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Transmittal Sheet

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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Developmental Disabilities Services

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Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: Community and Employment Supports (CES) 1915 (c) Waiver, CES Provider Manual and Certification Standards for CES Providers

Intended Effective Date
(Check One)

- ☐ Emergency (ACA 25-15-204)
- ☑ 10 Days After Filing (ACA 25-15-204)
- ☐ Other _____ (Must be more than 10 days after filing date.)

	Date
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Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Becky Murphy — becky.murphy@dhs.arkansas.gov

Contact Person — E-mail Address — Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Rose M Naff
Signature

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Director
Title

9-19-17
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – DDS Community and Employment Supports (CES)**

EFFECTIVE DATE: **October 1, 2017**

SUBJECT: **Provider Manual Update Transmittal DDSCES-New-17**

REMOVE		**INSERT**	
Section	**Effective Date**	**Section**	**Effective Date**
		ALL	10-1-17

Explanation of Updates

A new DDS Community and Employment Supports (CES) policy manual is available for all DDS Community and Employment Supports (CES) providers.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

SECTION II - DDS COMMUNITY AND EMPLOYMENT SUPPORTS (CES)

CONTENTS

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

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

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 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 beneficiaries they will serve, drop an existing county they serve, a service, or service level, the provider must identify any beneficiary currently being served who would be affected. The provider will be required to continue providing services to any beneficiary who 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 beneficiary currently receiving services from the provider. The provider's maximum number of beneficiaries 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 beneficiaries 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 beneficiaries until such time as the transition to a new provider has occurred. 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 beneficiaries. Other than business reasons for closing entire counties or programs, beneficiaries can only be discontinued if the provider cannot assure health and safety.

Option: Based on individual choice, a provider may continue to serve a beneficiary 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 10-1-17

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 10-1-17

The DDS CES waiver allows a provider who is licensed and certified as a DDS CES care coordination 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 sub-contract with an entity qualified to furnish the service. The subcontract must ensure financial accountability and that services were delivered, properly documented and billed. The primary use of OHCDS is consultation, adaptive equipment, environmental modifications, supplemental support and specialized medical supplies.

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

202.000 Documentation Requirements 10-1-17

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 10-1-17

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 10-1-17

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.

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

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord/tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS 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 10-1-17

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 prevent 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 (7) days a week)

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 deemed ineligible for Medicaid and thus the waiver program.

211.100 Selection Process for Entrance to the Waiver 10-1-17

Selection for entrance into the waiver is as follows:

A. In order of waiver application eligibility determination date for persons determined to have successfully applied for the waiver, but whom through administrative error, were or are inadvertently omitted from the waiver wait list.

B. In order of waiver application eligibility determination date of persons for whom waiver services are necessary to permit discharge from an institution, i.e., ICF/IID residents, nursing facility residents, and Arkansas State Hospital patients; or admission to Supported Living Arrangements (group homes and apartments).

C. In order of date the Department of Human Services (DHS) custodian chose waiver services for eligible person in the custody of DHS Division of Children and Family Services or DHS Adult Protective Services.

D. In order of waiver application eligibility determination date for all other persons.

Selection for priority consideration is in the order identified above. When more than one category of priority is identified in a ranking, the order of release shall be by date of eligibility determination within each category. Releases occur only when there is a vacant waiver slot.

211.200 Risk Assessment 10-1-17

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: care coordinator 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 or is an inmate in a state or local correctional facility.

6. The person is deemed ineligible based on a 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 beneficiary or another person) are allowed in cases of emergency. An emergency exists for any of the following conditions:
   a. The beneficiary has not responded to de-escalation techniques and continues to escalate behavior
   b. The beneficiary is a danger to self or others
   c. The safety of the beneficiary 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 (3) times per month, use should be discussed by the interdisciplinary team and addressed in the plan of care. When emergency procedures are implemented, person-centered service plan 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. Providers' 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 beneficiaries 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 beneficiary.

   When the behavior plan is implemented, all use of restrictive interventions must be documented in the beneficiary'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
   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

d. Seclusion

These interventions might be implemented to deal with aggressive or disruptive behaviors related to the activity or possession. Staff, families and the beneficiary 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 beneficiary 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 beneficiaries. The plan must include a provision for alternative methods to avoid the use of restraints and seclusions.

The behavior management plan must

1. Be written or supervised by a qualified professional who is at minimum a Qualified Developmental Disabilities Professional (QDDP)
2. Be designed so that the rights of the individual are protected
3. Preclude procedures that are punishing, physically painful, emotionally frightening involve deprivation, or put the individual at medical risk
4. Identify the behavior to be decreased
5. Identify the behavior to be increased
6. 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
7. Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person
8. Identify the event that likely occurs right before a behavior of concern
9. Identify what staff should do if the event occurs
10. Identify what staff should do if the behavior to be increased or decreased occurs, and
11. 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 beneficiary.

