator and assigned DDS Waiver Specialist. Annual choice is offered by DDS staff prior to the individual's annual review. The choice form provides a means to track whether choice was offered. It also provides supporting evidence that the options elicit an informed choice as attested to by the signature of the DDS representative.

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Participants may change individual service providers at any time.

- b. **Maintenance of Forms.** Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Individual Community and Employment Support Waiver application packets including the choice form are maintained in an electronic format during the application process. Each applicant's electronic case file is maintained by the assigned DDS Specialist who is located in a designated DHS county offices. Documentation of the individual's annual choice following initial entrance into the Waiver program is maintained in the electronic case file.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

DDS provides information in an alternate format once the need for accommodation is identified. Identification of need is made through observation, document review for diagnosis and other case related information, and self or third-party notification. Awareness is provided through training, employee technical assistance, communications with provider organizations and consumer advocates, and Department of Human Services (DHS) electronic medias. A HCBS Waiver handbook is available in Spanish, hardcopy and online. In addition, the handbook will be made available in any other language, large print or any other medium to reasonably accommodate needs as identified by the individual. DHS contracts for interpreter services when needed.

DDS also operates a TDD line to assist those individuals with hearing or speech difficulties.

Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

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C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

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

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternative Service Title (if any):

HCBS Taxonomy	
Category 1:	Sub-Category 1:

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01 Case Management	01010 case management
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
☉Service is included in approved waiver. The service specifications have been modified.	
Service Definition (Scope): Services that assist participants in gaining access to needed waiver and other state plan services; as well as, medical, social, educational and other generic services, regardless of the funding source for the services to which access is available. Case management includes responsibility for guidance and support in all life activities including locating, coordinating and monitoring the following: 1) All proposed waiver services; 2) Other state plan services; 3) Needed medical, social, educational and other publicly funded services (regardless of funding source); 4) Informal community supports needed by eligible participants and their families. Case Management services include the following activities: 1) Arranging for the provision of services and additional supports; 2) Monitoring and reviewing of services included in the participants PCSP; 3) Monitoring and reviewing of services to assure health and safety of the participant; 4) Facilitating crisis intervention; 5) Guidance and support to obtain generic needs; 6) Case planning; 7) Needs assessment and referral for resources; 8) Monitoring to assure quality of care and case reviews which focus on the participants progress in meeting goals and objectives established through the PCSP; 9) Providing assistance relative to the obtaining of waiver Medicaid eligibility and ICF/IID level of care eligibility determinations; 10) Assuring the integrity of all case management Medicaid waiver billing in that the service delivered must have DDS prior authorization, must meet required waiver service definitions, and must be delivered before	

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billing can occur;

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

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

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

14) Provides assistance with appeals when appeal is chosen.

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

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

i. Individual Areas

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

b. Behavioral;

c. Home living activities;

d. Community activities;

e. Employment;

f. Health and safety assessment; and

g. Social functioning

ii. Caregiver (natural supports) areas

a. Physical/behavioral (health);

b. Involvement;

c. Social resources;

d. Family Stress; and

e. Safety

iii. Current Risk Assessment Review

a. Safety Plan, if available;

b. Behavior Plan;

c. Physical Plan; and

d. Medical Plan

Current participants will be transferred as follows:

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

2) Participants now classified as limited or extensive will be classified as Tier 2, until their yearly PCSP is

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due and they undergo an Independent Assessment.

Starting in October 2017, DHS and DDS will implement a Provider Led Managed Care model of case management/care coordination where each Waiver Participant is assessed for a Tier Determination, as well as needs and risks. The participant will then be enrolled in a Provider Owned Shared Savings Entity (PASSE). The PASSE will receive a global payment for each participant based upon the participant's tier. The global payment will be used to provide services for the participant in accordance with his or her PCSP. DDS will submit a Waiver Amendment with a proposed effective date of October 1, 2017, that will incorporate these changes.

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

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

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

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

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

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

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

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

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

Service contacts minimum requirements are:

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

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

Service Delivery Method (check each that applies):	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input checked="" type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
Provider Category(s) (check one or both):	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Certified Case Management Provider
Provider Qualifications		
Provider Type:	License (specify)	Certificate (specify) Other Standard (specify)

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Agency		DDS certification as a case management provider. Persons who are designated as case managers by the provider must: 1(a). Hold a Bachelor's degree in a human services field, or (b). Have at least two years college credit and two years' experience working with individuals with developmental disabilities, or (c). Have two years of verified experience working with individuals with developmental disabilities and have been mentored by a case manager for two additional years or (d). Have four years of experience as a case manager in a related field. 2. Not be related by blood or marriage to the individual or to any paid caregiver, are not financially responsible for the individual or would benefit from the provision of direct services. 3. Not be disqualified from employment due to a criminal record according to Ark Code Ann. 20-38-101 et seq., 4. Not be listed on either the adult or child maltreatment registry, and 5. Have satisfactorily completed a drug screen in accordance with the certified case management organization's policies and procedures.	
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
	DDS Quality Assurance		Annually

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternative Service Title (if any):

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HCBS Taxonomy	
Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	Sub-Category 2:
09 Caregiver Support	09012 respite, in-home
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
⊙Service is included in approved waiver. There is no change in service specifications.	
Service Definition (Scope):	
<p>Respite services are provided on a short-term basis to participants unable to care for themselves due to the absence of or need for relief to the non-paid primary caregiver. Federal Financial Participation (FFP) may not be claimed for the cost of room & board, except when provided as part of the respite care furnished in a facility approved by the state; FFP may not be claimed for room and board when Respite is provided in the participant's home or private place of residence.</p> <p>Receipt of respite does not necessarily preclude a participant from receiving other services on the same day. For example, a participant may receive day services, such as supported employment, on the same day as respite services.</p> <p>When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite may not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.</p> <p>Respite services may be provided through a combination of basic child care & support services required to meet the needs of a child. Waiver will not pay for child care services.</p> <p>Respite may be provided in the following locations:</p> <ol style="list-style-type: none"> 1) Participant's home or private place of residence; 2) The private residence of a respite care provider; 3) Foster home; 4) Licensed respite facility; or 5) Other community residential facility approved by the state, not a private residence. Respite care may occur in a licensed or accredited residential mental health facility. 	

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Specify applicable (if any) limits on the amount, frequency, or duration of this service: There is a maximum daily rate for supportive living service, participant directed supportive living, and respite, collectively or individually. Individual daily rates in all levels require prior approval by DDS staff. 1) Tier 3 - maximum daily rate is \$391.95 with a maximum of \$143,061.75 annually. 2) Tier 2 - maximum daily rate is \$184.80 with a maximum of \$67,452.00 annually. There is a 30 day consecutive maximum on respite services in non-HCB settings. All units must be billed in accordance with the participant's PCSP. Extensions will be provided when extended benefits are determined to be medically necessary. DDS and DMS have developed a timeline for implementing a new cost methodology by October 1, 2017. The proposed cost methodology will be part of the next waiver amendment and will be based upon a rate study conducted by a third party actuary.						
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed		
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies: Certified Respite Provider		
Provider Qualifications						
Provider Type:	License (specify)	Certificate (specify)			Other Standard (specify)	
Agency		The provider entity must be certified by DDS as an HCBS provider and have elected to provide respite services. The provider must provide evidence that they require the following qualifications and requirements of staff who provide respite services: 1. Have one of the following: (a) high school diploma, or GED, and (b) At least one year of relevant supervised work experience with a public health, human services or other community service agency, or (c) Have two years of verifiable successful history working with persons with developmental disabilities.				

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

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

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternative Service Title (if any):

HCBS Taxonomy	
Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	Sub-Category 2:
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	Sub-Category 3:
03 Supported Employment	03022 ongoing supported employment, group
Category 4:	Sub-Category 4:

State:	
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⊙Service is included in approved waiver. The service specifications have been modified.

Service Definition (Scope):

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

Supported Employment array consist of the following supports:

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

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

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

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

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

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

The service provider must maintain the following documents to demonstrate compliance and delivery of

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services-Job Development Plan and participant's remuneration statement.

Employment Supports Job Coaching services are on-site activities that may be provided to a participant once employment is obtained. Activities provided under this services may include, but are not limited to, the following: Complete job duty and task analysis; assist the participant in learning to do the job by the least intrusive method; develop compensatory strategies if needed to cue participant to complete job; analyze work environment during initial training/learning of the job, and make determinations regarding modifications or assistive technology.

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

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

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

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

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

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

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian
Provider Category(s)	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Certified Supported Employment Vendor

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(check one or both):			
Provider Qualifications			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Agency		DDS Certification as a supported employment provider.	
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
	DDS Quality Assurance		Annually
	Arkansas Rehabilitation Services		Annually

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternative Service Title (if any): Supportive Living

HCBS Taxonomy	
Category 1:	Sub-Category 1:
02 Round-the-clock Services	02031 in-home residential habilitation
Category 2:	Sub-Category 2:
02 Round-the-clock Services	02011 group living, residential habilitation
Category 3:	Sub-Category 3:
04 Day Services	04010 prevocational services
Category 4:	Sub-Category 4:
04 Day Services	04020 day habilitation
©Service is included in approved waiver. The service specifications have been modified.	
Service Definition (Scope):	
Supportive Living is an array of individually tailored services & activities to enable participants to reside	

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

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

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

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

- Decision making, including the identification of & response to dangerously threatening situations, making decisions & choices affecting the person's life & initiating changes in living arrangement or life activities;
- Money management, including training, assistance or both in handling personal finances, making purchases & meeting personal financial obligations;
- Daily living skills, including habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medications (to the extent permitted under state law) & other areas of daily living including proper use of adaptive & assistive devices, appliances, home safety, first aid and emergency procedures;
- Socialization, including training, assistance or both in participation in general community activities, & establishing relationships with peers. Activity training includes assisting the person to continue to participate on an ongoing basis;
- Community integration experiences, including activities intended to instruct the person in daily living & community living skills in integrated settings. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. Community experiences include activities & supports to accomplish individual goals or learning areas including recreation and specific training or leisure activities. Each activity is then adapted according to the participant's individual needs. Transportation to or from community integration experiences is an integral part of this service and is included in the daily rate computation. DDS will ensure duplicate billing between Waiver services & other Medicaid state plan services will not occur. The habilitation objectives to be served by such training must be documented in the person's service plan;
- Mobility, including training, assistance or both aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing & using public transportation, independent travel or movement within the community;
- Communication, including training in vocabulary building, use of augmentative communication devices & receptive and expressive language;

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

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

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

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

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

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

- 1) The coordination of all direct service workers who provide care through the direct service provider;
- 2) Serving as liaison between the person, parents, legal representatives, case manager, & DDS officials;
- 3) Coordinating schedules for both waiver & generic service categories;
- 4) Providing direct planning input and preparing all direct service provider segments of any initial plan of care and annual continued stay review;
- 5) Assuring the integrity of all direct care service Medicaid waiver billing in that the service delivered must have DDS prior authorization & meet required waiver service definition and must be delivered before billing can occur;
- 6) Arranging for staffing of all alternative living settings;
- 7) Ensuring transportation as identified in participant's PCSP specific to supportive living services;
- 8) Timely collaboration with the case manager to obtain comprehensive behavior & assessment reports, continued PCSP, revisions as needs change and information and documents required for ICF/IID level of care & waiver Medicaid eligibility determination;
- 9) Reviewing the person's records & environments in which services are provided by accessing appropriate professional sources to determine whether the person is receiving appropriate support in the management of medication.

Health maintenance activities may be provided a supportive living worker. All health maintenance activities except injections and IV's, can be done in the home by a designated care aide, such as a waiver worker, with appropriate documentation of training. With the exception of injectable medication administration, tasks that consumers would otherwise do for themselves, or have a family member do, can be performed by a paid designated care aide at their direction, as long as the criteria specified in the Arkansas Nurse Practices Consumer Directed Care Act has been met. Health maintenance activities are available in the Arkansas Medicaid State Plan as self-directed services. State Plan services must be exhausted before accessing waiver funding for health maintenance activities.

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

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

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

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

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

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

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

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed		
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:		<input checked="" type="checkbox"/>	Agency. List the types of agencies:	
					Certified Supportive Living Provider	
Provider Qualifications						
Provider Type:	License (specify)	Certificate (specify)			Other Standard (specify)	
Agency		The provider must be certified by DDS as an HCBS provider and have elected to provide Supportive Living services. The provider must maintain evidence that they require the following qualification and requirements of staff who provide supportive living and transportation:				

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

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service:

Specialized Medical Supplies

State:	
Effective Date	

Alternative Service Title (if any):

HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	Sub-Category 2:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
☐ Service is included in approved waiver. There is no change in service specifications.	
Service Definition (Scope):	
<p>Specialized medical equipment and supplies include:</p> <ol style="list-style-type: none"> 1) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; 2) Such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations and has been deemed medically necessary by the prescribing physician; 3) Necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. The most cost effective item will be considered first. <p>Additional supply items are covered as a Waiver service when they are considered essential and medically necessary for home and community care. A physician must document and order all items. And all items must be included in the PCSP. When such items are included as a Medicaid state plan service, this will be an extension of such services. A denial of extension of benefits by utilization review will be required prior to approval for waiver funding by DDS. Items covered include:</p> <ol style="list-style-type: none"> 1) Nutritional supplements; 2) Non-prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage. 3) Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under state plan are exhausted. 	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The maximum for Specialized Medical Supplies, Supplemental Support Services, and Community	

State:	
Effective Date	

Transition Services, collectively or individually, is \$3,690.00 per year.							
When a non-prescription or prescription medication is necessary to maintain or avoid health deterioration and has been deemed medically necessary, the \$3,690.00 limit can be increased with the difference in the Specialized Medical Supplies maximum allowance and the required amount being deducted from the supported living maximum allowance. All such requests must be prior approved by the DDS Assistant Director of Waiver Services.							
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed			
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian	
Provider Category(s) (check one or both):							
<input type="checkbox"/>		Individual. List types:		<input checked="" type="checkbox"/>		Agency. List the types of agencies:	
						Certified Specialized Medical Supplies Provider	
Provider Qualifications							
Provider Type:	License (specify)	Certificate (specify)				Other Standard (specify)	
Agency		The Provider must be certified by DDS as an HCBS provider and have elected to provide the service Specialized Medical Supplies					
Verification of Provider Qualifications							
Provider Type:	Entity Responsible for Verification:				Frequency of Verification		
	DDS Quality Assurance				Annually		

C-1/C-3: Service Specification

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

Service Type:

Other Service

Service:

Adaptive Equipment

Alternative Service Title (if any):

State:	
Effective Date	

HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 Personal Emergency Response System (PERS)
Category 2:	Sub-Category 2:
14 Equipment, Technology, and Modifications	14020 Home and/or vehicle accessibility adaptations
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
ⓄService is included in approved waiver. The service specifications have been modified.	
Service Definition (Scope):	
<p>Adaptive Equipment means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants.</p> <p>This service includes adaptive, therapeutic and augmentative equipment that enables a person to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. Adaptive equipment needs for supported employment for a person is also included. This service may include specialized equipment such as devices, controls or appliances that will enable the person to perceive, control or communicate with the environment in which they live and to improve the person's functional capacity to perform daily life tasks that would not be possible otherwise.</p> <p>Adaptive equipment includes enabling technology, such as safe home modifications, that empower participants to gain independence through customizable technologies that allow them to safely perform activities of daily living without assistance while still providing monitoring and response for those participants, as needed. Enabling technology allows participants to be proactive about their daily schedule and integrates participant choice. Before any enabling technology may be approved, it must be shown to meet a goal of the PCSP, ensures the participant's health and safety, and provides for adequate monitoring and response. Each participant who receives enabling technology must have an assessment conducted and a plan created for how that technology will be used to meet a PCSP goal, ensure the participant's health and safety, and provide adequate monitoring and response.</p> <p>Personal Emergency Response Systems (PERS) can be approved when it can be illustrated to be necessary to protect the health and safety of the participant. PERS is a stationary or portable electronic device used in the participant's place of residence, which enables the participant to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device. PERS services are limited to participants who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. Included in this support are assessment, purchase, installation and monthly rental fee. PERS shall consist of installation and testing, as well as monthly monitoring performed by a response center.</p> <p>Equipment may only be purchased if not available to the person from any other source. When items are included as a Medicaid state plan service, a denial by utilization review will be required prior to approval for waiver funding by DDS. Professional consultation must be accessed to ensure that the equipment will meet the needs of the person when the purchase will at a minimum but not necessarily exceed \$500.00. Consultation must be</p>	

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conducted by a medical professional applicable as determined by the participant's condition for which the equipment is needed. Computer equipment can be approved when it will allow the participant control of their environment, to assist the participant to gain independence, or it can be demonstrated as necessary to protect the health and safety of the participant. The waiver does not cover supplies. Printers may be approved for non-verbal participants. Computer desks or other furniture items will not be covered. Communication boards are an allowable device. Computers may be approved for communication when there is substantial documentation that a computer will meet the needs of the person more appropriately than a communication board. Software will be approved only when required to operate the accessories included for environmental control; or to provide text-to-speech capability.

Vehicle Modifications are adaptations to an automobile or van to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant. Payment for permanent modification of a vehicle is based on the cost of parts and labor, which must be quoted and paid separately from the purchase price of the vehicle to which the modifications are or will be made. Transfer of any part of the purchase price of a vehicle, including preparation and delivery, to the price of a modification is fraudulent activity. All suspected fraudulent activity will be reported to the Office of Medicaid Inspector General (OMIG) for investigation. Reimbursement for a permanent modification cannot be used or considered as down payment for a vehicle. Lifts that require vehicle modification and the modifications are, for purposes of approval and reimbursement, one project and cannot be separated by plan of care years in order to obtain up to the maximum.

Vehicle Modification Exclusions: The following are specifically excluded:

- 1) Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the participant;
- 2) Purchase, down payment, monthly car payment, or lease cost of the vehicle;
- 3) Regularly scheduled upkeep and maintenance of the vehicle.

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

All adaptive equipment must be solely for the waiver individual and used only by that individual. All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over

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<p>\$1,000.00 will require three bids with the lowest bid with comparable quality being awarded; however, DDS may require 3 bids for any requested purchase. Swimming pools (in-ground or above ground) and hot tubs are not allowable as either an environmental modification or adaptive equipment.</p>					
<p>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</p>					
<p>The annual expenditure cap for environmental modifications and adaptive equipment is \$7,687.50.</p>					
<p>The \$7,687.50 limit can be increased with the difference in the Adaptive Equipment maximum allowance and the total required amount being deducted from the supportive living maximum allowance. The allowed maximum can be increased upon a showing of medical necessity, with the difference in the total rate amount and the amount allowed being deducted from the supplemental living maximum allowance.</p>					
<p>Service Delivery Method (check each that applies):</p>		<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed		
<p>Specify whether the service may be provided by (check each that applies):</p>		<input type="checkbox"/> Legally Responsible Person	<input checked="" type="checkbox"/> Relative	<input type="checkbox"/> Legal Guardian	
<p>Provider Category(s) (check one or both):</p>					
<input type="checkbox"/> Individual. List types:		<input checked="" type="checkbox"/> Agency. List the types of agencies:			
		Certified Adaptive Equipment Provider			
<p>Provider Qualifications</p>					
<p>Provider Type:</p>	<p>License (specify)</p>	<p>Certificate (specify)</p>		<p>Other Standard (specify)</p>	
<p>Agency</p>		<p>The Provider must be certified by DDS as an HCBS provider and have elected to provide the service Adaptive Equipment.</p>			
<p>Verification of Provider Qualifications</p>					
<p>Provider Type:</p>	<p>Entity Responsible for Verification:</p>		<p>Frequency of Verification</p>		
	<p>DDS Quality Assurance</p>		<p>Annually</p>		

C-1/C-3: Service Specification

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

Service Type:

Other Service

Service:

<p>State:</p>	
<p>Effective Date</p>	

Community Transition Service

Alternative Service Title (if any):

HCBS Taxonomy	
Category 1:	Sub-Category 1:
16 Community Transition Service	16010 community transition service
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<input checked="" type="radio"/> Service is included in approved waiver. There is no change in service specifications.	
Service Definition (Scope):	
<p>Community Transition Services are non-recurring set-up expenses for participants who are transitioning from an institutional or provider-operated living arrangement, such as an ICF or group home, to a living arrangement in a private residence where the participant or his or her guardian is directly responsible for his or her own living expenses. Waiver funds can be accessed once it has been determined that the Waiver is the payer of last resort.</p> <p>Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the PCSP development process, clearly identified in the PCSP, and the person is unable to meet such expenses or when the services cannot be obtained from other sources.</p> <p>Community Transitions Services cannot duplicate environmental modifications. This will be prevented through DDS control of prior authorizations.</p> <p>Costs for Community Transition Services, furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the Waiver, are considered to be incurred and billable when the person is determined to be eligible for Waiver services. If for any unseen reason, the individual does not enroll in the Waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid as an administrative cost.</p> <p>Exclusions: Community Transition Services may not include payment for room and board; monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a Waiver provider where the provision of these items and services are inherent to the service they are already providing. Diversionary or recreational items such as televisions, cable TV access or VCR's are not allowable.</p>	

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Specify applicable (if any) limits on the amount, frequency, or duration of this service:																						
The maximum annual allowance for Supplemental Support Services, Community Transition Services and Specialized Medical Supplies is \$3,690.00.																						
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E			<input checked="" type="checkbox"/> Provider managed																	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative	<input type="checkbox"/> Legal Guardian																	
<table border="1"> <tr> <td rowspan="4">Provider Category(s) (check one or both):</td> <td><input type="checkbox"/></td> <td>Individual. List types:</td> <td><input checked="" type="checkbox"/></td> <td>Agency. List the types of agencies:</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Certified Community Transition Service Provider</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>						Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:				Certified Community Transition Service Provider								
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:																		
				Certified Community Transition Service Provider																		
Provider Qualifications																						
Provider Type:	License (specify)	Certificate (specify)			Other Standard (specify)																	
Agency		<p>The provider entity must be certified by DDS as an HCBS provider and have elected to provide community transition services. The provider must maintain evidence that they require the following qualifications and requirements of staff who coordinate expenditure of community transition funds:</p> <ol style="list-style-type: none"> 1. Must have at least one of the following: <ol style="list-style-type: none"> a. Hold a Bachelor's degree in a human services field, or b. Have at least two years college credit and two years' experience working with persons with developmental disabilities, or c. Have two years of verified experience working with persons with a developmental disability and have been mentored by a case manager for two additional years, or d. Have four years of experience as a case manager in a related field; 2. Must: <ol style="list-style-type: none"> a. Not be disqualified from employment due to a criminal record according to Ark. Code Ann. §20-38-101 et seq., b. Not be listed on either the adult or child maltreatment registry, and c. Have satisfactorily completed a drug screen in accordance with the Organization's policies. 																				

State:	
Effective Date	

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

C-1/C-3: Service Specification

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

Service Type:

Other Service

Service:

Consultation

Alternative Service Title (if any):

HCBS Taxonomy	
Category 1:	Sub-Category 1:
17 Other Service	17990 other
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<input checked="" type="radio"/> Service is included in approved waiver. There is no change in service specifications.	
Service Definition (Scope):	
<p>Consultation services are clinical and therapeutic services which assist the participant, parents, legally responsible persons, responsible individuals and service providers in carrying out the person's PCSP. Consultation activities are provided by professionals licensed as one of the following:</p> <ol style="list-style-type: none"> 1) Psychologist 2) Psychological Examiner 3) Mastered Social Worker 4) Professional Counselor 	

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- 5) Speech Pathologist
- 6) Occupational Therapist
- 7) Registered Nurse
- 8) Certified Parent Educator or Provider Trainer
- 9) Certified Communication and Environmental Control Specialist
- 10) Qualified Developmental Disability Professional (QDDP)
- 11) Positive Behavior Support (PBS) Specialist
- 12) Physical Therapist
- 13) Rehabilitation Counselor
- 14) Dietitian
- 15) Recreational Therapist
- 16) Behavior Analyst

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

- 1) Provision of updated psychological and adaptive behavior assessments;
- 2) Screening, assessing and developing therapeutic treatment plans;
- 3) Assisting in the design and integration of individual objectives as part of the overall individual service planning process as applicable to the consultation specialty;
- 4) Training of direct services staff or family members in carrying out special community living services strategies identified in the participant's PCSP as applicable to the consultation specialty;

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- 5) Providing information and assistance to the persons responsible for developing the participant's overall PCSP as applicable to the consultation specialty;
- 6) Participating on the interdisciplinary team, when appropriate to the consultant's specialty;
- 7) Consulting with and providing information and technical assistance with other service providers or with direct service staff or family members in carrying out the participant's PCSP specific to the consultant's specialty;
- 8) Assisting direct services staff or family members to make necessary program adjustments in accordance with the participant's PCSP applicable to the consultant's specialty;
- 9) Determining the appropriateness and selection of adaptive equipment to include communication devices, computers and software consistent with the consultant's specialty;
- 10) Training or assisting participants, direct services staff or family members in the set up and use of communication devices, computers and software consistent with the consultant's specialty;
- 11) Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment and plan modification consistent with the consultant's specialty;
- 12) Training of direct services staff or family members by a professional consultant in:
 - a) Activities to maintain specific behavioral management programs applicable to the participant,
 - b) Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the participant,
 - c) The provision of medical procedures not previously prescribed but now necessary to sustain the participant in the community.
- 13) Training or assisting by advocacy consultants to participants and family members on how to self-advocate.
- 14) Rehabilitation Counseling for the purposes of supported employment supports that do not supplant the federal Rehabilitation Act of 1973 and PL 94-142 and the supports provided through the Arkansas Rehabilitation Services.
- 15) Training and assisting participants, direct services staff or family members in proper nutrition and special dietary needs.

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

The maximum annual amount is \$1,320.00 and is reimbursable at no more than \$136.40 per hour.

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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State:	
Effective Date	

Specify whether the service may be provided by <i>(check each that applies)</i> :		<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
Provider Category(s) <i>(check one or both)</i> :	<input checked="" type="checkbox"/>	Individual. List types:		<input type="checkbox"/>	Agency. List the types of agencies:		
		Certified Consultation Provider					
Provider Qualifications							
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>				Other Standard <i>(specify)</i>	
Individual		<p>DDS Certification as an HCBS provider and have selected to provide Consultation services. The certified HCBS provider must ensure that the individual providing Consultation has current credentials which correspond to the specific area of consultation they provide. Consultation service providers must demonstrate evidence that they require that professionals who provide the direct service hold a current license or certification by the Arkansas state board or organization of licensing or certification as follows:</p> <ol style="list-style-type: none"> 1. Psychologists: Current license from the Arkansas Psychology Board as a Psychologist 2. Psychological Examiners: Current license from the Arkansas Psychology Board as a Psychological Examiner. 3. Mastered Social Workers: Current license as an LMSW or ACSW by the Arkansas Social Work Licensing Board. 4. Professional counselors: Current license as a counselor by the Arkansas Board of Examiners in Counseling. 5. Speech pathologists: Current license in Speech Therapy by the Arkansas Board of Examiners in Speech Language Pathology and Audiology. 6. Occupational therapists: Current license in Occupational Therapy by the Arkansas State Medical Board. 7. Registered Nurses: Current license as a Registered Nurse by the Arkansas State Board of Nursing. 8. Certified parent educators: Qualified Developmental Disabilities Professional (QDDP) as defined in 42 C.F. R. Subsection 483.430(a). 9. Certified communication and environmental control 					

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		<p>adaptive equipment or aids providers: Documentation as a current provider of Durable Medical Equipment with the Arkansas Medicaid Program.</p> <p>10. QDDP must present documentation of credentials in accordance with 42 CFR Subsection 483.430(a).</p> <p>11. Positive Behavior Support Specialist must be certified through our Center of Excellence University of Arkansas Partners for Inclusive Communities.</p> <p>12. Physical Therapists as licensed by Arkansas State Board of Physical Therapy.</p> <p>13. Rehabilitation counselors with Masters Rehabilitation Counseling must be certified through Arkansas Rehabilitation Service.</p> <p>14. Dietitians with degree in Nutrition must be certified by Arkansas Dietetics Licensing Board.</p> <p>15. Recreational Therapists with degree in Recreational Therapy-State certification not required but to provide services must provide credentials (appropriate degree).</p> <p>16. Behavior Analyst certified by the Behavior Analyst Certification Board as defined in Arkansas Code Ann. §23-99-418.</p>	
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
	DDS Quality Assurance		Annually

C-1/C-3: Service Specification

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

Service Type:

Other Service

Service:

Crisis Intervention

Alternative Service Title (if any):

HCBS Taxonomy	
Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention

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Category 2:		Sub-Category 2:	
10 Other Mental Health and Behavioral Services		10040 behavior support	
Category 3:		Sub-Category 3:	
Category 4:		Sub-Category 4:	
<input checked="" type="checkbox"/> Service is included in approved waiver. There is no change in service specifications.			
Service Definition (Scope):			
Crisis Intervention is delivered in the eligible person's place of residence or other local community site by a mobile intervention team or professional. Intervention shall be available 24 hours a day, 365 days a year. Intervention services shall be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geographic area conducive to rapid intervention as defined by the provider responsible to deploy the team or professional. Services may be provided in a setting as determined by the nature of the crisis; i.e., residence where behavior is happening, neutral ground, local clinic or school setting, etc., for persons participating in the Waiver program and who are in need of non-physical intervention to maintain or re-establish a behavior management or positive programming plan.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The maximum rate is \$127.10 per hour. The annual maximum is \$2640.00.			
This waiver service is only provided to individuals age 21 and over. All medically necessary Crisis Intervention services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.			
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Certified Crisis Intervention Provider
Provider Qualifications			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Agency		Crisis Intervention service providers must demonstrate evidence that they require that professionals who provide the direct service hold a current license or certification by the Arkansas Board of licensing or certification as follows: 1. Psychologists: Current license as a Psychologist by the Arkansas Board of Psychology.	