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

E. Reports of Use of Restraints or Restrictive Interventions

All use of restraint must be documented in the beneficiary'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 unauthorized 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 10-1-17

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. Care Coordination Services

I. Consultation Services

J. Crisis Intervention Services

K. Community Transition Services

213.000 Supportive Living 10-1-17

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 an integrated community setting. 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. 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 their ability to reside as independently as possible in the community. The supports that may be provided to a beneficiary include:

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 beneficiary 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 beneficiary'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

1. Language skills
2. Increased 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. Coordinating all direct service workers who provide care through the direct service provider
2. Serving as liaison between the beneficiary, parents, legal representatives, care coordination 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 care coordination 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:
    a. 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.

b. Staff, at all times, are aware of the medications being used by the beneficiary.
c. Staff are knowledgeable of potential side effects of the medications being used by the beneficiary through the prescribing physician, nurse and pharmacist at the time medications are ordered.
d. All medications consumed are prescribed or approved by the beneficiary's physician or other health care practitioner.
e. The beneficiary or legally responsible person is informed by the prescribing physician about the nature and effect of medication being consumed and consents to the consumption of those medications prior to consumption.
f. 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 care coordinator at least monthly.
g. If psychotropic medications are being used for behavior, the direct care supervisor and care coordinator are responsible to assure appropriate positive behavior programming is present and in use with programming reviews at least monthly.
h. The consumption of medications is monitored at least monthly by the direct care supervisor to ensure that they are accurately consumed as prescribed.
i. Toxicology screenings are conducted on a frequency determined by the prescribing physician with care coordinator oversight.
j. 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 care coordinator at least monthly.
k. Medications are regularly reviewed to monitor their effectiveness, to address the reason for which they were prescribed and for possible side effects.
l. 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.
m. Frequency of monitoring is based on the physician's prescription for administration of medication.
n. 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 or recoupment of payment of services.

Beneficiaries 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 review with providers responsible

for maintaining adequate time records and activity case notes or activity logs that support the service deliveries. A 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 made only 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 care coordinator. Retainer payments may be made to providers of habilitation while the waiver beneficiary is hospitalized or absent from his/her home.

213.100 Supportive Living Arrangements (Provider owned group homes or apartments) 10-1-17

Persons residing in supportive living arrangements are eligible for the same services and service level as any other waiver participant. Staff working in such arrangements must have hours of compensation prorated according to the number of individuals, waiver and non-waiver, residing in the supportive living arrangement. Additional one-on-one staffing may be provided when the need is justified. Supportive living arrangements include:

A. Existing group homes serving groups of no more than 14 unrelated adults (age 18 and older) with developmental disabilities in the residential setting.

B. Existing DDS licensed supportive living apartments serving up to 4 unrelated adults (age 18 and older) with developmental disabilities in each self-contained apartment unit up to the total number of licensed units in the complex.

C. Adults served in their family home, in their own home or in an integrated apartment complex or in an alternative living setting with no more than 4 unrelated adults with developmental disabilities in the home.

D. Children served in their family home or in an alternative family with no more than 4 unrelated children with developmental disabilities in the home.

Exception: Only those supportive living apartments and group homes licensed by the DDS prior to July 1, 1995, are approved to serve more than 4 adults. No expansions will be approved beyond the July 1, 1995, total capacity (waiver and non-waiver).

213.200 Supportive Living Exclusions 10-1-17

Only hired caregivers may be reimbursed for supportive living services provided.

The payments for these services exclude the costs of room and board, including general maintenance, upkeep or improvement to the beneficiary's own home or that of his or her family.

Routine care and supervision for which payment will not be made are defined as those activities that are necessary to assure a person's well-being but are not activities that directly relate to active treatment goals and objectives.

It is the responsibility of the provider to assure compliance with state and federal Department of Labor wage and hour laws.

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

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

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

Exclusions:

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

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

C. Educational aids are not included.

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

E. Computer supplies.

F. Computer desks or other furniture items are not covered.

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

213.300 Benefit Limits for Supportive Living 10-1-17

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 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 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 and do not exceed the maximum daily rate.

See Section 260.000 for billing information.

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

214.000 Respite Services 10-1-17

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. Group home.

E. Licensed respite facility

F. Other community residential facility approved by the state, not a private residence

G. Licensed or accredited residential mental health facility

214.100 Benefit Limits for Respite Services 10-1-17

The maximum daily rate for the supportive living array, which includes both supportive living and respite services, collectively or individually is based upon the tier 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 10-1-17

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 if 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. 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. Plan for how many employers will be contacted each week
      h. 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.
   3. 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 10-1-17

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 10-1-17

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 person-centered service plan, the beneficiary's progress notes, and the Arkansas Rehabilitation Services Referral to demonstrate compliance and delivery of service.

For Job Development Plan 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 statement (paycheck stub) 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 10-1-17

Discovery/Career Planning: Allowed maximum is 50 hours per week over a six-week period to complete the activities and create the Individual Career Profile. There is an outcome payment upon submission of the Profile and required documentation.

Employment Path: Allowed maximum is 25 hours per week alone or combined with Employment Supports in 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 $3000.00. 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. The 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 10-1-17

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 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 beneficiary. The waiver does not cover supplies. Printers may be approved for non-verbal beneficiaries.

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 beneficiary 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 (2) 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. Computer supplies.

C. Computer desk or other furniture items are not covered.

D. 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 10-1-17

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 themselves 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 amount allowed.

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 and the modification to the vehicle.

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

A PERS may be approved when it can be demonstrated as necessary to protect the health and safety of the beneficiary. A 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. A 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 10-1-17

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

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 10-1-17

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 10-1-17

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 care coordinator. 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 10-1-17

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 10-1-17

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

218.000 Specialized Medical Supplies 10-1-17

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 10-1-17

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

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 10-1-17

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 10-1-17

219.200 Supplemental Support Service Benefit Limits 10-1-17

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.

220.000 Care coordination Services 10-1-17

Care coordination is ensuring that specialty services are coordinated and appropriately delivered by specialty providers. Care Coordination will be provided to waiver beneficiaries until they are attributed to a PASSE. Care Coordination is not available to beneficiaries who have been

attributed to a PASSE. These beneficiaries will receive care coordination through the PASSE entity.