State:	
Effective Date	

		<p>2. Psychological Examiners: Current license as a Psychological Examiner by the Arkansas Board of Psychology.</p> <p>3. Mastered social workers: Current license as an LMSW, LCSW, or ACSW by the Arkansas Social Work Licensing Board.</p> <p>4. Professional counselors: Current license as a counselor by The Arkansas Board of Examiners in Counseling.</p> <p>5. Qualified Developmental Disabilities Professional as defined in 42 C.F.R. Subsection 483.430(a).</p> <p>6. Certified Positive Behavior Supports Specialist</p> <p>Crisis Intervention Providers must maintain documentation that they require that professionals who provide the direct service have satisfactorily passed a criminal background check and adult and child maltreatment registry checks. Criminal background checks and adult maltreatment checks must be repeated every five years and child maltreatment registry check every two years.</p> <p>Crisis Intervention Providers must require that direct staff have satisfactorily passed a pre-employment drug screen.</p>	
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
	DDS Quality Assurance		Annually

C-1/C-3: Service Specification

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

Service Type:

Other Service

Service:

State:	
Effective Date	

Environmental Modifications

Alternative Service Title (if any):

HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<input checked="" type="radio"/> Service is included in approved waiver. There is no change in service specifications.	
Service Definition (Scope):	
<p>Environmental Modifications are modifications made to or at the home, required by the participant's PCSP, which are necessary to ensure the health, welfare and safety of the participant, or that enable the participant to function with greater independence, and without which, the participant would require institutionalization. Such environmental modifications may include the installation of ramps, widening of doorways, modification of bathroom facilities, installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment, installation of sidewalks or pads to accommodate ambulatory impairments, and home property fencing when medically necessary to assure non-elopement, wandering or straying of persons who have dementia, Alzheimer's disease, other causes of memory loss or confusion as to location or decreased mental capacity or aberrant behaviors.</p> <p>Expenses for the installation of the modification and any repairs made necessary by the installation process are allowable. Portable or detachable modifications that can be re-located with the individual and that have a written consent from the property owner or legal designee will be considered. All services shall be provided in accordance with applicable state and local building codes. Requests for modifications must include an original photo of the site where modifications will be done; to scale sketch plans of the proposed modification project; identification of other specifications relative to materials, time for project completion and expected outcomes; labor and materials breakdown and assurance of compliance with any local building codes. Final inspection for the quality of the modification and compliance with specifications and local codes is the responsibility of the Waiver case manager. Payment to the contractor is to be withheld until the work meets specifications, including a signed customer satisfaction statement.</p> <p>Exclusions: Outside fencing is limited to one fence per lifetime. Total perimeter fencing is excluded. Excluded are those modifications or improvements to the home which are of general utility, and are not of direct medical and remedial benefit to the individual, such as carpeting, roof repair, central air conditioners, etc. Also excluded are modifications or improvements that are of aesthetic value (such as wallpaper, marble countertops, or ceramic tile) Modifications that add to the total square footage of the home are excluded from this benefit. Expenses for remodeling or landscaping which are cosmetic, designed to hide the existence of the modification, or result from erosion are not allowable. Environmental modifications that are permanent fixtures will not be approved for rental property without the prior written authorization and a release of current or future liability by the residential property owner. Environmental modifications may not be used to adapt living arrangements that are owned or leased by providers of waiver servicesSwimming pools (both in and out of ground) and hot tubs</p>	

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are not allowable. The moving of modifications, such as fencing or ceiling tracks and adaptive equipment that may be permanently affixed to the structure or outside of a premises is not allowed.

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

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

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

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

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian

Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Certified Environmental Modifications Provider

Provider Qualifications

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

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
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State:	
Effective Date	

	DDS Quality Assurance	Annually

C-1/C-3: Service Specification

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

C-1/C-3: Service Specification

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

Service Type:

Other Service

Service:

Supplemental Support

Alternative Service Title (if any):

HCBS Taxonomy	
Category 1:	Sub-Category 1:
17 Other Service	17990 other
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<input checked="" type="radio"/> Service is included in approved waiver. There is no change in service specifications.	
Service Definition (Scope):	
<p>Supplemental Support services meet the needs of the person to improve or enable the continuance of community living. Supplemental Support Services will be based upon demonstrated needs as identified in a person's PCSP as unforeseen problems arise that, unless remedied, could cause a disruption in the participant's services, placement, or place the participant at risk of institutionalization. Waiver funds will be used as the payer of last resort.</p>	
<p>This service can be accessed ONLY as a last resort. Lack of other available resources must be proven.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<p>The maximum annual allowance for Supplemental Support Services, Community Transition Services and Specialized Medical Supplies, collectively or individually, is \$3,690.00.</p>	

State:	
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Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E		<input checked="" type="checkbox"/>	Provider managed	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:		<input checked="" type="checkbox"/>	Agency. List the types of agencies:	
					Certified Supplemental Support Provider	
Provider Qualifications						
Provider Type:	License (specify)	Certificate (specify)			Other Standard (specify)	
Agency		<p>The provider entity must be certified by DDS as an HCBS provider and have elected to provide supplemental support services. The provider must maintain evidence that they require the following qualifications and requirements of staff who coordinate expenditure of supplemental support funds:</p> <ol style="list-style-type: none"> 1. Must have at least one of the following: <ol style="list-style-type: none"> a. A Bachelor's degree in a human services field, or b. At least two years college credit and two years' experience working with persons with developmental disabilities, or c. Two years of verified experience working with persons with a developmental disability and have been mentored by a case manager for two additional years, or d. Four years of experience as a case manager in a related field; 2. These individuals must: <ol style="list-style-type: none"> a. Not be disqualified from employment due to a criminal record according to Ark. Code Ann. §20-38-101 et seq.; b. Not be listed on either the adult or child maltreatment registry; and c. Have satisfactorily completed a drug screen in accordance with the Organization's policies. 				
Verification of Provider Qualifications						
Provider Type:	Entity Responsible for Verification:		Frequency of Verification			

State:	
Effective Date	

	DDS Quality Assurance	Annually

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

<input type="radio"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants.
<input checked="" type="radio"/>	Applicable – Case management is furnished as a distinct activity to waiver participants. Check each that applies:
<input checked="" type="checkbox"/>	As a waiver service defined in Appendix C-3 (<i>do not complete C-1-c</i>)
<input type="checkbox"/>	As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

N/A

Appendix C-2: General Service Specifications

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-(*select one*):

<input checked="" type="radio"/>	<p>Yes. Criminal history and/or background investigations are required. <i>Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):</i></p> <p>Arkansas Code Ann. §20-38-101 <i>et seq.</i>, Standards for Conducting Criminal Record Checks for Employees of Developmental Disabilities Service Providers, and HCBS Waiver Standards require HCBS Waiver providers to conduct criminal background checks for all employees, as defined in statute and standards. In certain circumstances a provider may waive DDS disqualification of an applicant or employee in accordance with section 504 of the DDS Criminal Records Standards (Act 990 of 2013).</p> <p>Employee is defined as a person who:</p> <p>1) is employed by a service provider to provide care to individuals with disabilities served by the service provider; or</p> <p>2) provides care to individuals with disabilities served by a service provider on behalf of,</p>
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State:

Effective Date

	<p>under supervision of, or by arrangement with the service provider; or</p> <p>3) submits an application to a service provider for the purposes of employment; or</p> <p>4) is a temporary employee placed by an employment agency with a service provider to provide care to individuals with disabilities served by the service provider; or</p> <p>5) submits an application to the Licensing or Certification Agency for the purpose of being licensed or certified as a service provider; or</p> <p>6) resides in an alternative living home in which services are provided to individuals with developmental disabilities; and</p> <p>7) has or may have unsupervised access to individuals with disabilities served by a service provider.</p> <p>Criminal record checks are required for all employees and shall include both a state and national record check. A "state only" criminal record check is allowed if the provider can verify the applicant has lived continuously in the State of Arkansas for the past five years.</p> <p>The provider may extend an offer of conditional employment pending the outcome of the DDS determination of employment eligibility, unless the applicant has self-reported a disqualifying offense. If the provider receives a criminal record report on an employee from the Arkansas State Police that shows no criminal record, the provider may continue to employ the person. If the provider receives a criminal record report on an employee from the Arkansas State Police that shows a criminal record, the provider must remove the person from unsupervised access to persons served.</p> <p>DDS checks the Arkansas State Police website for criminal records. If DDS finds a criminal record on a provider employee, DDS makes a determination for employment eligibility based on the record and sends notice to the provider. If a FBI record check is required, the FBI report is sent to DDS Quality Assurance. DDS makes a determination of employment eligibility based on the record and sends notice to the provider.</p> <p>The DDS determination of employment eligibility is based on comparison of the conviction noted in the Arkansas State Police or FBI criminal record report with those offenses identified in Arkansas Code Ann. §20- 38-101 et seq. as disqualifying offenses. A person who is defined as an employee in this statute is not eligible to work for a DDS provider if they have a disqualifying offense. The provider is required to terminate employment of a person who has been disqualified. DDS Quality Assurance staff reviews evidence of criminal record checks by providers and employment determinations by DDS during the annual review of all certified providers.</p> <p>In certain narrowly prescribed circumstances, a provider may waive DDS disqualification of an applicant or employee in accordance with Section 504 of the DDS Criminal Record Check Standards.</p>
<input type="radio"/>	<p>No. Criminal history and/or background investigations are not required.</p>

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

<input checked="" type="radio"/>	<p>Yes. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or</p>
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State:	
Effective Date	

	<p>the operating agency (if applicable):</p> <p>Arkansas maintains two statewide Central Registries of substantiated cases of abuse and neglect. The DHS Division of Children and Family Services (DCFS) maintains the child abuse registry and Adult Protective Services (APS) maintains the adult abuse registry. All DDS certified Waiver providers must initiate a check of both registries. Providers must also check any adult over the age of 18 residing in an alternative living home or group home, including employee's spouses. This check will provide documentation that the prospective employee's name and any adult family members' who reside with Waiver participants, names do not appear on the statewide central registry. Each provider is required to adopt policies that comply with Licensure Standards addressing what actions will be taken if an adult family member's name appears on the central registry when the individual being served is in an alternative living home or group home. If a record is found in either registry, the individual who received this information shall notify the Director of the program in writing so that corrective measures may be determined. When a provider is notified that an individual's name is on either Registry, the provider must take corrective measures to comply with DDS Licensure Standards. DDS Quality Assurance staff reviews evidence of central registry checks for each provider during the annual review.</p> <p>In addition, all DDS staff are required to undergo abuse registry checks. If any disqualifying record is found, the individual's employment with DDS is terminated.</p> <p>Process for ensuring that mandatory screenings have been conducted: on-site Quality Assurance monitoring by Licensure/Certification staff includes review of personnel files for compliance.</p>
<input type="radio"/>	<p>No. The State does not conduct abuse registry screening.</p>

c. Services in Facilities Subject to §1616(e) of the Social Security Act. Select one:

<input type="radio"/>	<p>No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i></p>
<input checked="" type="radio"/>	<p>Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Complete Items C-2-c.i – c.iii.</i></p>

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

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

State:	
Effective Date	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The State has undertaken activities as described in the transition plan to ensure that all residential settings comply with the characteristics described in the Final Rule. The group homes are community based and located in residential areas. The homes provide access to typical facilities in a home such as a kitchen with cooking facilities and small dining areas. Each group home contains bedrooms and bathrooms that allow privacy. Individuals are allowed free use of all space within the group home with due regard for privacy, personal possessions of other residents and staff and reasonable house rules. The living and dining areas are provided with furnishings that promote the functions of daily living and social activities. Participants in Group Homes are provided easy access to community resources and supports and are encouraged to build community relationships. Participants are granted access to visitors at times convenient to him or her. Participants are allowed a choice of roommates, if they are in a shared bedroom.

Group homes, owned and operated by Waiver certified providers, must meet all applicable state and federal laws and regulations. Existing group homes licensed by DDS prior to July 1, 1995 may serve groups of no more than fourteen unrelated adults, age 18 years and above, with developmental disabilities. Arkansas imposed a moratorium and no additional group homes of this size have been approved since July 1, 1995. Group homes built after July 1, 1995 are limited to a capacity of no more than 4 unrelated adults with developmental disabilities.

Supported living apartments owned and operated by waiver providers, regardless of date of DDS licensing, may serve the number of participants consistent with the number of bedrooms each apartment contains. In no event may there be more than four unrelated adults, age 18 and above, with developmental disabilities in each self-contained apartment unit.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Supported living arrangement apartments owned and operated by waiver providers

Waiver Service	Provided in Facility
Case Management	<input checked="" type="checkbox"/>
Respite	<input type="checkbox"/>
Supported Employment	<input checked="" type="checkbox"/>
Supportive Living	<input checked="" type="checkbox"/>
Specialized Medical Supplies	<input checked="" type="checkbox"/>
Adaptive Equipment	<input checked="" type="checkbox"/>
Community Transition	<input type="checkbox"/>
Consultation	<input checked="" type="checkbox"/>
Crisis Intervention	<input checked="" type="checkbox"/>
Environmental Modification	<input type="checkbox"/>
Supplemental Support	<input type="checkbox"/>
Delivered or Congregate Meal	<input type="checkbox"/>
Participant Directed Services	<input type="checkbox"/>

State:	
Effective Date	

Financial Management	<input type="checkbox"/>
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Facility Capacity Limit:

No more than 4 unrelated adults in each self-contained apartment.

- iii. **Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following (*check each that applies*):

Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Staff resident ratios are determined for each individual and included in their PCSP. If they may share staff in a living arrangement, that is also documented in their PCSP.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Homes

Waiver Service	Provided in Facility
Case Management	<input checked="" type="checkbox"/>
Respite	<input type="checkbox"/>
Supported Employment	<input checked="" type="checkbox"/>
Supportive Living	<input checked="" type="checkbox"/>
Specialized Medical Supplies	<input checked="" type="checkbox"/>
Adaptive Equipment	<input checked="" type="checkbox"/>
Community Transition Services	<input type="checkbox"/>

State:	
Effective Date	

Consultation	<input checked="" type="checkbox"/>
Crisis Intervention	<input checked="" type="checkbox"/>
Environmental Modification	<input type="checkbox"/>
Supplemental Support	<input type="checkbox"/>
Delivered or Congregate Meal	<input type="checkbox"/>
Participant Directed Services	<input type="checkbox"/>
Financial Management	<input type="checkbox"/>

Facility Capacity Limit:

14 beds.

- iii. **Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following (*check each that applies*):

Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Staff resident ratios are determined for each individual and included in their PCSP. If they may share staff in a living arrangement, that is also documented in their PCSP.

State:	
Effective Date	

- d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

<input checked="" type="radio"/>	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of <i>extraordinary care</i> by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

- e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

<input type="radio"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input checked="" type="radio"/>	<p>The State makes payment to relatives/legal guardians under <i>specific circumstances</i> and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.</i></p> <p>Payment for waiver services will not be made to the adoptive or natural parent, step-parent or legal representative or legal guardian of a person less than 18 years old. Payments will not be made to a spouse or a legal representative for a person 18 year of age or older.</p> <p>For purposes of exclusion, "parent" means natural or adoptive parents and step parents. For any service provider, all DDS qualifications and standards must be met before the person can be a paid service provider. Qualified relatives, other than as specified in the foregoing, can provide any service. Controls are maintained through documentation as is required for all services provided; specific to date and time of service delivery with descriptor or activities linked to the approved plan of care goals and objectives. In addition, incident reports received through the DHS automated incident reporting system are analyzed annually.</p> <p>Controls for services rendered: All care staff are required to document all services provided daily according to their work schedules, direct care support service supervisors are responsible for the day to day supervision and monitoring of the direct care staff; case managers are responsible to periodically review with the participant any problems in care delivery and report any deficiencies to the Waiver DDS Specialist and DDS Quality Assurance provider certification staff. DDS</p>

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	specialists conduct a 100% review of service utilization for each PCSP at the time of each PCSP 12 month expiration date to identify any gaps in approved services with corrective action by the provider to be taken; DDS Quality Assurance conducts annual provider reviews; and DMS conducts both random Quality Assurance audits and audits specific to the financial integrity of services delivered.
○	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3. Specify the controls that are employed to ensure that payments are made only for services rendered.
○	Other policy. <i>Specify:</i>

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- f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any willing and qualified organization may apply for certification as a Waiver provider. DDS provides continuous open enrollment for certification as a Waiver provider. Interested parties who call or email DDS are directed to the DDS web page created for this purpose.

<http://humanservices.arkansas.gov/ddds/Pages/WaiverServiceProviders.aspx>

At this site, applicants have access to information regarding the requirements and procedures to become certified as a Waiver provider. In the application, providers may specify the maximum number of persons they can serve, the areas of the state they serve, and the services they wish to offer. Providers may stipulate in the application that they reserve the right to refuse to offer services to a participant who chooses them as a provider, if they can document and justify that they cannot ensure the health and safety of the participant. When an organization completes an application and prepares all other requested information, the DDS Certification and Licensure Administrator assigns staff to review the application and provide technical assistance regarding the application process to the organization. After an organization has satisfied initial requirements, DDS issues a temporary certificate to the organization. At this point, the provider may contact the Medicaid fiscal agent's Provider Enrollment Unit to enroll with Medicaid and obtain provider numbers for each service. The provider's transition from temporary to regular certification is dependent upon the provider's demonstration of compliance with DDS standards in the delivery of services to one or more individuals during an on-site visit by Certification and Licensure staff.

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

i. Performance Measures

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

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

Performance Measure:	QP A1: Number and percentage of providers who obtained initial certification in accordance with promulgated standards. Numerator: Number of applicants who obtained initial certification in accordance with promulgated standards; Denominator: Total number of completed new provider applications.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify:			
Report of Initial Certifications			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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Performance Measure:	QP A2: Number and percentage of providers that obtained annual re-certification in accordance with promulgated standards. Numerator: Number of providers that obtained annual re-certification in accordance with promulgated standards; Denominator: Total number of providers reviewed.
-----------------------------	--

Data Source (Select one) (Several options are listed in the on-line application): Other

If 'Other' is selected, specify:

Report of Certification Activity

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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

i. Performance Measures

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

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

- c Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

i. Performance Measures

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

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

Performance Measure:	QP C1: Number and percentage of provider agencies that meet DDS requirement for abuse and neglect reporting training for staff. Numerator: Number of provider agencies investigated who complied with Standard 303.A.1.1 & 304.A.8; Denominator: Total number of provider agencies reviewed or investigated.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify: Report of Abuse and Neglect Staff Training Deficiencies			
Report of Abuse and			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence

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			Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	QP C2: Number and percentage of provider agencies that meet DDS requirements for training staff on the specific needs of the persons they serve. Numerator: Number of provider agencies who complied with Standard 305.A.2.a-d, 305.A.3.a, & 305.A.4.a-c; Denominator: Total number of provider agencies reviewed or investigated.
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Data Source (Select one) (Several options are listed in the on-line application): **Other**

If 'Other' is selected, specify: **Report of Individualized Staff Training Deficiencies**

Report of Abuse and			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	

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		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

DDS verifies annually, during an on-site visit, the providers who adhere to promulgated state standards regarding Waiver providers; then identifies and rectifies situations where providers do not meet DDS requirements.

b. Methods for Remediation/Fixing Individual Problems

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

(PM QP A1) If deficiencies are cited as a result of the on-site review of a temporary provider, DDS gives the provider an opportunity to develop a plan of correction. Within 30 days after receipt of an acceptable plan of correction, DDS staff returns for a follow-up onsite review. If the provider has not achieved substantial compliance, DDS does not issue a permanent Certificate to the temporary

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provider.

(PM QP A2, C1,C2) If deficiencies are cited as a result of an annual onsite certification review of a certified provider, DDS gives the provider an opportunity to develop a plan of correction. The plan of correction must address how individual problems have been resolved as well as what processes the provider will put in place to assure the deficiencies do not occur again in the future. After receipt of an acceptable plan of correction, depending on the severity of the cited deficiencies, DDS staff either issues a Certificate, or returns for a follow-up onsite review. If the follow-up review reveals that the provider has not successfully corrected the deficiencies, DDS may impose an array of enforcement remedies, and may ultimately revoke the certification of the provider.

(PM QP A2, C1,C2)DDS maintains investigative staff so that, on an ongoing basis, they may investigate any complaints regarding the provider. Utilizing a process similar to certification, DDS requires a plan of correction, referred to in this case as an Assurance of Adherence to Standards, and may impose enforcement remedies and revoke certification if the provider does not comply with requirements.

(PM QP A2, C1,C2)When DDS determines, during a certification review or an investigation, that the provider has not provided required abuse and neglect reporting training, or has not provided required training on the specific needs of the person the staff serves, the provider is cited and must submit an acceptable plan of correction. The plan must include an attestation that the identified staff has been trained, as well as a description of the processes the provider will put in place to assure the deficiencies do not occur again in the future.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other: Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

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	Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
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N/A

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

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

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

<input type="radio"/>	Not applicable – The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
<input checked="" type="radio"/>	Applicable – The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

<input checked="" type="checkbox"/>	<p>Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. <i>Furnish the information specified above.</i></p> <p>The rates included in this waiver were initially set in 1990. Arkansas proposed in the last waiver, effective , that it will submit an amendment to implement a new rate methodology for all services within 12 months. Arkansas also promised to provide a timeline for the new rate methodology within 3 months of the effective date of that amendment. In order to honor that commitment, Arkansas DMS and DDS are working with a third party vendor to conduct a comprehensive rate study of all HCBS Waiver services. AR will consult with CMS during the development of the rate methodology and will comply with all public notice requirements.</p> <p>Proposed timeline of rate methodology amendments:</p> <ul style="list-style-type: none"> • March 10, 2017: Have all data submitted to the actuary for the rate study. • April 9, 2017: Receive the propose rate methodology from the actuary. • April 10-May 8, 2017: Draft Waiver Amendment, including DHS Internal Review and approval; obtain stakeholder engagement and input.
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- May 8-15, 2017: Governor's office review and approval of waiver amendments, including rate methodology.
- May 15-June 15, 2017: Public Comment Period and Public Hearing.
- June 15-30, 2017: Review public comments, respond to comments, and compile comments for submission with Waiver amendment.
- July 1, 2017: Submit the rate methodology as part of the waiver amendments to CMS.

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

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

Current Limits:

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

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

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

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

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

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

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

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

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

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

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

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

Current participants will be transferred as follows:

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

Tier 2 has a maximum daily rate of 184.80, the previous extensive level maximum. Tier 3 now has a maximum daily rate of 391.95, the previous Pervasive level maximum.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*

☒ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors,

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participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*

All waiver participants will now receive an independent assessment upon entry into the waiver or expiration of their existing case plan. This independent assessment will be one of many tools used to place participants into a level (or tier) of support. Tier 2 is for participants who need less than 24 hours a day, seven days a week of care. Tier 3 is for participants who need 24 hours a day, seven days a week of care.

The Independent Assessment, along with the individual's application packet and functional assessments, will determine whether the Participant is in Tier 2 or Tier 3. The Independent Assessment will assess the participant in the following areas:

i. Individual Areas

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

ii. Caregiver (natural supports) areas

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

iii. Current Risk Assessment Review

- a. Safety Plan, if available;
- b. Behavior Plan;
- c. Physical Plan; and
- d. Medical Plan

DDS has transferred the old three level methodology over to the new two tier system. Tier 2 has a maximum daily rate of 184.80, based on the extensive level of care. Tier 3 now has a maximum daily rate of 391.95, the previous Pervasive level maximum.

Current participants will be transferred as follows:

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

DDS is currently undergoing a comprehensive rate study and will re-evaluate all service rates and

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	limits. DDS plans to implement a new rate methodology based on this study beginning in October 2017.
<input type="checkbox"/>	Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i>

Appendix C-5: Home and Community-Based Settings

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

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

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

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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

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

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input checked="" type="checkbox"/>	Case Manager (qualifications specified in Appendix C-1/C-3)
<input type="checkbox"/>	Case Manager (qualifications not specified in Appendix C-1/C-3). <i>Specify qualifications:</i>
<input type="checkbox"/>	Social Worker <i>Specify qualifications:</i>
<input type="checkbox"/>	Other <i>Specify the individuals and their qualifications:</i>

- b. **Service Plan Development Safeguards.**

Select one:

<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
<input checked="" type="radio"/>	<p>Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.</p> <p>The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i></p> <p>The new Provider-owned Arkansas Shared Savings Entity (PASSE) model will implement conflict free case management for all waiver participants. The target date for enrolling every waiver participant into a PASSE is December 31, 2018. Until that time, DDS will continue to implement the following firewalls and mitigation strategies:</p> <ol style="list-style-type: none"> 1) DDS will make eligibility determinations for the Waiver, including both level of care and financial need determinations; 2) DDS will review the Provider conducted annual clinical needs-based assessment prior

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	<p>to approving each participant's PCSP;</p> <ol style="list-style-type: none"> 3) The individual who performs the annual needs based assessment may not be a provider of services on the PCSP and may not provide direct care. DDS will monitor to make sure that assessors are not providing treatment or direct care to waiver participants; 4) DDS will perform utilization reviews; 5) DDS will review and approve/deny participants' PCSPs at the annual time of renewal or with any submitted amendment/modification; 6) Participants will be encouraged to advocate or have an advocate present during planning meetings; 7) Providers will administratively separate case management functions and staff and direct care functions and staff; 8) DDS established a consumer council to monitor issues of choice; 9) DDS established an accessible means for consumers to file grievances or complaints and to appeal to DDS regarding concerns about choice, quality, and outcomes; 10) DDS Waiver Specialists and the DDS Assistant Director of Waiver Services will oversee all plans to ensure consumer choice and control; and 11) DDS has tools in place that measure consumer experiences and capture the quality of care.
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- c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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

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

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

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

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

- d. Service Plan Development Process** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A. Before the Person Centered Case Plan (PCSP):

1. Independent Assessments

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

2. Interim Service Plan (ISP)

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

B. Developing the PCSP:

1. Development, Participation and Timing

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

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

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

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

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

3. Information regarding availability of services

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

4. Addressing goals, needs and preferences and assignment of responsibilities

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

5. Coordination of services

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

6. Updating the PCSP

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

7. Participant Engagement

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

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- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

DDS requires that the Interdisciplinary Team address risks to the participant during the PCSP development process. In conjunction with the participant and their legal guardian, the team must address health and behavioral risks and risks to personal safety, either real or perceived, and known or potential. The team must document each identified risk and write the PCSP with individualized mitigation strategies. The strategies must be designed to respect the needs and preferences of the participant. The team must identify how and who will be responsible for the ongoing monitoring of risk levels and risk management strategies as well as addressing how key staff will be trained regarding those risks. Additionally, the case manager must make sure that the team analyzes the risk management strategies and how effective those strategies are. The analysis must occur at least quarterly as part of the quarterly PCSP review.

DDS requires that providers document practices and decisions regarding risk assessment and the ongoing management of risks. Providers must specify the tool they use. HCBS Waiver participants, as they exercise their rights about their services, make choices about the amount of risk they wish to take. In negotiating trade-offs between choice and safety, providers are required to document the concerns of the team members, the negotiation process and the analysis and rationale for the decisions made and the actions taken.

DDS Certification Standards require that case management providers in conjunction with direct service providers develop and implement behavior management plans to address behavioral risks. The specific details of behavior management plans are addressed in Appendix G2.Ai. The Standards also require that case management and direct service providers minimize certain personal safety risks by imposing certain "physical plant" requirements without compromising the natural, home-like atmosphere in any setting in which the participant resides.

DDS requires that providers develop backup plans to address contingencies such as emergencies, including the failure of a support worker to appear when scheduled. Complete descriptions of backup arrangements must be included in the PCSP. Each provider must specify the type of backup arrangements that are employed, and make sure that each PCSP addresses the unique needs and circumstances of the participant.

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

DDS staff explain the HCBS Waiver program, service options, and provider choice and give written information in a face-to-face meeting with the participant and his or her legal representative. When desired by the participant and his or her legal representative, DDS provides information by phone, mail, or email. The DDS staff gives the participant and his or her legal representative a copy of the HCBS Waiver Certified Provider List prepared and maintained by DDS Quality Assurance initially as services begin, annually, and upon request. DDS staff encourages the participant and his or her legal representative to visit, call, or look at the website of a provider if the person lacks experience with that provider. DDS ensures that participants may choose providers of each service in the service plan.

Annually, DDS staff offers each participant and his or her legal representative an opportunity to

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change their choice of setting of service from community (HCBS Waiver) services to services in an ICF/IID. DDS staff also offers a choice of a different provider annually, and upon the participant's request. DDS staff supports the participant in making a choice of provider without giving any specific recommendations that could sway the participant's choice. DDS prohibits providers from soliciting participants to choose their organization. Providers are permitted to engage in marketing of their services consistent with DDS Policy 1091 and DDS Certification Standards. The Arkansas Waiver Association has a checklist that may assist people in choosing a provider; it is available at http://arkansaswaiver.com/resources/Prov_Select.pdf

DDS provides information to promote awareness of a participant's right to change providers annually and upon request in the Waiver Handbooks posted on the DDS and Arkansas Waiver Association websites, in the promulgated Medicaid Provider manual, and on the Rights and Choice Form that is given annually to participants. The Rights and Choice Form states, "I have the right to change providers at any time. I may choose without fear of retaliation". People with complaints regarding obtaining information about and selecting from among qualified providers may call DDS Quality Assurance, which will investigate the complaint in accordance with DDS Policy 1010, Service Concern Investigation. The DDS Ombudsman works with people to obtain information about and select from among qualified providers.

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DMS arranges with DDS for a specified number of PCSPs to be reviewed annually as specified in the interagency agreement with DMS in their role as overseer. DMS conducts a retrospective review of identified program, financial and administrative elements critical to CMS quality assurance. DMS randomly reviews PCSPs and ensures that they have been developed in accordance with applicable policies and procedures, that PCSPs ensure the health and welfare of the Waiver recipient and that financial components or prior authorizations, billing and utilization are correct and in accordance with applicable policies and procedures. DMS oversight results are reconciled quarterly with DDS. Where applicable individual actions to correct any known non-compliance or questionable practice are taken with the service provider or DDS staff, sometimes a change in policy or procedure may be necessary when systemic issues are discovered.

DMS uses the sampling guide "A Practical Guide for Quality Management in Home & Community-Based Waiver Programs" developed by Human Services Research Institute and the Medstat Group for CMS in 2006. A systematic random sampling of the active case population is drawn whereby every "nth" name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 8%, is drawn. An online calculator is used to determine the appropriate sample size for this Waiver population. To determine the "nth" integer, the sample is divided by the population. Those names are drawn until the sample size is reached.

To provide PCSP for this review, DMS requires providers to submit an electronic copy of the PCSP, including all components described in Appendix D.1.d and D.1.e, to DDS. DMS communicates findings from the review to DDS for remediation. Systemic findings may necessitate a change in policy, standards, or manuals.

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

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<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input checked="" type="radio"/>	Every twelve months or more frequently when necessary
<input type="radio"/>	Other schedule Specify the other schedule:

- i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
<input checked="" type="checkbox"/>	Operating agency
<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other Specify:

Appendix D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

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

The case management provider is charged with the first-line responsibility for monitoring the implementation of the PCSP and the participant's health and welfare. They must maintain regular contact with the participant, making *at least* one contact with the participant or their legal representative each month. During the contact, the case manager must discuss issues related to HCBS Waiver and non-waiver services and whether or not the participant feels that their needs are being met, if they remain satisfied with their provider and express an understanding that they may change providers, and any issues related to their health and safety. If the participant identifies problems, the case manager must take action to remediate the issue. The case manager is required to maintain documentation of their conversation with the participant as evidence that they are fulfilling their obligation to monitor the PCSP.

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

DDS HCBS staff conducts a file review and a random on-site review of PCSPs. DDS staff compares planned services to those actually provided as documented on utilization reports from the Medicaid

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Management Information System (MMIS). These activities are conducted once every twelve months for each PCSP as it is renewed but may be conducted more frequently or when problems requiring remediation are identified.

DDS Quality Assurance staff conduct annual onsite reviews of 100% of certified providers. They select a sample of at least 10% of participants served by the provider and conduct interviews, observations and file reviews to monitor implementation of the PCSPs and the participants' health and welfare. If any of the processes reveal a problem with implementation of the PCSP or participants' health and welfare, QA staff cite a deficiency in the report of their review to the provider. The provider must submit an acceptable plan of correction and implement corrective actions.

Division of Medical Services (DMS) staff (the Medicaid agency) also conducts a follow-behind review of 20% of PCSP previously reviewed by DDS staff as part of their oversight responsibilities.