Care Coordination includes the following activities:

A. Health education and coaching;

B. Coordination with other healthcare providers for diagnostics, ambulatory care, and hospital services;

C. Assistance with social determinants of health, 3 such as access to healthy food and exercise;

D. Promotion of activities focused on the health of a patient and the community, including without limitation outreach, quality improvement, and patient panel management;

E. Coordination of Community-based management of medication therapy.

The care coordinator is responsible for the total plan of care for each beneficiary assigned to him or her. This includes, but is not limited to, the following:

A. Behavioral Health Treatment Plan;

B. Person-Centered Service Plan;

C. Primary Care Physician Care Plan;

D. Individualized Education Program;

E. Individual Treatment Plans for developmental clients in day habilitation programs;

F. Nutrition Plan;

G. Housing Plan;

H. Any existing Work Plan;

I. Justice system-related plan;

J. Child welfare plan; or

K. Medication management plan.

The care coordinator is responsible for obtaining copies of all treatment and service plans related to an individual beneficiary and coordinating services between those plans. The goal is to prevent duplication of services, ensure timely access to all needed services, and identify any service gaps for the beneficiary. The ultimate goal of the care coordinator is to assist the beneficiary in remaining in the most appropriate and least restrictive setting for that beneficiary.

Other services provided by the care coordinator include:

A. Coordinating and arranging all CES waiver services and other state plan services;

B. Identifying and accessing needed medical, social, educational and other publicly funded services (regardless of funding source);

C. Identifying and accessing informal community supports needed by eligible beneficiaries and their families.

D. Monitoring and reviewing services provided to the beneficiary to ensure all plan services are being provided and to ensure the health and safety of the beneficiary;

E. Facilitating crisis intervention;

F. Providing guidance and support to meet generic needs;

G. Conducting appropriate needs assessments and referral for resources;

H. Monitoring services provided to ensure quality of care and case reviews which focus on the beneficiary's progress in meeting goals and objectives established on existing case plans;

I. Providing assistance relative to obtaining waiver Medicaid eligibility and ICF/IID level of care eligibility determinations;

J. Ensuring submission of timely (advanced) and comprehensive behavior and assessment reports, continued PCSPs, revisions as needs change and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;

K. Arranging for access to advocacy services as requested by beneficiary.

L. Providing assistance upon receipt of DDS or DHS notices or denials, including assistance with the reconsideration and appeal process.

The care coordinator will also be responsible for assisting the beneficiary with transitioning between service settings, for example with transition from the residential treatment setting to community based care.

Care coordination services must be available to attributed beneficiaries 24 hours a day through a hotline or web-based application.

If a beneficiary has already been assigned to or selected a PCP or PCMH, that PCP or PCMH will be responsible for coordinating the beneficiary's medical care. If the beneficiary does not have a PCP selected, care coordinator must assist the beneficiary with selecting a PCP or provide a referral to a PCP.

A care coordinator cannot have more than 50 beneficiaries on its caseload at any one time. The care coordinator must make a monthly face-to-face contact with each beneficiary assigned. The care coordinator must also obtain all treatment plans for the beneficiary and obtain all medical records for the beneficiary in order to adequately coordinate services, identify health needs, and provide health coaching and health education.

If the beneficiary is seen in an emergency room or urgent care clinic or is admitted to an acute inpatient psychiatric facility, the care coordinator must follow up with the beneficiary within seven (7) days of discharge from the facility. The follow up visit is to ensure that all discharge instructions are being followed and any follow-up appointments have been scheduled. Care coordination services must be available to attributed beneficiaries 24 hours a day.

Care Coordination 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. Care Coordination 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 care coordination 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; and

C. Provides will administratively separate care coordination functions and staff and direct care functions and staff.

Care Coordination services are available at two tiers of support. They are:

Tier 2 – The individual meets the institutional level of care criteria but does not currently require 24 hours a day of paid support and services to maintain his or her current placement.

Tier 3 – The individual meets the institutional level of care criteria and does require 24 hours a day of paid support and services to maintain his or her current placement.

The minimum requirement for service contacts is a monthly face-to-face contact. After the initial contact, the monthly contact can be made via videoconferencing.

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 or stabilization. Monthly contacts shall continue when a beneficiary is in abeyance.

See Section 260.000 for billing information.

220.010 Person-Centered Service Plan Development 10-1-17

Person-Centered Service Plan Development is a service provided through supportive living that consists of the development of the PSCP. The Person-Centered Service Plan is a treatment plan developed and driven by the beneficiary and/or parent or guardian to deliver specific services to enhance and maintain community living, support the person in all major life activities, determine the person's choices about their life, assist the person in carrying out those choices, access employment services, and assist the person with integrating into the life and activities of his or her community. The Person-Centered Service Plan Developer is responsible for developing and implementing the PCSP.

Person-Centered Service Plan Development may be billed when the beneficiary enters the Waiver and must be reviewed at least annually or more frequently if there is documentation of a significant change of condition that requires an update in the beneficiary's treatment plan.

Yearly maximum of 1 per year (prior authorization for additional PCSP development can be requested).There will be a maximum rate of $90.00 per Plan development.

220.100 Transitional Care Coordination 10-1-17

Care coordination services may be available during the last 180 consecutive days of a Medicaid eligible person’s institutional stay to allow care coordination activities to be performed related to transitioning the person to the community. The person must be approved and in the waiver program for care coordination to be billed.