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

b. Monitoring Safeguards. Select one:

<input type="radio"/>	<p>Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.</p>
<input checked="" type="radio"/>	<p>Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.</p> <p>The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i></p> <p>Case managers have frontline responsibility for monitoring implementation of PCSPs and participants' health and welfare.</p> <p>The new Provider Owned Shared Savings Entities (PASSE) model will implement conflict free case management for all waiver participants. The target date for enrolling every waiver participant into a PASSE is December 31, 2018. Until that time, DDS will continue to implement the following firewalls and mitigation strategies:</p> <ol style="list-style-type: none"> 1) DDS will make eligibility determinations for the Waiver, including both level of care and financial need determinations; 2) DDS will review the Provider conducted annual clinical needs-based assessment prior to approving each participant's PCSP; 3) The individual who performs the annual needs based assessment may not be a provider of services on the PCSP and may not provide direct care. DDS will monitor to make sure that assessors are not providing treatment or direct care to waiver participants; 4) DDS will perform utilization reviews; 5) DDS will review and approve/deny participants' PCSPs at the annual time of renewal or with any submitted amendment/modification; 6) Participants will be encouraged to advocate or have an advocate present during planning meetings; 7) Providers will administratively separate case management functions and staff and direct care functions and staff; 8) DDS established a consumer council to monitor issues of choice;

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	<p>9) DDS established an accessible means for consumers to file grievances or complaints and to appeal to DDS regarding concerns about choice, quality, and outcomes;</p> <p>10) DDS Waiver Specialists and the DDS Assistant Director of Waiver Services will oversee all plans to ensure consumer choice and control; and</p> <p>11) DDS has tools in place that measure consumer experiences and capture the quality of care.</p>
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Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance

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

i. Sub-assurances:

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

i. Performance Measures

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

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

Performance Measure:	SP A1: Number and percentage of providers who developed service plans that were adequate and appropriate to the needs of individuals as indicated by their assessment(s). Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1408.A.3 Denominator: Total number of provider agencies reviewed or investigated.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify:			
Report of Service Plan Assessment Deficiencies			
	Responsible Party for data collection/generation (check each that)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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	applies)		
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	SP A2: Number and percentage of providers who developed service plans that addressed the individual's personal goals. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1404.A.6, 1404.G, & 1408.A.4; Denominator: Total number of provider agencies reviewed or investigated.
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Data Source (Select one) (Several options are listed in the on-line application): **Other**

If 'Other' is selected, specify:

Report of Service Plan Personal Goal Deficiencies

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

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				Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually		
		<input checked="" type="checkbox"/> Continuously and Ongoing		<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:		
				<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

SP A3: Number and percentage of providers who developed service plans that addressed the individual's risk factors. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1404.C; Denominator: Total number of provider agencies reviewed or investigated.

Data Source (Select one) (Several options are listed in the on-line application): **Other**

If 'Other' is selected, specify:

Report of Service Plan Risk Factor Deficiencies

	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence

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			Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

b.Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

i. Performance Measures

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

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

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

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

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

Performance Measure:	SP C1: Number and percentage of providers who updated service plans at least annually. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1401.A.6 & 1412.A; Denominator: Total number of provider agencies reviewed or investigated.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify:			
Report of Service Plan Annual Update Deficiencies			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

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	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other
	Specify:

Performance Measure:	SP C2: Number and percentage of providers who reviewed and revised service plans as warranted by changes in individual needs. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 1401.A.6 & 1411.A.3&4; Denominator: Total number of provider agencies reviewed or investigated.
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Data Source (Select one) (Several options are listed in the on-line application): **Other**

If 'Other' is selected, specify:

Report of Service Plan Individual Needs Deficiencies			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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- d. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

i. Performance Measures

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

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

Performance Measure:	SP D1: Number and percentage of providers who delivered services in the type, scope, amount, frequency & duration specified in the PCSP. Numerator: Number of provider agencies reviewed or investigated who complied with Standard 2201.F and 2202.E and 2203.E and 2205.F and 2206.F and 2207.E and 2208.E; Denominator: Total number of provider agencies reviewed or investigated.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify:			
Report of Service Plan Frequency and Duration Deficiencies			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and	Frequency of data aggregation and
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State:	
Effective Date	

analysis (check each that applies)	analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually
Specify:	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other
	Specify:

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

i. Performance Measures

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

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

Performance Measure:	SP E2: Number and percentage of participants who were offered choice as indicated by an appropriately completed and signed freedom of choice form that specified choice of providers. Numerator: Number of participants who were offered choice as indicated by an appropriately completed and signed freedom of choice form that specified choice of providers; Denominator: Number of files reviewed.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify:			
Individual File Review			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	95% with a +/- margin of error

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		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

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

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

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

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

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	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

<input type="radio"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input checked="" type="radio"/>	No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

<input type="radio"/>	Yes. The State requests that this waiver be considered for Independence Plus designation.
<input type="radio"/>	No. Independence Plus designation is not requested.

Don't need Appendix E

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

It is initially the responsibility of the DDS Intake and Referral Specialist to inform the person or the legally responsible representative of appeal rights specific to application intake policies and procedures:

- 1) As HCBS Waiver services are requested; and
- 2) When initial choice of home and community based services as an alternative to institutional care is offered.

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It is the responsibility of DDS to inform the person or the legally responsible representative of appeal rights specific to the applicant or program denial of ICF/IID Level of Care or Medicaid Income Eligibility.

It is the responsibility of DDS staff to inform the person or legally responsible representative of appeal rights specific to closure of an application case for failure of the person or legal representative to comply with requests for required application assessment information. DDS staff sends copies of official letters to the DDS Psychology Team. When the determination is favorable to the applicant the team issues a notice of approval.

When the applicant is determined to meet eligibility criteria DDS staff inform the person or the legally responsible person of appeal rights specific to:

- 1) Continued choice for institutional or community based services;
- 2) Provider choice, including the right to change providers;
- 3) Service denials;
- 4) When their chosen providers refuse to serve them, and
- 5) Case closure.

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

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

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

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

Notices of adverse action and the opportunity to request a fair hearing are maintained in the case file. When the adverse action is case closure, services shall continue during the appeal process if a fair hearing is timely requested.

If the HCBS Waiver participant does not request a fair hearing during the time allowed the case will be closed.

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Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

<input checked="" type="radio"/>	No. This Appendix does not apply
<input type="radio"/>	Yes. The State operates an additional dispute resolution process

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

<input type="radio"/>	No. This Appendix does not apply
<input checked="" type="radio"/>	Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Division of Developmental Disabilities Services (DDS)-the Operating Agency

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS maintains an investigative unit which investigates complaints and concerns. The unit will accept any concern or complaints except those that are related only to an employee grievance against their employer or any other personnel issues, unless it affects the provision of services to individuals. DDS Policy 1010 Service Concern Resolution prescribes the methods and timeframes for conducting an investigation of a concern or complaint.

In brief, the investigator has three working days from the time the concern or complaint is received to make initial contact with the person making the complaint. The investigator must begin the fact finding process within one day of initiation of the investigation and must complete the investigation within 30 days, unless granted an extension for cause. The investigator may have an onsite visit to conduct face-to-face interviews with involved parties, as well as reviewing pertinent documents and records. The investigator provides a written report to the certified provider and to the individual making the complaint. If the investigator substantiates the complaint, they issue a deficiency to the certified provider and request an Assurance of Adherence to Standards which must explain how they will remedy the situation with the individual involved as well as how they will prevent similar situations from occurring in the future.

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

<input checked="" type="radio"/>	Yes. The State operates a Critical Event or Incident Reporting and Management Process <i>(complete Items b through e)</i>
<input type="radio"/>	No. This Appendix does not apply <i>(do not complete Items b through e).</i> <i>If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.</i>

- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Arkansas Child Maltreatment Act, Ark. Code Ann. §12-18-101 et seq., and the Arkansas Adult Maltreatment Act, Ark. Code Ann. §12-12-1701 et seq. defines the acts that are considered abuse or neglect. The acts define who is a mandated reporter and includes employees of DDS and Certified Waiver Providers. Failure on the part of a mandated reporter to report suspected abuse or neglect is a criminal offense. The AR Department of Human Services (DHS), Division of Children and Family Services (DCFS) and the Arkansas State Police, Crimes Against Children Division (CACD) are responsible for investigating allegations of child abuse or neglect. The DHS Division of Aging and Adult Services is responsible investigating allegations of adult abuse or neglect.

DHS Incident Reporting Policy 1090 and DDS Certification Standards for HCBS Waiver Services, Section 300 describe the incidents that the certified providers must report. The certified providers must report incidents, using automated form DHS 1910 via secure e-mail, to the DDS Quality Assurance Certification and Licensure section within two working days following the incident. In instances that might be of interest to the media, the providers must immediately report the incident to DDS QA staff who in turn notifies the DHS Communication Director. Providers must report suicide, death from adult abuse or child maltreatment, or a serious injury within one hour of occurrence, regardless of the hour.

The following is a list of the incidents which must be reported and are tracked by DDS. However, the State does not require follow-up or investigation of each listed incident. A description of how DDS makes the determination that follow-up action is required and by whom is described in Item

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G-1-d. Specifically, DDS has designated the following incidents as critical and sufficiently serious as to require follow-up:

- 1) attempted suicide,
- 2) suspected abuse or neglect,
- 3) elopement,
- 4) use of restrictive interventions,
- 5) death, and
- 6) arrest.

When investigative staff receive reports of any of the critical incidents, they evaluate the information contained in the report to determine if the incident requires an investigation or possible follow up at the next annual review of the provider.

Incidents which must be reported (but are not necessarily considered critical, unless also on the above list):

1. Death
2. The use of any restrictive intervention, including seclusion, or physical, chemical or mechanical restraint,
3. Suspected maltreatment or abuse as defined in Ark. Code Ann. §§ 12-18-103 & 12-12-1703;
4. Any injury that:
 - a. Requires the attention of an Emergency Medical Technician, a paramedic, or physician,
 - b. May cause death,
 - c. May result in a substantial permanent impairment, or
 - d. Requires hospitalization.
5. Suicide, threatened or attempted,
6. Arrest or conviction of any crime,
7. Any situation in which the location of a person has been unknown for two hours,
8. Any event in which a staff threatens a person served by the program,
9. Sentinel events, such as unexpected occurrences involving actual or risk of death or serious physical or psychological injury,
10. Medication errors made by staff that cause or have the potential to cause serious injury or illness,
11. Any rights violation that jeopardizes the health and safety or quality of life of a person served by the program,
12. Communicable disease,
13. Violence or aggression,
14. Vehicular accidents,
15. Biohazardous accidents,
16. Use or possession of illicit substances or licit substances in an unlawful or inappropriate manner,
17. Property destruction, and
18. Any condition or event that prevents the delivery of services for more than 2 hours.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

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DDS provides training and information to participants and legally responsible persons in the form of the Arkansas Guide to Services for Children and the Arkansas Guide to Services for Adults, The DDS Waiver Handbook, and the DDS website. DDS Quality Assurance investigations staff will provide training to providers regarding the reporting requirements contained in the Certification Standards for HCBS Waiver Services. Additionally, the Certification Standards require that certified providers provide training to all staff regarding the prevention of adult and child maltreatment, reporting adult and child maltreatment and DHS and DDS requirements for reporting incidents. The requirement stipulates that the provider conduct this training each year. The HCBS Waiver Certification Standards also require that certified providers inform all participants of their rights and provide support and training to them so that participants may recognize attempts to exploit them.

DHS Division of Children and Family Services (DCFS) provides statewide training on child abuse and neglect prevention, as well as how to report suspected abuse or neglect. The DHS Division of Aging and Adult Services provides statewide training regarding adult maltreatment.

- d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The DHS Division of Aging and Adult (DAAS), Adult Protective Services, (APS) receives reports of critical events designated as adult abuse or neglect and investigates those allegations. The methods to evaluate the reports and the time-frames for responding are defined at Ark. Code Ann. § 12-12-1711(b)(1). The law requires that, if the APS staff who receives the report believes that the act described by the reporter constitutes criminal behavior, they must contact the appropriate law enforcement agency. If the APS staff believes the individual to have an immediate need, the staff must treat it as an emergency and report it to 911 services. The APS investigator must see the individual within 24 hours of the report. In non-emergency situations, investigation staff must see the individual who is the subject of concern within three working days and must complete the investigation within 60 days. Based on information provided in the Case Summary Report and the recommendation of the APS staff, the APS Field Manager determines if the allegations are unfounded, founded or incomplete. If founded, the case summary report must contain details of how the APS staff met their responsibility to protect the person and to remedy the circumstances found to exist.

The DHS Division of Children and Family Services (DCFS) receives reports of critical events designated as child abuse or neglect and investigates those allegations. The method to evaluate the report and the time-frames for responding are defined at Ark. Code Ann. § 12-18-601 et seq. The Arkansas Child Maltreatment Hotline accepts reports of alleged maltreatment and determines if the report constitutes an event defined as abuse or neglect and if the report constitutes a Priority I or Priority II offense. A Priority I offense is sexual abuse, death, broken bones, head injuries, exposure to poison and noxious chemicals and substances and other critical injuries or events. A Priority II offense is one that involves serious issues, but those that are not life threatening.

Generally, DHS DCFS investigates allegations designated as Priority II and the Arkansas State Policy, Crimes Against Children Division (CACD) investigates Priority I allegations. If the nature of a child maltreatment report suggests that a child is in immediate risk, DCFS or CACD initiates an investigation immediately or as soon as possible. DCFS maintains primary responsibility for

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ensuring the health and safety of children regardless of whether the investigation is conducted by CACD or DCFS. DCFS and CACD complete investigations and make an investigative determination within 45 days. If the circumstances of the child present an immediate danger, the DCFS may take the child into protective custody for up to 72 hours.

When a DDS certified provider reports an incident to the Adult or Child Hotline, they must also submit an incident report (DHS 1910) to the DDS Quality Assurance (QA) investigation unit. The QA investigator reviews and evaluates the incident reports to determine if correct procedures and timeframes are followed. If the certified provider staff did not report the incident according to proscribed timeframes, the investigative staff will issue a deficiency to the certified provider and request an Assurance of Adherence of Standards which describes how the provider will ensure future compliance with the required reporting time frames.

If the investigator reviewing the incident report determines that the incident should have been reported to a hotline and was not, the investigator will immediately report the incident to the appropriate hotline. Additionally, the investigative staff will issue a deficiency to the certified provider and request an Assurance of Adherence of Standards which describes how the provider will ensure future compliance with the required hotline reporting requirements.

If an incident warrants investigation, the QA investigator will initiate an investigation according to DDS Policy 1010-Service Concern Resolution. The policy requires that investigative staff complete an investigation within 30 days.

DDS has designated the death of an individual as a critical incident. DDS Policy 1018, Mortality Review of Deaths guides the process to conduct a review of each death in order to identify issues and trends related to deaths in order to improve division and provider practices by identifying issues, recommending changes, influencing development of excellent policies and to gather data in order to identify and analyze trends. The purpose is to facilitate Continuous Quality Improvement by gathering information to identify systemic issues that may benefit from scrutiny and analysis in order to make system improvements and to provide opportunities for organizational learning DDS maintains an investigation unit which investigates complaints and concerns, which may or may not constitute a critical incident. DDS Policy 1010 Service Concern prescribes the methods and timeframes for conducting an investigation of a concern or complaint. In brief, the investigator has three working days from the time the complaint is received to make initial contact with the person making the complaint. The investigator must begin the fact finding process within one day of initiation of the investigation and must complete the investigation within 30 days. The investigator provides a written report to the certified provider and to the individual making the complaint. If the investigator substantiates the complaint, they issue a deficiency to the certified provider and requests an Assurance of Adherence to Standards which must explain how they will remedy the situation with the individual involved as well as how they will prevent similar situations from occurring in the future.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DDS Quality Assurance Certification and Licensure section is responsible for overseeing the reporting of and response to critical incidents regarding Waiver participants. There are three primary facets to the oversight process. One part of the process occurs during the annual onsite review of the certified provider to ensure that the provider is following applicable policies and procedures and that necessary follow up is conducted on a timely basis. The second occurs as the

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investigative staff reviews and responds to reports of incidents that certified providers submit to the DDS Investigative Unit. Thirdly, the DDS Certification and Licensure unit maintains a database of incidents in order to facilitate the identification of trends and patterns in the occurrence of critical incidents in order to identify opportunities for improvement and support the development of strategies to reduce the occurrence of incidents in the future.