220.200 Benefit Limits for Care Coordination 10-1-17

The maximum reimbursement limit per beneficiary is $173.33 per month.

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.

221.000 Consultation Services 10-1-17

Consultation services are clinical and therapeutic services that 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 trainers
10. Certified communication and environmental control specialists
11. Dietitians
12. Rehabilitation counselors
13. Recreational therapists
14. Qualified Developmental Disabilities Professionals (QDDP)
15. Positive Behavioral Supports (PBS) Specialists
16. Behavior Analysts

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. Providing 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

221.100 Benefit Limits for Consultation Services 10-1-17

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

See Section 260.000 for billing information.

222.000 Crisis Intervention Services 10-1-17

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 10-1-17

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 10-1-17

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.

224.000 Payment to Relatives or Legal Guardians 10-1-17

Payment for waiver services will not be made to the adoptive or natural parent, step-parent or legal representative or legal guardian of a beneficiary less than 18 years old. Payments will not be made to a spouse or a legal representative for a beneficiary 18 years of age or older. The employment of eligible relatives (regardless of the waiver beneficiary's age) shall require prior approval from DDS authority.

Payment to relatives, other than parents of minor children, legal guardians, custodians of minors or adults, or the spouse of adults, must be prior approved by DDS to provide services. 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 approved as a paid service provider. Qualified relatives, other than as specified in the foregoing, can provide any service.

In no case will a parent or legal guardian be reimbursed for the provision of transportation for a minor.

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 day-to-day supervision and monitoring of the direct-care staff; care coordinators are responsible for periodically reviewing with the beneficiary any problems in care delivery and reporting any deficiencies to the Waiver DD Specialist and DDS Quality Assurance provider certification staff. DDS specialists conduct a 100% review of service utilization for each person-centered service plan at the time of each plan of care 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.

230.000 Eligibility Assessment 10-1-17

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

A. Determination of categorical eligibility

B. Institutional level-of-care determination

C. Comprehensive diagnosis and evaluation, including an independent assessment for functional need

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 10-1-17

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 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 (3) months prior to the receipt of the Medicaid application, whichever is less.

230.200 Level of Care Determination 10-1-17

Based on intellectual and behavioral assessment submitted by the provider, the ICF/IID level of care determination is performed by the Division of Developmental Disabilities. The ICF/IID 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/IID.

B. Need institutionalization in an ICF/IID 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/IID level of care.

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

230.210 Tiers of Support 10-1-17

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

Tier 3: The individual meets the institutional level of care criteria and does require 24 hours a day of paid support and services to maintain his or her current placement.

Tier 2: The individual meets the institutional level of care criteria but does not currently require 24 hours a day of paid support and services to maintain his or her current placement.

Tiers will be determined through an independent assessment conducted by a third-party vendor that will assess the beneficiary in three (3) areas. Refer to the Independent Assessments and Developments Screens provider manual for a complete listing of areas addressed.

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 10-1-17

A comprehensive diagnosis and evaluation (D&E) must be administered in order to determine that applicants are persons with a developmental disability and meet institutional level of care prior to receiving CES waiver services from 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 care coordination 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 10-1-17

During the initial sixty (60) days of DDS CES waiver services, a beneficiary receives services based on a DDS pre-approved interim person-centered service plan that provides for care coordination 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 care coordination 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, including a person-centered service plan developer, 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 care coordinator, 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 care coordinator is required to ensure 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 that safeguards the beneficiary's rights.

F. Documented carefully, with assurance that appropriate records will be maintained.

G. Will assure the beneficiary's and others' health and safety. The person-centered service plan development process identifies risks and makes sure that they are addressed through backup plans and risk management agreements, including how and who will be responsible for ongoing monitoring of risk level and risk management strategies, and how staff will be trained regarding those risks. A complete description of backup arrangements must be included in the person-centered service plan. All strategies must be designed to respect the needs and preferences of the beneficiary. All risk management strategies must be analyzed by the team at least quarterly as part of the PCSP review.

H. Consider cost-efficient options that foster independence, such as shared staffing and other adaptions. When such options are not utilized in the PCSP for a Tier 3 participant, it must be documented that the participant's health and safety require one-on-one staffing, 24 hours a day.

The Person-Centered Service Plan Developer will be responsible for the development and implementation of the PSCP.

230.410 Person-Centered Service Plan Required Documentation 10-1-17

A. General Information

Identification information must include:

1. Beneficiary's full name and address
2. Beneficiary's Medicaid number
3. Guardian or Power of Attorney with an address (when applicable)
4. Number of individuals with ID/IID 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. 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 care coordination provider, care coordinator, supportive living provider, and direct care supervisor

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

D. The person-centered service plan must include:

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

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

240.000 PRIOR AUTHORIZATION 10-1-17

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 10-1-17

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

A. The DDS prior authorization process requires that all Tier 3-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 care coordinator.
2. The DDS Person-Centered Service Plan 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 beneficiary 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 care coordination provider, with cooperation from the procurement source, to satisfy the request(s) within the prescribed time frames.

H. It is the responsibility of the care coordination 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 sixty (60) days of DDS CES waiver services based on a DDS pre-approved interim service plan. The pre-approved interim plan will include care coordination 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 care coordination, the sixty (60)-day interim plan begins with the date of discharge.

1. At any time during the initial sixty (60) days or transitional care coordination period, the PCSP Developer 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.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 10-1-17

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 a 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.

252.000 Rate Appeal Process 10-1-17

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program or provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she wishes, for a full explanation of the factors involved and the Program decision. Following review, the Assistant Director will notify the provider of the action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the program and/or provider conference.

When the provider disagrees with the decision made by the Assistant Director of the Division of Medical Services, the provider may appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department Human Services (DHS) management staff, who will serve as chairperson.

The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director of the Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the questions and a recommendation will be submitted to the Director of the Division of Medical Services.

260.000 BILLING PROCEDURES

261.000 Introduction to Billing 10-1-17

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 10-1-17

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	Care coordination Services	1 Month	12, 99, 14
T2025			Y	Consultation Services	1 Hour	12, 99, 14
T2028			Y	Specialized Medical Equipment	1 Package	12, 99,14
T2020	UA	U1	Y	Community Transition Services	1 Package	99, 14, 54
T2022	U2		Y	Transitional Care coordination	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

262.100 National Place of Service (POS) Codes 10-1-17

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Codes
Patient's Home	12
Other	99
Group Home	14
ICF/IID	54

262.200 Billing Instructions - Paper Only 10-1-17

DHS' fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.

Bill Medicaid for professional services with form CMS-1500. **View a sample form CMS-1500.** Field Code Changed

Carefully follow these instructions to help the fiscal agent efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the fiscal agent's claims department. **View or print fiscal agent claims department contact information.** Field Code Changed

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

262.210 Completion of CMS-1500 Claim Form 10-1-17

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.

Field Name and Number		Instructions for Completion
	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.
	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.

Field Name and Number	Instructions for Completion
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.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.

Field Name and Number	Instructions for Completion
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.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.

Field Name and Number		Instructions for Completion
24A.	DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B.	PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.100 for codes.
C.	EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D.	PROCEDURES, SERVICES, OR SUPPLIES	
	CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Section 262.000.
	MODIFIER	Modifier(s) if applicable.
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any beneficiary of the provider’s services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
	NPI	Not required.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider’s Medicaid file. If it changes, please contact Provider Enrollment.

Field Name and Number	Instructions for Completion
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.
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.

262.300 Special Billing Procedures 10-1-17

Not applicable to this program.

Arkansas Department of Human Services

Division of Developmental Disabilities Services

DDS COMMUNITY AND EMPLOYMENT SUPPORTS (CES) WAIVER MINIMUM CERTIFICATION STANDARDS

EFFECTIVE OCTOBER 1ST, 2017

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100 ORGANIZATIONAL/MANAGEMENT REQUIREMENTS AND SOLICITATION

101. Organizational Requirements

1. Standards are not comprehensive: These DDS Community and Employment Supports Waiver Minimum Certification Standards ("**Certification Standards**") establish those Provider policies, activities, and areas where DDS Quality Assurance will monitor Provider compliance.

   However, these Certification Standards do not contain a comprehensive listing of all laws, statutes, guidelines, or other rules and regulations with which a Provider must comply. Depending on the services or programs a Provider chooses to offer and participate in, there may be other federal, state and local statutes, acts, and regulations with which a Provider must comply, including, but not limited to, the following:

   - Health Insurance Portability and Accountability Act
   - Freedom of Information Act
   - Individuals with Disabilities Education Act
   - American with Disabilities Act
   - Federal Privacy Act
   - Developmental Disabilities Assistance & Bill of Rights Act.

   DDS Quality Assurance has the right to sanction Provider non-compliance with any laws, statutes, guidelines, or other regulations not found in the Certification Standards applicable to a Provider.

2. Provider Governing Documents Available for DDS Inspection: All governing documents, policies, procedures, or other equivalent operating documents of a Provider shall at all times be readily available for DDS inspection and review upon request.

3. Legal Existence and Good Standing: A Provider shall at all times be duly organized, validly existing and in good standing as a legal entity under the laws of the State of Arkansas, with the power and authority under the appropriate federal, state or local statues to own and operate its business as presently conducted.

4. Provider Name and Control Changes:

   a. *Name Changes*: Any change to the legal name of a Provider or the name under which a Provider conducts business in the State of Arkansas must be reported to DDS Quality Assurance within seven (7) days.

b. *Control Changes*: Any change in the control of a Provider must be reported to DDS within seven (7) days. A "change in control" shall mean a change in the Executive Director or other titled position that is considered the highest position of authority for the Provider.

5. Governing Body Requirement: Each Provider's governing body shall include at least one individual with developmental disabilities as an ex officio member (see Ark. Code Ann. § 20-48-705).

6. Provider Inability to Continue as Going Concern: If DDS receives information that would reasonably cause it to doubt a Provider's ability to continue as a going concern, DDS Quality Assurance has the right to demand that the Provider present evidence that the Provider is still able to safely provide services in full compliance with these Certification Standards. Examples of actions or events that might trigger this concern include, but are not limited to, IRS liens, threats to revoke non-profit status, and the inability to pay employees, subcontractors, or others.

102. Management Requirements

1. DDS QA Point of Contact: Each Provider must appoint a single member of management as the point of contact for all DDS Quality Assurance matters. This manager must have authority over all Provider employees, and would have sole responsibility for ensuring that DDS Quality Assurance's requests, concerns, and inquiries are investigated and carried out.

2. Executive Director. Each Provider must appoint an Executive Director, or other titled officer position, that is vested with the authority and responsibility of overseeing all day-to-day Provider operations.