DDS Certification Standards require that certified providers develop and implement policy that mandates reporting adult or child maltreatment to the Child or Adult Maltreatment Hotline. Standards also require that certified providers develop and implement policy that mandates program staff report certain incidents that occur within the program. The policy must:

1. Include all incidents described as critical by DDS,
2. Include any other incidents determined reportable by the program,
3. Require notification to the parent or guardian of all children age birth to 18 or adults who have a guardian, each time the provider submits an incident report to DDS or according to the program's Internal Incident Reporting policy, and
4. Develop and implement policy regarding follow-up of all incidents.

During the annual onsite review, Certification and Licensure staff review the documentation maintained by the provider that supports compliance with these requirements. Staff review documentation of incidents to determine if the incident constitutes a reportable incident and confirm that a report was submitted. Certification and Licensure staff interview provider staff to determine if they are familiar with the requirements of incident reporting.

DDS investigative staff receive and review incident reports that certified providers submit according to guidelines described in G-1-d. above. They review the report to determine if the provider responded appropriately to the incident; reported it timely and to the appropriate hotline, if necessary; and if it requires investigation by the DDS investigative unit.

DDS Certification and Licensure unit maintains a database of incidents that includes the type of incident, the name of the provider, the name of the Waiver participant, and the date of occurrence. Certification and Licensure staff review incident information on a quarterly basis to determine if there are trends that are relative to specific providers at a system-wide level or within the Waiver population. If trends are identified, the information is provided to the DDS Quality Assurance Committee which meets quarterly to determine if any actions are needed.

DDS Certification and Licensure Administration maintains oversight of investigative activities. Investigative staff maintains a database that includes timeframes regarding initiation and resolution of incidents, including notification to the parties involved. Staff generate monthly reports and administrative staff analyzes data on a quarterly basis. Systemic issues, when identified, are presented to the DDS Quality Assurance Committee which meets on a quarterly basis.

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

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

<input type="radio"/>	The State does not permit or prohibits the use of restraints Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
<input checked="" type="radio"/>	The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

- i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS permits the use of physical restraints when the challenging behavior exhibited by the Waiver participant threatens the health or safety of the participant or others. Physical restraint means the application of physical force without the use of any device, for the purposes of restraining the free movement of an individual's body. Manually holding all or part of a person's body in a way that restricts the person's free movement; including any approved controlling maneuvers. This does not include briefly holding, without undue force, a person in order to calm the person, or holding a person's hand to escort the person safely from one area to another.

DDS does not permit medications to be used to modify behavior or for the purpose of chemical restraint. Chemical Restraint means the use of medication for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition.

DDS does not permit the use of mechanical restraints. Mechanical Restraint means any physical apparatus or equipment used to limit or control challenging behavior. This apparatus or equipment cannot be easily removed by the person and may restrict the free movement, or normal functioning, or normal access to a portion or portions of a person's body, or may totally immobilize a person.

Definitions:

"Challenging behaviors" are behaviors defined as problematic or maladaptive by others who observe the behaviors or by the person displaying the behaviors. They are actions that:

1. Come into conflict with what is generally accepted in the individual's community,
2. Often isolate the person from their community, or
3. Can be barriers to the person living or remaining in the community, and

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4. Vary in seriousness and intensity.

DDS requires that, before a provider may use physical restraints, they must have developed alternative strategies to avoid the use of restraints by developing a behavior management plan which incorporates the use of positive behavior support strategies as an integral part of the plan. The plan must:

1. Be designed so that the rights of the individual are protected,
2. Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or puts the individual at medical risk,
3. Identify the behavior to be decreased,
4. Identify the behavior to be increased,
5. Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior,
6. Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person,
7. Identify the event that likely occurs right before a behavior of concern,
8. Identify what staff should do if the event occurs,
9. Identify what staff should do if the behavior to be increased or decreased occurs,
10. Involve the fewest interventions or strategies possible, and
11. Specify the length of time restraints must be used, who will authorize the use of restraints, and methods for monitoring restraints.

A behavior management plan must be written and supervised by a qualified professional who is, at a minimum, a Qualified Developmental Disabilities Professional. The provider must provide training to all persons who implement the behavior management plan. Training requirements include Introduction to Behavior Management, Abuse and Neglect and any other training as necessary.

The provider must collect data and review the plan. Since the success of a behavior management plan is measured by reductions in challenging behaviors, performance of alternative behaviors and improvements in quality of life, the provider is required to:

1. Develop a simple, efficient and manageable method of collecting data,
2. Collect data regarding the frequency, length of time of each use, the duration of use over time and the impact of the use of restraint, restrictive intervention or seclusion,
3. Review the data regularly, and
4. Revise the plan as needed if the interventions do not achieve the desired results.

DDS Standards require that the provider report to DDS the use restraints. The DDS investigative staff review each report to determine if the use of the technique was authorized or misapplied. Additionally, in an effort to detect the unauthorized use of or misapplication of restraints, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider.

DDS Standards stipulate that providers prohibit maltreatment or corporal punishment of individuals. DDS Standards also require that providers guarantee an array of rights which includes the right to be free from the use of a physical or chemical restraint, medications, or isolation as punishment for the convenience of the provider except when such measure is necessary for the health and safety of the individual or others.

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- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DDS Quality Assurance Certification and Licensure section is responsible for overseeing the use of restraints. DDS Standards require that the provider report to DDS the use of restraints. The DDS investigative staff review each report to determine if the use of the technique was authorized or misapplied. Additionally, in an effort to detect the unauthorized use of or misapplication of restraints, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider. DDS also maintains an investigative unit, whose staff investigates any complaints or concerns regarding the possible misuse of restraints.

DDS investigative staff collect data from provider incident reports. The data includes the frequency of use, length of time of each use, the duration of use over time and the impact of use for restraints. The staff produces a report on a monthly basis and reviews the data to detect any trends specific to individuals or providers that may emerge. On a quarterly basis, the Certification and Licensure Administrator presents a quarterly report of the data to the DDS Quality Assurance Committee. If a trend is identified, DDS may initiate an investigation to identify root causes and require corrective action to reduce or eliminate the inappropriate use of restraints and restrictive interventions.

DDS investigative staff also collect data from deficiencies cited by the Certification and Licensure staff based on their annual onsite provider reviews as well as deficiencies cited by investigative staff based on complaints or concerns. This data is analyzed as described in the above paragraph.

b. **Use of Restrictive Interventions**

<input type="radio"/>	The State does not permit or prohibits the use of restrictive interventions Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
<input checked="" type="radio"/>	The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive interventions are defined as procedures that restrict an individual's freedom of movement, restrict access to their property, prevent them from doing something they want to

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do, require an individual to do something they do not want to do, or remove something they own or have earned. Restrictive interventions include the use of time-out or separation (exclusionary and non-exclusionary).

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

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

DDS requires that, before a provider may use any restrictive intervention, they must have developed alternative strategies to avoid the use of those interventions by developing a behavior management plan which incorporates the use of positive behavior support strategies as an integral part of the plan. The plan must:

1. Be designed so that the rights of the individual are protected,
2. Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or puts the individual at medical risk,
3. Identify the behavior to be decreased,
4. Identify the behavior to be increased,
5. Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior,
6. Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person,
7. Identify the event that likely occurs right before a behavior of concern,
8. Identify what staff should do if the event occurs,
9. Identify what staff should do if the behavior to be increased or decreased occurs, and
10. Involve the fewest interventions or strategies possible.

A behavior management plan must be written, implemented and supervised by a qualified professional who is, at a minimum, a Qualified Developmental Disabilities Professional (QDDP). The provider must provide training to all persons who implement the behavior management plan. Training requirements include Introduction to Behavior Management, Abuse and Neglect and any other training as necessary.

The provider must collect data and review the plan. Since the success of a behavior management plan is measured by reductions in challenging behaviors, performance of alternative behaviors and improvements in quality of life, the provider is required to:

1. Develop a simple, efficient and manageable method of collecting data,
2. Collect data regarding the frequency, length of time of each use, duration of use over time and impact of restraints, restrictive interventions and seclusion,
3. Review the data regularly, and
4. Revise the plan as needed if the interventions do not achieve the desired results.

DDS Standards require that the provider report to DDS the use of any restrictive intervention.

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The DDS investigative staff review each report to determine if the use of the technique was unauthorized or misapplied. Additionally, in an effort to detect the unauthorized use or misapplication of restraints, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider.

DDS Standards stipulate that providers prohibit maltreatment or corporal punishment of individuals. DDS Standards also require that providers guarantee an array of rights which includes the right to be free from the use of a physical or chemical restraint, medications, or isolation as punishment for the convenience of the provider except when such measure is necessary for the health and safety of the individual or another.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DDS Quality Assurance (QA) is responsible for overseeing and detecting the unauthorized use of restrictive interventions. DDS Standards require that the provider report to DDS the use of any restrictive intervention. The DDS investigative staff review each report to determine why the use of the technique occurred and what corrective action the provider took to prevent the reoccurrence of the use of restrictive intervention. Additionally, in an effort to detect the unauthorized use of restrictive intervention, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider. DDS also maintains an investigative unit, whose staff investigates any complaints or concerns regarding the possible use of restrictive interventions.

DDS investigative staff collect data from provider incident reports. The data includes the frequency, length of time of each use, duration of use over time and impact of the restrictive intervention. The staff produces a report on a monthly basis and reviews the data to detect any trends specific to individuals or providers that may emerge. On a quarterly basis, the Certification and Licensure Administrator presents a report of the data to the DDS QA Committee. If a trend is identified, DDS may initiate an investigation to identify root causes and require corrective action to reduce or eliminate the use of restrictive interventions.

- c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

☒ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Seclusion is defined as the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving. DDS QA is responsible for overseeing and detecting the unauthorized use of

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	<p>seclusion. Seclusions are not permitted.</p> <p>DDS Standards require that the provider report to DDS the use of seclusion. The DDS investigative staff review each report to determine why the use of the technique occurred and what corrective action the provider took to prevent the reoccurrence of the use of seclusion. Depending on the circumstances described in the incident report, DDS investigative staff conduct an onsite investigation and cite providers with deficient practices as necessary.</p> <p>Additionally, in an effort to detect the unauthorized use of seclusion, DDS Certification and Licensure staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider. DDS also maintains an investigative unit, whose staff investigates any complaints or concerns regarding the possible use of seclusion.</p>
<input type="radio"/>	<p>The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.</p>

- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

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Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. **Applicability.** Select one:

<input type="radio"/>	No. This Appendix is not applicable <i>(do not complete the remaining items)</i>
<input checked="" type="radio"/>	Yes. This Appendix applies <i>(complete the remaining items)</i>

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b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The direct care service providers have on-going responsibility for first-line monitoring of participant medication regimens. The provider is responsible at all times to assure that the PCSP identifies and addresses all needs with other supports as necessary to assure the health and welfare of the participant, even if they do not provide round-the-clock services to that person.

The provider must develop and implement a Medication Management Plan for all participants receiving prescription medications. The plan must describe:

1. How that direct service staff will, at all times, remain aware of the medications being used by the participant,
2. How the direct service staff will be made aware of the potential side effect effects of the medications being used by the participant,
3. How the program staff will ensure that the participant or his or her guardian will be made aware of the nature and the effect of the medication,
4. How the program staff will ensure that the participant or his or her guardian gives their consent prior to the use of the medication, and
5. How the program staff will ensure that administration of the medication will be performed in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

The provider staff providing direct services must maintain medications logs that document at least the following:

1. Name and dosage of the medication given,
2. Route medication was given,
3. Date and time the medication was given,
4. Initials of the person administering or assisting with administration of the medication,
5. Any side effects or adverse reactions, and
6. Any errors in administering the medication.

The direct service provider must ensure that a supervisory level staff monitors the administration of medications at least monthly by reviewing medication logs to ensure that:

1. The participant consumed the medications accurately as prescribed,
2. The medication is effectively addressing the reason for which it was prescribed, and
3. Any side effects are being managed appropriately.

When medication is used to treat a specifically diagnosed mental illness, the medication must be prescribed and managed by a psychiatrist who is periodically provided information regarding the effectiveness of and any side effects experienced from the medication. The prescription and management may be by a physician, if a psychiatrist is not available, or when requested and agreed to by the person or the person's guardian and when based upon the documented need of the person. Medications may not be used to modify behavior in the absence of a specifically diagnosed mental illness, or for the purpose of chemical restraint.

DDS standards recognize that prescription PRN and over-the-counter medications are appropriate in the use of treating specific symptoms of illnesses. The Provider must keep data regarding:

1. How often the medication is used,

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2. The circumstances in which the medication is used,
3. The symptom for which the medication is used, and
4. The effectiveness of the medication.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DDS Quality Assurance unit is responsible for overseeing the second-line medication management process to ensure that participant medications are managed appropriately. The DDS Quality Assurance Certification and Licensure staff conduct an onsite review of every provider every year. During the onsite review, Certification and Licensure reviews records, conducts interviews and observes interactions between staff and Waiver participants. Certification and Licensure staff reviews medication management plans and medication logs. They also review internal incident reports, as well as those incident reports that the provider submitted to DDS to detect any potentially harmful practices. If they find errors, Certification and Licensure staff cite the provider with a deficient practice and require a plan of correction. When warranted, Certification and Licensure staff perform a follow-up review of the provider to determine if it has implemented the practices described in its plan of correction.

DDS maintains an investigative unit that will investigate complaints or concerns regarding how providers manage medications. The investigative staff cite the provider with a deficient practice and require a plan of correction if they identify a harmful or potentially harmful practice.

Prescription drugs are a state plan Medicaid service. The DMS Drug Utilization Review (DUR) Committee and the DUR Board monitors how prescription drugs are prescribed. Their monitoring includes checking the number of medications prescribed and the possible concurrent use of contraindicated medications.

c. **Medication Administration by Waiver Providers**

- i. **Provider Administration of Medications.** *Select one:*

<input type="radio"/>	Not applicable (<i>do not complete the remaining items</i>)
<input checked="" type="radio"/>	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (<i>complete the remaining items</i>)

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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Providers must adhere to the Arkansas Nurse Practice Act, which addresses how medications may be administered and by whom. DDS Certification Standards build upon that by describing requirements for medication management plans, medication logs, monitoring effects, reporting errors, and use of PRN and OTC medications. The direct service provider must develop and implement a Medication Management plan for all participant's receiving prescription medications. The plan must describe:

1. How the program will ensure that direct service supervisors and direct service staff will, at all times, remain aware of the medications being used by the participant,
2. How the program will ensure that direct service supervisors and direct service staff will be made aware of the potential side effect effects of the medications being used by the participant,
3. How the program will ensure that the participant will be made aware of the nature and the effect of the medication,
4. How the program will ensure that the participant gives their consent prior to the administration of the medication, and
5. How the administration of the medication will be performed in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

The Organization providing direct services must ensure that staff maintain Medication Logs that document at least the following:

1. Name and dosage of the medication given,
2. Route of medication,
3. Date and time the medication was given,
4. Initials of the person administering or assisting with administration of the medication,
5. Any side effects or adverse reactions, and any actions taken as a result, and
6. Any errors in administering the medication.

A. The Organization providing direct services must ensure that a supervisory level staff documents oversight of the administration of medications at least monthly by reviewing medication logs to determine if:

1. The participant consumed the medications accurately as prescribed,
2. The medication is effectively addressing the reason for which it was prescribed, and
3. Any side effects are noted, reported and are being managed appropriately.