103. Organized Health Care Delivery System

DDS has established an optional Organized Health Care Delivery System election as per 42 C.F.R. 447.10(b) for Providers. A Provider must deliver to DDS, in writing, a guarantee that the Provider will ensure the services of each subcontractor will comply with all Medicaid regulations and the Certification Standards. The Provider assumes all liability for subcontractor non-compliance. The Provider must deliver at least one HCBS Waiver service utilizing its own employees. DDS Quality Assurance's annual review will determine compliance with the Certification Standards.

The Provider is required to have a duly executed subcontract in place that specifies the services to be rendered and assures that services will be completed by the subcontractor in a timely manner and be satisfactory to the beneficiary. The Provider is also responsible for the financial accountability of any subcontractor by ensuring that subcontractor services were delivered and proper documentation was submitted.

104. Solicitation

Solicitation of a beneficiary by a Provider is strictly prohibited, and a Provider that is found to be engaging in solicitation of a beneficiary will be subject to enforcement remedies. "Solicitation" means when a Provider (through its employees, owners, independent contractors, family members, or other agents) attempts to influence a beneficiary (or his or her family/guardian). Examples of prohibited solicitation include, but are not limited to, the following:

1.) Contacting a beneficiary or their family currently receiving services from another Provider to induce them to choose/switch Providers;

2.) Offering cash or gift incentives to a beneficiary or their family to induce them to choose/switch Providers;

3.) Offering free goods and/or services not available to other similarly stationed beneficiaries or their families to induce them to choose/switch Providers;

4.) Refusing to provide access to entitlement services for which the beneficiary is eligible if the beneficiary or their legal guardian selects another Provider for services;

5.) Making negative comments to a beneficiary or their family regarding the quality of services performed by another Provider;

6.) Promising to provide CES home and community based waiver services or other services in excess of those necessary to induce a beneficiary or their legal guardian to choose the Provider;

7.) Directly or indirectly giving a beneficiary or their family the false impression that the Provider is the only Provider that can perform the services desired by the beneficiary or their family; and

8.) Engaging in any activity that DDS Quality Assurance reasonably determines was intended to be "solicitation" as defined herein.

Marketing by a Provider is distinguishable from solicitation and is considered an allowable practice. Examples of acceptable marketing practices include, but are not limited to: (i) advertising using traditional media; (ii) distributing brochures and other informational materials regarding the services offered by a Provider; (iii) conducting tours of a Provider to interested beneficiaries; (iv) mentioning other services offered by the Provider in which a beneficiary might have an interest; and (v) hosting informational gatherings during which the services offered by a Provider are honestly described. All marketing must be factual and honestly presented, or a Provider could be subject to enforcement remedies.

200 HIRING PROCEDURES & PERSONNEL RECORD MAINTENANCE

201. Hiring Procedures and Required Personnel Records

A. Prior to Employment

The Provider must obtain and verify each of the following from an applicant prior to employment:

1. A completed job application that includes all the applicant's required current and up-to date credentials.
2. A signed criminal conviction statement.
3. All required criminal background checks, as outlined in DDS Policy #1087 (A.C.A. § 20-38-101 et. seq. and §20-48-812, or any applicable successor statutes). DDS requires criminal background checks for the applicant, their spouse, and any children or other adult over the age of eighteen (18) if a beneficiary is to be permitted to stay overnight in an applicant's residence.
4. A signed declaration of truth of statement.
5. Completed reference checks.
6. A successfully passed drug screen.
7. If the applicant is applying for a position where transportation is required, a current and valid driver's license or a commercial driver's license (CDL), as appropriate.

B. Post-Employment

The Provider shall obtain and verify within thirty (30) days of an applicant's employment:

1. A completed Adult Maltreatment Central Registry check (see A.C.A. § 12-12-1716, or any successor statutes), or a second submission request if a response has not been received. An Adult Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adult over the age of eighteen (18) that resides in a residence where a beneficiary is approved and permitted to stay overnight.

2. A completed Child Maltreatment Central Registry check (A.C.A. § 12-18-901 et. seq., or any successor statutes), or a second submission request if a response has not been received. A Child Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adult over the age of eighteen (18) that resides in a residence where a beneficiary is approved and permitted to stay overnight.

3. A successfully passed criminal background check for the employee, their spouse, and any children or other adult over the age of eighteen (18) residing in a residence where a beneficiary is approved and permitted to stay overnight.

The Provider shall maintain the above documentation in the employee's personnel file for at least one (1) year following termination of employment.

C. Required Follow-up Checks

The child maltreatment registry checks required upon hiring in Section 201 must be repeated for each employee at least once every two (2) years. The criminal background and adult maltreatment registry checks required upon hiring in Section 201 must be repeated for each employee at least once every five (5) years. Failure to pass any required follow-up check at any time requires that the employee immediately cease unsupervised contact with beneficiaries.

D. New Information after Employment

If DDS or the Provider receives additional information after hiring that creates a reasonable belief that an employee has had a change in status in connection with one of the requirements in Section 201 (A) or (B) above (i.e. a license has been revoked/expired, an employee would no longer pass a criminal background and/or registry check, etc.), then the Provider must verify that the employee still meets all requirements for employment.

E. Exception

Any applicant who submits evidence of holding a current professional license is exempt from the criminal background, adult maltreatment and child maltreatment check requirements of this Section.

202. Job Description Requirements

The Provider shall create written job descriptions for each position offered that describe the duties, responsibilities, and qualifications for such staff position. In addition, the job description shall include the physical and educational qualifications and licenses/certifications required for each position. All employees that require a professional license must maintain current credentials.