The direct service provider must ensure that designated staff report to a supervisor and record the following medication errors missed dose, wrong dose, wrong time of dose, wrong route, and wrong medication.

The direct service provider must ensure that designated staff record any charting omission, loss of medication, unavailability of medications, falsification of records, and any theft of medications.

Additionally, the direct service provider must keep data regarding how often the medication is used, the circumstances in which the medication is used, the symptom for which the medication was used, and the effectiveness of the medication.

Providers are also required to develop and implement policies that describe how staff will administer or assist with the administration of medications. The policy must, at a minimum, describe the qualifications of who may administer medications, describe the qualifications of who may assist with the administration of medications, specify which class of drugs may be administered by which staff, and require that PRN medications are used only with the consent of the participant and according to approval from the prescribing health care professional.

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Providers are required to provide training to staff who provide direct services that details the specifics of the participant's PCSP including training that provides information related to any medications taken by the person they serve, including possible side effects.

iii. **Medication Error Reporting.** *Select one of the following:*

<input checked="" type="radio"/>	Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported: Providers are required to report medication errors to the DDS Quality Assurance unit.
	(b) Specify the types of medication errors that providers are required to record: The direct services provider must ensure that designated staff report to a supervisor and record medication errors as follows: missed dose, wrong dose, wrong time of dose, wrong route, and wrong medication. The direct services provider must ensure that designated staff record the following: any charting omission, loss of medication, unavailability of medications, falsification of records, and theft of medications.
	(c) Specify the types of medication errors that providers must report to the State: Providers are required to report medication that cause or have the potential to cause serious injury or illness errors to the DDS Quality Assurance unit.
<input type="radio"/>	Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DDS Quality Assurance unit is responsible for monitoring the performance of providers in the administration of medications to participants. The DDS Quality Assurance Certification and Licensure staff conduct an onsite review of every provider every year. During the onsite review, Certification and Licensure reviews records, conduct interviews and observes interactions between staff and Waiver participants. Staff review medication management plans, logs and error reports. They also review internal incident reports as well as those incident reports that the provider submitted to DDS to detect any potentially harmful practices. If they find errors, Certification and Licensure staff cite the provider with a deficient practice and require a plan of correction. When warranted, Certification and

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Licensure staff perform a follow-up review of providers to determine if they have implemented the practices described in their plan of correction.

DDS maintains an investigative unit that will investigate complaints or concerns regarding how providers manage medications. The investigative staff cite the provider with a deficient practice and require a plan of correction if they identify a harmful or potentially harmful practice.

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**

The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. **Sub-assurances:**

a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

i. **Performance Measures**

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

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

Performance Measure:	HW1: Number and percentage of participants or legal guardians who received information about how to report abuse, neglect, and exploitation as documented on the applicable form. Numerator: Number of participants who received information about how to report abuse, neglect, and exploitation as documented on the
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applicable form; Denominator: Number of files reviewed.			
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify: Individual File Review			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	95% with a +/- 5% margin of error
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	HW2: Number and percentage of providers who reported critical incidents to DDS within required timeframes. Numerator: Number of providers who reported critical incidents within required timeframes; Denominator: Total number of critical incidents reported to DDS.
Data Source (Select one) (Several options are listed in the on-line application): Other	

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If 'Other' is selected, specify: **Report of Critical Incidents Reported to DDS**

Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
	<input type="checkbox"/> Other Specify:	
		<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

HW3: Number and percentage of critical incidents reported to APS or DCFS.
Numerator: Number of critical incidents reported to APS or DCFS; **Denominator:** Total number of critical incidents required to be reported to APS or DCFS.

Data Source (Select one) (Several options are listed in the on-line application): Other

If 'Other' is selected, specify: **Report of Critical Incidents Reported to APS or DCFS**

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	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	HW4: Number and percentage of providers who took corrective actions regarding critical incidents to protect the health and welfare of the individual. Numerator: Number of providers who took corrective actions regarding critical incidents to protect the health and welfare of the individual; Denominator: Number of providers required to take protective actions regarding critical incidents.
Data Source (Select one) (Several options are listed in the on-line application): Other	
If 'Other' is selected, specify: Report of Corrective Actions	

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	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

HW5: Number and percentage of criminal background checks determinations completed by DDS on a timely basis. Numerator: Number of criminal background checks determinations completed by DDS on a timely basis; Denominator: Total number of criminal background checks determinations due.

Data Source (Select one) (Several options are listed in the on-line application): Other

If 'Other' is selected, specify: Report of Criminal Background Check Determinations

	Responsible Party for data	Frequency of data collection/generation:	Sampling Approach (check each that applies)

State:	
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	collection/generation (check each that applies)	(check each that applies)	applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	HW6: Number and percentage of complaint investigations that were completed on a timely basis. Numerator: Number of complaint investigations that were completed on a timely basis; Denominator: Number of complaint investigations.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify: Report of Timely Completed Complaint Investigations			
	Responsible Party for data collection/generation	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

State:	
Effective Date	

	(check each that applies)	applies)	
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	HW7: Number and percentage of reported deaths which were reviewed by the Mortality Review Committee Numerator: Number of reported deaths which were reviewed timely by the Mortality Pre-Review Committee; Denominator: Number of deaths reviewed.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify: Report of Timely Mortality Reviews			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	HW8: Number and percentage of individuals for whom providers adhered to DDS requirements for the use of restrictive interventions. Numerator: Number of individuals for whom providers adhered to DDS requirements for the use of restrictive interventions as documented on an incident report; Denominator: Number of individuals for whom the provider utilized restrictive intervention.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify: Report of Restrictive Interventions			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified; Describe Group:
	<input type="checkbox"/> Other Specify:	
		<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:	HW9-Number and percentage of providers who demonstrate responsibility for maintaining overall health care standards. Numerator: Number of provider agencies who complied Standard 1404.C and 1408.A.8.f and 2202.A.1 and 2202.B.13. Denominator: Total number of provider agencies reviewed or investigated.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify: Report of Provider Deficiencies			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

State:	
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	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. **Sub-assurance:** The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

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

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

Performance Measure:	HW4: Number and percentage of providers who took corrective actions regarding critical incidents to protect the health and welfare of the individual. Numerator: Number of providers who took corrective actions regarding critical incidents to protect the health and welfare of the individual; Denominator: Number of providers required to take protective actions regarding critical incidents.
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Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify: Review of Incident Reports			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- c. **Sub-assurance: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

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

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

Performance Measure:	HW8: Number and percentage of individuals for whom providers adhered to DDS requirements for the use of restrictive interventions. Numerator: Number of individuals for whom providers adhered to DDS requirements for the use of restrictive interventions as documented on an incident report; Denominator: Number of individuals for whom the provider utilized restrictive intervention.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify: Review of Incident Reports			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

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	Specify:

- d. **Sub-assurance:** The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

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

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

Performance Measure:	HW9-Number and percentage of providers who demonstrate responsibility for maintaining overall health care standards. Numerator: Number of provider agencies who complied Standard 1404.C and 1408.A.8.f and 2202.A.1 and 2202.B.13. Denominator: Total number of provider agencies reviewed or investigated.		
Data Source (Select one) (Several options are listed in the on-line application): If 'Other' is selected, specify:			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

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Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually
Specify:	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other
	Specify:

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

(HW 1) DDS mails the DDS ACS 106 "Waiver Rights and Choice Form" to each participant annually. The form contains a statement which informs them that they have the right to report abuse and contains the contact information for Child and Adult Abuse Hotlines. Participants are required to return the signed form to DDS Waiver section.

(HW4) Prior to initiation of an annual onsite provider certification review, Certification and Licensure (C&L) staff gathers incident reports which the provider has submitted throughout the year. C&L staff identifies reports that describe incidents which require protective actions, such as behavior management plans, changes in staffing levels, or changes in goals. During the onsite review, the reviewers determine, through the use of interviews, observations and file reviews, if the provider has taken necessary action to protect the participant in question.

(HW 5) DDS investigative staff reviews criminal background checks which are provided to DDS by the Arkansas State Police, Online Criminal Background System. Staff accesses the system each Friday and provides a written response to the provider who requested the background check. If a disqualifying conviction appears on the background check, DDS staff includes a determination that the prospective employee is disqualified from employment. The staff must provide the response to the provider within 14 calendar days.

(HW 6) DDS Policy 1010, Service Concern Resolution, requires that DDS investigative staff complete an investigation within 30 calendar days of receipt of the concern.

(HW 8) DDS requires that providers submit incident reports each time they utilize a restrictive intervention. DDS investigative staff reviews each report and determines if the methods described in the incident report adhere to the requirements for the use of the type intervention used. DDS staff may contact the provider to obtain additional information, if necessary.

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b. Methods for Remediation/Fixing Individual Problems

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

(HW 1) If the signed form is not in the DDS file, the Specialist will contact the participant to ensure that they received the form and will secure a signed form for the file.

(HW 2) When DDS determines, during an investigation, or based on Incident Reports submitted by the provider, that the provider has consistently not complied with reporting timeframes, or has not complied with reporting requirements with regard to critical incidents, the investigation manager cites a deficiency and requires the provider to submit an Assurance of Adherence to Standards. The Assurance must include a description of the processes the provider will put in place to assure the deficiencies do not occur again.

(HW3) Additionally, when the DDS staff reviews an Incident Report and determines that the described incident is reportable to APS or DCFS and has not been reported by the provider, the DDS staff immediately calls the appropriate hotline to report the incident.

(HW4) Prior to initiation of an annual onsite provider certification review, Certification and Licensure (C&L) staff gathers incident reports which the provider has submitted throughout the year. C&L staff identifies reports that describe incidents which require protective actions, such as behavior management plans, changes in staffing levels, or changes in goals. During the onsite review, the reviewers will determine, through the use of interviews, observations and file reviews, if the provider has taken necessary action to protect the participant in question.

(HW6) If a DDS staff member consistently does not complete investigations within required timeframes, or if DDS staff does not provide timely responses to providers requesting criminal background checks, the C&L Manager counsels the staff and utilizes the DHS Minimum Conduct Standards for Employees and DHS Employee Discipline policy to ensure compliance.

(HW8) If DDS staff determines that a provider did not adhere to regulations regarding the use of restrictive interventions, the DDS staff issues a deficiency and requires an Assurance of Adherence to Standards from the provider. DDS investigative staff may conduct an onsite investigation if determined necessary.

(HW 7) The Death Review Coordinator prepares an annual report that addresses any trend identified by the Committee as well as the identification of any prevention activities proposed because of any review. The report contains recommendations regarding specific actions such as:

1. Revision of provider or Division policy or forms,
2. Development of new provider or Division policy to address systemic issues discovered in the review process,
3. Training, either on a statewide or individual provider basis,
4. Facilitation of best practice, including new risk-prevention practices, through dissemination of recommendations for development of or modification to provider policies, or
5. Issuance of a statewide safety alert.

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ii. Remediation Data Aggregation

	Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix H: Quality Improvement Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies

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how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

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Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

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H.1 Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DDS and DMS, in consultation with a CMS technical assistance contractor, developed the framework for a Performance Measure report in May 2013 as the basis for the Quality Improvement System (QIS). The purpose of the Performance Measure report is to produce acceptable evidence for Arkansas' compliance with HCBS Subassurances. The Performance Measure report accomplishes this purpose by prioritizing areas of discovery, gathering data in those areas, analyzing trends among the data, and determining how best to implement system improvements.

DDS Quality Assurance (QA) staff and DDS Waiver staff refined the measurements within the framework. QA staff developed a format for the report and began gathering data on specific measures from sections for each subassurance in July 2013. The first Performance Measure Report was published in October 2013 and was reviewed by the DDS QA Committee on 10/22/13. A quarterly Performance Measure report has been reviewed at each QA Committee meeting since that time. The first Annual report was reviewed by the QA Committee on 07/21/14.

In addition to the Performance Measure Report, DDS performs an on-site review of each provider annually, reviews incident reports, performs investigations of service concerns, and performs Mortality Review. Information from these activities provide the data for the Performance Measure Report.

1) Roles and Responsibilities - DMS remains responsible for the administration and oversight of all Medicaid waivers, including those operated by other divisions. DMS Waiver Quality Assurance (QA) Administrator represents DMS in the development and implementation of the QIS and monitors each 1915(c) HCBS waiver. The DMS Waiver QA Administrator works closely with the operating agencies and serves as primary liaison with CMS regarding the waivers. This position serves to centralize responsibility and accountability for the waiver with DMS, and also provides leadership in promoting and improving quality in 1915(c) HCBS waivers. The DMS Waiver QA Administrator reports to the DMS Assistant Director, who keeps the DMS Director informed of concerns about and activities related to the waiver. The DMS Waiver QA Administrator serves on the DDS QA Committee.

The DDS Assistant Director for Waiver Services is responsible for the operation of the Waiver program. This includes helping design, develop and implement portions of the QIS for the Waiver. The DDS Assistant Director, managers and staff are responsible for technical assistance to providers, monitoring person centered service plan (PCSP) implementation by providers, financial and statistical reports, prior authorization of individual PCSP budgets, internal operations, application processing, the PCSP database system, participation on the DDS QA Committee and regular contact with people served.

The DDS QA Unit develops and reviews DDS' compliance with Performance Measures. The Performance Measure Report is posted quarterly and reviewed at DDS QA meetings. The DDS QA Unit performs an on-site review of each provider annually, reviews incident reports, performs investigations of service concerns, and performs Mortality Review.

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The DMS Waiver QA Unit reviews a representative sample of individual case files annually. This Unit reviews for compliance with assurances including level of care, PCSP, qualified providers, health and welfare, administrative authority, and financial accountability. The DMS Waiver QA Unit reports findings to the DMS Division Director, the DDS Assistant Director for Waiver Services and the DDS Assistant Director for Quality Assurance, advises on any needed remediation and tracks system improvements.

2) Processes to Establish Priorities and Develop Strategies for Remediation & Improvement - The DDS Waiver Program and Quality Assurance Assistant Directors and managers share Performance Measure Reports and other reports with DMS Waiver QA Unit, discuss findings of the reports, and address any issues or concerns. DDS and DMS establish priorities and develop strategies for any necessary remediation and system improvement. DDS personnel are responsible to track data, perform remediation activities, and report improvement to their Assistant Directors.

When major issues are identified that impact one or more of the Subassurances, the DDS Waiver Program and Quality Assurance Assistant Directors and managers will inform the DDS and DMS Directors and Assistant Directors and seek their input on the issues and any needed remediation.

3) Compiling and Communicating Quality Management Information - At the end of each Waiver year, the DMS QA Administrator will compile a report based on findings from DDS, DMS Quality Assurance, and the CMS 372 report. This annual report will include key information relevant to each subassurance, information about participation in and cost of the Waiver based on the CMS 372 report and information on any key findings, including status of remediation and improvement activities. The DMS QA Administrator will make the report available to DDS and DMS administrations.

4) Periodic Evaluation and Revision of the QIS - The QIS, including Performance Measure Reports, will be revised during implementation as DDS measures performance related to the subassurances and the evidence that is produced. The DMS Waiver QA Administrator and the DDS Waiver Program and Quality Assurance Assistant Directors and managers will meet annually to review and discuss the QIS, including the Performance Measure Report and to make any necessary changes. If the QIS is revised as a result of this annual review, the DMS Waiver QA Administrator will send the revised QIS to CMS.

DDS section responsibilities within the Quality Improvement Strategy are:

1) Quality Assurance:

- a) Provider Certification and Recertification
- b) Review of provider compliance with DDS Standards
- c) Intake and Referral and initial application for services
- d) Eligibility
- e) Service concern investigations
- f) Critical incident reviews
- g) Initial Informed Choice between institutional and community services
- h)

2) DDS Waiver Services:

- a) Annually and as requested - Informed Choice between institutional and community services.
- b) Application process monitoring
- c) Provider choice
- d) Oversight of implementation of Person Centered Services Plans (PCSPs)

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- e) Providing information on Participant's rights and responsibilities
- 3) DDS Children's Services
 - a) Intake and Referral and initial application for services
 - b) Initial Informed choice between institutional and community services

ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of monitoring and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Other Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Arkansas DDS has developed and implemented an HCBS Quality Improvement Strategy (QIS) that includes:

- 1) Continuous improvement process: In November of 2011, DDS convened a Quality Assurance (QA) Committee, made up of state agency staff, providers, and other stakeholders. This Committee meets at least quarterly.
- 2) Measures of program performance: DDS has developed robust measures of program performance though Performance Measures related to the subassurances.
- 3) Experience of care: DDS has conducted the National Core Indicator Adult Consumer Survey since July of 2006. During these seven survey cycles, DDS has improved its process and the transparency of its results. NCI survey data is available on the DDS webpage.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DDS and DMS will review the Quality Improvement Strategy (QIS) annually. Review consists of

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analyzing reports and progress toward stated initiatives, resolution of individual and systemic issues found through discovery and notating desired outcomes. When change in the strategy is indicated, a collaborative effort between DMS and DDS is set in motion to complete a revision to the QIS that may include changes for submission as an amendment of the Waiver to CMS. The collaborative process includes participation by the section or unit who has specific strategy responsibility with open discussion opportunity prior to a strategy change of direction.

Appendix I: Financial Accountability

PPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

MMIS claims data are audited periodically for program policy alignment; and claims processing worksheets are audited, processed and returned on a daily basis. Discovery and monitoring also includes an ongoing review of CMS-372 reports and CMS-64 reports.

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

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

DDS is responsible for reviewing billing claims activity for each provider with DDS Specialists conducting a 100% post payment financial audit annually. This audit consists of a paper review of paid services based on MMIS records as compared to DDS prior approved Waiver services for the PCSP

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being reviewed. This audit occurs prior to approval of all renewed PCSPs with providers required to justify any underutilization and correct any billing errors found. When payment is questioned, a referral is made to the DMS Program Integrity for onsite resolution.

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

DDS Individual File Reviews include a review of claims paid to provider agencies for services specified in the service plan. DMS arranges with DDS for a specified number of service plans to be reviewed annually as specified in the interagency agreement with DMS in their role as overseer. DMS conducts a retrospective review of identified program, financial and administrative elements critical to CMS quality assurance. DMS randomly reviews plans and ensures that they have been developed in accordance with applicable policies and procedures, that plans ensure the health and welfare of the participant and that financial components or prior authorizations, billing and utilization are correct and in accordance with applicable policies and procedures. DMS uses the sampling guide "A Practical Guide for Quality Management in Home & Community-Based Waiver Programs" developed by the Human Services Research Institute and the Medstat Group for CMS in 2006. A systematic random sampling of the active case population is drawn whereby every "nth" name in the population is selected for inclusion in the sample for Individual File Review. The sample size is based on a 95% confidence level with a margin of error of $\pm 5\%$. An online calculator is used to determine the appropriate sample size for the Waiver population. To determine the "nth" integer, the sample is divided by the population. Names are drawn until the sample size is reached. The sample is divided by twelve for monthly review. DMS oversight results are reconciled quarterly with DDS. Where applicable, individual actions are taken with the provider or DDS staff to correct any known non-compliance or questionable practices; sometimes a change in policy or procedure may be necessary when systemic issues are discovered. Corrective action plans are required if indicated by file review. Payment Integrity looks at the circumstances to determine if fraud is suspected. If so, Payment Integrity forwards the case to the Office of Medicaid Inspector General. If policy manual or rules change are indicated, a recommendation is made to the Medicaid Program, Planning and Development.

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

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

There are no generally accepted principles of statistical sampling; however, it is the goal of the data analytics department to ensure that the frames for the planned sample of claims are appropriate for the review and are composed of a representative sample of that provider's population. OMIG does not

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extrapolate overpayments, they only use statistically valid random sampling as a means to conduct a probe audit of a providers' claims when the sampling frame is too large for a full review.

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

1. Select a provider for review
2. Select a period to be reviewed
3. Define the claims universe, the sampling unit (number of recipients), and sampling frame (recipients to choose from)
4. Design a sampling plan and select the sample for review

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

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

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

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability Assurance**

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-assurances:

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a Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

a.i. Performance Measures

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

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

Performance Measure:	FA1: Number and percent of HCBS Waiver claims that were paid using the correct rate as specified in the HCBS Waiver application. Numerator: Number of claims paid at the correct rate; Denominator: Number of claims.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify:			
Recipient Claims History Profile			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Source (Select one) (Several options are listed in the on-line application): Other
If 'Other' is selected, specify:

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	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

FA2: Number and percent of reviewed claims with services specified in the PCSP.
Numerator: Number of claims with services specified in the PCSP; Denominator: Number of claims.

Data Source (Select one) (Several options are listed in the on-line application): **Other**

If 'Other' is selected, specify:

Recipient Claims History Profile

	Responsible Party for	Frequency of data	Sampling Approach
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State:

Effective Date

data collection/generation (check each that applies)	collection/generation: (check each that applies)	(check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	95% with a +/- 5% margin of error.
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
	<input type="checkbox"/> Other Specify:	
		<input type="checkbox"/> Other Specify:

Data Source (Select one) (Several options are listed in the on-line application): **Other**

If 'Other' is selected, specify:

DDS Quarterly QA Report

Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	95% with a +/- 5% margin of error.
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
	<input type="checkbox"/> Other Specify:	
		<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for	Frequency of data
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State:	
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data aggregation and analysis (check each that applies)	aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. **Sub-assurance:** The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

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

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

Performance Measure:	FA1: Number and percent of HCBS Waiver claims that were paid using the correct rate as specified in the HCBS Waiver application. Numerator: Number of claims paid at the correct rate; Denominator: Number of claims.		
Data Source (Select one) (Several options are listed in the on-line application): Other			
If 'Other' is selected, specify:			
Recipient Claims History Profile			
	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =

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	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Developmental Disabilities Services (DDS-operating agency) and the Division of Medical Services (DMS-the State Medicaid agency) participate in periodic team meetings to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DDS and DMS have an Interagency Agreement that includes measures related to financial accountability for the HCBS Waiver.

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The performance measure for number and percent of Waiver claims paid using the correct rate specified in the Waiver application will always result in 100% compliance because the rates for services are already set in MMIS; therefore, claims will not be paid at any other rate.

DDS's remediation for claims without specified services includes writing deficiencies to providers based on discovery of their failure to provide services specified in the PCSP, training providers and conducting a face-to-face visit with the participant to determine if there are negative outcomes as a result of the lack of services. DDS also reviews the file to determine if the provider has reported a lapse in services which may have resulted in a failure to provide services.

The tool used for record review captures and tracks remediation in these areas.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

N/A

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APPENDIX I-2: Rates, Billing and Claims

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Case Management - The monthly rate for case management is \$117.70. This rate is consistent with the rate paid for the preceding five years of this waiver.

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

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

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

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

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

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

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

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

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

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

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

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

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The waiver services included in the plan of care must be prior approved by DDS.

The rates included in this waiver were initially set in 1990. Arkansas proposed in the last waiver, effective [REDACTED], that it will submit an amendment to implement a new rate methodology for all services within 12 months. Arkansas also promised to provide a timeline for the new rate methodology within 3 months of the effective date of that amendment. In order to honor that commitment, Arkansas DMS and DDS are working with a third party vendor to conduct a comprehensive rate study of all HCBS Waiver services. AR will consult with CMS during the development of the rate methodology and will comply with all public notice requirements.

Timeline of rate methodology amendments:

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

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

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

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

- b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

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Providers bill directly through the state Medicaid Management Information System (MMIS).

c. **Certifying Public Expenditures** (*select one*):

<input checked="" type="radio"/>	No. State or local government agencies do not certify expenditures for waiver services.
<input type="radio"/>	Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid. <i>Select at least one:</i>
<input type="checkbox"/>	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). <i>(Indicate source of revenue for CPEs in Item I-4-a.)</i>
<input type="checkbox"/>	Certified Public Expenditures (CPE) of Local Government Agencies. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). <i>(Indicate source of revenue for CPEs in Item I-4-b.)</i>

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- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The assessed needs of each participant are identified by the provider case manager through a functional assessment. Services to meet assessed needs are authorized by DDS staff prior to the beginning of services through input into the MMIS system. MMIS edits prevent payment of unauthorized services or of amounts above the authorized limit. The provider case manager develops, oversees, and coordinates a written plan, called the Person Centered Service Plan (PCSP). Providers assure that services are delivered in accordance with the PCSP prior to billing for services.

Providers maintain case notes of each service day with the person served. Providers maintain administrative records such as timesheets and payroll records for provider staff. MMIS verifies eligibility of both the person and the billing provider prior to payment for billed services. DDS Waiver staff perform service-to-billing audits annually which include off-site desk review of 100% of files and on-site interview with 10% of people served. DDS Quality Assurance staff perform an on-site review of 100% of providers annually using interview, observation, and record review of a random sample of participants served by each provider.

To assure that claims through MMIS are processed correctly and in a timely manner, amounts and codes are compared to MMIS edits and the services and amounts that were prior authorized by DDS. DDS Provider Standards mandate that providers report any 30 consecutive day interruptions in the provision of services to a participant. These processes ensure that services are paid at the correct rate, billing does not exceed maximum approved amounts, and gaps in services are reported and investigated. When a provider becomes aware of errors, the provider performs remediation through adjusting the claim in error in future billings. DDS refers issues that were not or cannot be remediated through adjusted provider billing to the Medicaid audit unit for recoupment and other remedies.

The DDS Quality Assurance (QA) unit performs an on-site review of 100% of providers annually. When issues related to scope, frequency, or duration of services are discovered during this review or as the result of a complaint investigation, DDS refers issues to the Medicaid audit unit for adjusted billing, recoupment and other remedies and notifies the DDS Waiver unit of the referral. The MMIS system also edits for qualified providers by requiring an active certification date in the system. DDS QA works with the Medicaid MMIS contractor to insure timely and correct dates are entered into the system. The DDS Medicaid Income Eligibility Unit, a part of DDS QA, verifies that each person receiving waiver services has a valid code (W1) in the MMIS system before the first service can be billed. This assures that the person is approved for Medicaid prior to the delivery of services. MMIS requires prior authorization data to be entered by the DDS Waiver unit prior to the provider billing for services. Data fields include beginning and ending dates, total plan amount, and procedure codes. Adjustments may be made for a service set that includes more than one service, such as supportive living and respite.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

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APPENDIX I-3: Payment

a. Method of payments — MMIS (*select one*):

<input type="radio"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="radio"/>	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
<input type="radio"/>	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
<input type="radio"/>	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

<input type="checkbox"/>	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
<input checked="" type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input type="checkbox"/>	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
<input type="checkbox"/>	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

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- c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

<input checked="" type="radio"/>	No. The State does not make supplemental or enhanced payments for waiver services.
<input type="radio"/>	Yes. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

- d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

<input checked="" type="radio"/>	No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
<input type="radio"/>	Yes. State or local government providers receive payment for waiver services. Complete item I-3-e. Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish. <i>Complete item I-3-e.</i>

- e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

<input type="radio"/>	The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
<input type="radio"/>	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

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○	<p>The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.</p> <p>Describe the recoupment process:</p>

- f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

⊙	<p>Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.</p>
○	<p>Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.</p> <p>Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.</p>

g. **Additional Payment Arrangements**

- i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

⊙	<p>No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.</p>
○	<p>Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).</p> <p>Specify the governmental agency (or agencies) to which reassignment may be made.</p>

- ii. **Organized Health Care Delivery System.** *Select one:*

○	<p>No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.</p>
⊙	<p>Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.</p> <p>Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:</p>

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	<p>DDS has established an Organized Health Care Delivery System (OHCDS) option as per 42 CFR447.10(b) for certified HCBS Waiver providers. This is incorporated into the DDS ACS Waiver Provider Manual at § 201.200. Providers agree, in writing, to guarantee that the services of a subcontractor will comply with Medicaid regulations. The OHCDS provider assumes all liability for contract non-compliance. The OHCDS provider must provide at least one Waiver service directly utilizing its own employees. The OHCDS provider must also have a written contract that specifies the services and assures that work will be completed in a timely manner and be satisfactory to the person served. OHCDS is optional.</p> <p>DDS Quality Assurance reviews compliance with DDS Standards annually during an on-site visit. DDS reviews 10% of OHCDS files, up to 10 files.</p> <p>When OHCDS is used, the enrolled provider is required to have a duly executed sub-contract in place and must review and ensure financial accountability. The provider must ensure that services were delivered and proper documentation was submitted for services delivered under OHCDS.</p>
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iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

<input checked="" type="radio"/>	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
<input type="radio"/>	<p>The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.</p> <p>Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.</p>
<input type="radio"/>	<p>This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.</p>
<input type="radio"/>	<p>This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115f waiver specifies the types of health plans that are used and how payments to these plans are made.</p>

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APPENDIX I-4: Non-Federal Matching Funds

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

<input checked="" type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid agency
<input checked="" type="checkbox"/>	Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency. If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c: Developmental Disabilities Services receives state funding that is used for Medicaid Waiver match. The money is transferred to DMS through an interagency agreement.
<input type="checkbox"/>	Other State Level Source(s) of Funds. Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select one:*

<input checked="" type="radio"/>	Not Applicable. There are no local government level sources of funds utilized as the non-federal share.
<input type="radio"/>	Applicable <i>Check each that applies:</i>
<input checked="" type="checkbox"/>	Appropriation of Local Government Revenues. Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:
<input type="checkbox"/>	Other Local Government Level Source(s) of Funds. Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local

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		government agencies as CPEs, as specified in Item I-2- c:

- c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

<input checked="" type="radio"/>	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.
<input type="radio"/>	The following source(s) are used. <i>Check each that applies.</i>
<input type="checkbox"/>	Health care-related taxes or fees
<input type="checkbox"/>	Provider-related donations
<input type="checkbox"/>	Federal funds
For each source of funds indicated above, describe the source of the funds in detail:	

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

- a. **Services Furnished in Residential Settings.** *Select one:*

<input type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual.
<input checked="" type="radio"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Supplemental Security Income (SSI)/personal accounts are used to cover room and board costs and are maintained separately from HCBS Waiver reimbursements. Providers are prohibited from including room and board as any part of Waiver direct/indirect expense formulations.

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APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

<input checked="" type="radio"/>	No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
<input type="radio"/>	<p>Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.</p> <p>The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

<input checked="" type="radio"/>	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="radio"/>	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

i. Co-Pay Arrangement

Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services <i>(if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance

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<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>Specify:</i>

ii Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

--

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	Basis

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input checked="" type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

<input checked="" type="radio"/>	No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
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○	Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded; and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care (specify):							
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 7 less Column 4)
1							
2							
3							
4							
5							

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Appendix J-2: Derivation of Estimates

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1			
Year 2			
Year 3			
Year 4 (only appears if applicable based on Item 1-C)			
Year 5 (only appears if applicable based on Item 1-C)			

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-a.

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

--

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
	<u>manage components</u>
	<u>manage components</u>
	<u>manage components</u>
	<u>manage components</u>
	<u>manage components</u>
	<u>manage components</u>

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

<input checked="" type="radio"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input type="radio"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. **Estimate of Factor D – Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

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

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

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

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

State:	
Effective Date	

PROPOSED

State:	
Effective Date	

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

State:	
Effective Date	

- [illegible]

Appendix J-2: 9

Waiver Year: Year 2						
Waiver Service / Component	Col. 1 Check if included in capitation	Col. 2 Unit	Col. 3 # Users	Col. 4 Avg. Units Per User	Col. 5 Avg. Cost/ Unit	Col. 6 Total Cost
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

State:	
Effective Date	

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[illegible]