203. Sub-Contractors/Volunteer/Interns

Each Provider must ensure that sub-contractors, students, interns, volunteers, and trainees or any other person who has regular, routine contact with beneficiaries are in compliance with all the requirements applicable to an "employee" that are contained in this Section 200. The classification of a worker as something other than an "employee" will not negate the responsibilities of the Provider under this Section 200.

300 INCIDENT REPORTING

301. Reportable Incidents

Providers must submit an incident report to DDS Quality Assurance using the automated form DHS 1910 via secure e-mail upon the occurrence of any one of the following events:

1. Death of beneficiary.

2. The use of any restrictive intervention, including seclusion, or physical, chemical, or mechanical restraint on a beneficiary.

3. Suspected maltreatment or abuse of a beneficiary.

4. Any injury to a beneficiary that:

    - Requires the attention of an Emergency Medical Technician, a paramedic, or physician
    - May cause death
    - May result in a substantial permanent impairment
    - Requires hospitalization

5. Threatened or attempted suicide by a beneficiary.

6. The arrest of a beneficiary, or commission of any crime by a beneficiary.

7. Any situation in which the whereabouts of a beneficiary is unknown for more than two (2) hours (i.e. elopement and/or wandering), or where services are interrupted for more than two (2) hours.

8. Any event where a staff member threatens a beneficiary.

9. Unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary.

10. Medication errors made by staff that cause or have the potential to cause serious injury or illness to a beneficiary, including, but not limited to, loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time, by the wrong route, and the administration of the wrong medication.

11. Any violation of a beneficiary's rights that jeopardizes the health, safety, or quality of life of the beneficiary.

12. Any incident involving property destruction by a beneficiary.

13. Vehicular accidents involving a beneficiary.

14. Biohazard incidents involving a beneficiary.

15. An arrest or conviction of a staff member providing direct care services.

16. Any use or possession of a non-prescribed medication or an illicit substance by a beneficiary.

17. Any other event that might have resulted in harm to a beneficiary or could have reasonably endangered the health, safety, or welfare of the beneficiary.

In addition to submitting incident reports for the reportable incidents described above to DDS Quality Assurance using the automated form DHS 1910 via secure e-mail, Providers are to also forward a copy of each incident report to the appropriate DDS Regional Area Group email address. This requirement also applies to any required follow-up incident reports described in Section 303. The DDS Regional Area Group email addresses are as follows:

DHS.DDS.Central@arkansas.gov
DHS.DDS.NorthCentral@arkansas.gov
DHS.DDS.Northeast@arkansas.gov
DHS.DDS.Northwest@arkansas.gov
DHS.DDS.Southeast@arkansas.gov
DHS.DDS.Southwest@arkansas.gov

Providers should contact DDS Waiver Services with any questions regarding the appropriate DDS Regional Area Group email.

302. Reporting Timeframes

A. Immediate Reporting

Providers must report the following incidents to the DDS Quality Assurance emergency number ((501) 765-9018) within one (1) hour of occurrence, regardless of hour:

- Suicide
- Death from adult abuse
- Death from child maltreatment
- Serious injury

B. Incidents Involving Potential Publicity

Incidents, regardless of category, that a Provider should reasonably know might be of interest to the public and/or media must be immediately reported to DDS Quality Assurance in central office if

during business hours, and to the DDS Quality Assurance emergency number ((501) 765-9018), if after business hours.

C. All Other Incident Reports

Except as otherwise provided above in subsection A and B, all reportable incidents must be reported to DDS Quality Assurance using the automated form DHS 1910 via secure e-mail no later than two (2) days following the incident. Any incident that occurs on a Friday is still considered timely if reported by the Monday immediately following.

303. Required Incident Report Contents

A. Initial Incident Report: Each initial incident report filed by a Provider must contain the following information:

1. Date of the incident
2. Detailed description of the accident/injury
3. Time of the incident
4. Location of incident
5. Persons involved in the incident
6. Other agencies contacted regarding incident, and the name of the individual in the agency that was contacted
7. Whether the guardian was notified of the incident and time of notification,
8. Whether the police were involved, and if so, a detailed description of their involvement
9. Any action taken by Provider or staff of Provider, both at the time of the incident and subsequent to the incident
10. Any expected follow-up
11. Name of person that prepared the report

When applicable, the Provider shall notify the parent or legal guardian of the beneficiary any time an incident report is submitted.

B. Follow-up Incident Reports: Information that is not available at the time of the initial incident report filing must be submitted in follow-up or final incident reports. These reports should be submitted in the same manner as soon as the additional information becomes available.

- The initial report should be resubmitted with the "follow-up" or "final" report areas checked and dated in the appropriate space on the incident report form.

- The current date should precede the new information in the text/narrative sections to differentiate follow-up information from the information originally submitted.

- A new form DHS-1910 should be submitted for follow-up and final reports only when there is insufficient space on the original form. Whenever a new form is submitted, the date of the original written report must be included for cross-referencing.

304. Mandated Reporters

The Arkansas Child Maltreatment Act and the Arkansas Adult Maltreatment Act deem all staff of Providers to be mandated reporters of any suspected adult or child abuse, neglect, exploitation, and maltreatment. Failure on the part of a Provider to properly report suspected abuse, neglect, exploitation, and maltreatment to the appropriate hotline is a violation of these Certification Standards.

400 BENEFICIARY AND LEGAL GUARDIAN RIGHTS

401. Beneficiary/Guardian Rights Policy

Each Provider must implement policies that enumerate in clear and understandable language each beneficiary's rights and the rights of the legal guardian of each beneficiary. The Provider must take reasonable steps to ensure beneficiaries and their legal guardians are: (i) informed of their rights; (ii) provided copies of the policies enumerating their rights prior to the initiation of services and at any other time upon request; and (iii) that the information is transmitted in a manner that the beneficiary and their legal guardian are able to read and understand.

402. Beneficiary Rights

Each Provider must, at a minimum, ensure the following beneficiary rights:

1. The right to be free from:

    - physical or psychological abuse or neglect
    - retaliation
    - coercion
    - humiliation
    - financial exploitation

    The Provider must ensure that the application of corporal punishment to beneficiaries is prohibited. "Corporal punishment" refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.

2. The freedom to control their own financial resources.

3. The freedom to receive, purchase, possess, and use individual personal property. Any restriction on this right must be supported by an assessed need and justified in the beneficiary's person centered service plan ("**PCSP**").

4. The freedom to actively and meaningfully make decisions affecting their life and access pertinent information in a timely manner to facilitate such decision making.

    - If a beneficiary is age eighteen (18) or older, he/she is considered competent unless there is a court appointed legal guardian. Competent adults must always sign their own consents, releases, or other documentation requiring a signature.

    - A beneficiary who has a court appointed legal guardian retains all legal and civil rights except those which have been expressly limited by the court in the court

order, or which have been specifically granted to the legal guardian pursuant to the court order.

- Adult individuals who are legally competent shall have the right to decide whether their family will be involved in planning and implementing the PCSP.

5. The right to privacy. Any restriction on this right must be supported by an assessed need and justified in the PCSP.

6. The right to choice of roommate when sharing a bedroom.

7. The freedom to associate and communicate publicly or privately with any person or group of people of the beneficiary's choice at any time. Any restriction on this right must be supported by an assessed need and justified in the PCSP.

8. The freedom to have visitors of their choosing at any time.

9. The freedom of religion.

10. The right to be free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment.

11. The opportunity to seek employment and work in competitive, integrated settings to the same degree as those not receiving home and community based services through Medicaid.

12. Freedom from being required to work without compensation.

    - There is a limited exception when residing in a Provider owned/controlled setting if the required work is related to the upkeep of the beneficiary's own living space, or the common living area and grounds that the beneficiary shares with others.

13. The right to be treated with dignity and respect.

14. The right to receive due process.

    - Providers must ensure beneficiaries have access to legal entities for appropriate and adequate representation, advocacy support services, and must adhere to research and ethics guidelines (45 CFR § 46.101 et. seq.).

    - Provider rules may not contain provisions that result in the unfair, arbitrary, or unreasonable treatment of a beneficiary.

15. The right to contest and appeal Provider decisions affecting the beneficiary.

16. The right to request and receive an investigation in connection with an alleged infringement of a beneficiary's rights.

    - The Provider must maintain the documentation relating to all investigations of alleged beneficiary rights violations, and the actions taken to intervene in such situations. The Provider will ensure that the beneficiary has been notified of their right to appeal according to DDS Policy #1076.

17. The freedom to access their own records, including information regarding how their funds are accessed and utilized and what services were billed for on the beneficiary's behalf. Additionally, all beneficiaries and legal guardians must be informed of how to access the beneficiary's service records and the Provider must ensure that appropriate equipment is available for them to obtain such access.

    - Beneficiaries may not be prohibited from having access to their own service records, unless a specific state law indicates otherwise.

18. The right to live in a manner that optimizes, but does not regiment, beneficiary initiative, autonomy, and independence in making life choices, including but not limited to:

    - Choice of Provider
    - Service delivery
    - Release of information
    - Composition of the service delivery team
    - Involvement in research projects, if applicable
    - Daily activities
    - Physical environment
    - With whom to interact

19. Other legal and constitutional rights.

403. Informing Beneficiary and/or Legal Guardian of their Rights

The beneficiary and/or legal guardian shall be informed of their rights. The Provider shall maintain documentation in the beneficiary's service record showing that the following information has been provided to the beneficiary or legal guardian in writing:

1. All service options available to the beneficiary, including those not presently provided by the Provider and any available non-disability specific settings.

2. A copy of the appeal procedure for decisions made by the Provider.

3. A list of available external advocacy services.

4. A document informing the beneficiary or legal guardian of their right to appeal any service decision to DDS, along with a copy of DDS Policy #1076 regarding appeal procedures.

5. The care coordinator's name and contact information.

6. The name and phone number of the DDS Waiver Manager for the area.

7. A document describing any positive behavior programming practices (including, but not limited to, restraints) used by the Provider.

404. Grievances and Appeals

1. The Provider must institute and maintain policies that provide beneficiaries the right to file formal complaints/grievances and appeals.

2. The Provider must make complaint procedures and, if applicable, forms, readily available to all beneficiaries and their legal guardians. The complaint and appeals procedures must be in writing and understandable to the beneficiaries and legal guardians.

3. Complaint and appeal procedures shall be explained to personnel, beneficiaries, and legal guardians in a format that is easily understandable and meets their needs. This explanation may include, but is not limited to, a video, audiotape, a handbook, and interpreters.

405. Financial Safeguards

This Section applies if the Provider serves as a representative payee of a beneficiary, is involved in managing the funds of the beneficiary, receives benefits on behalf of the beneficiary, or temporarily safeguards funds or personal property for the beneficiary. Every supportive living Provider must comply with this Section.

A. Financial Safeguards and Procedures

The Provider must demonstrate, to the reasonable satisfaction of DDS, that there is a system in place to protect the financial interests of all beneficiaries. Provider personnel that have any involvement with beneficiary funds and the beneficiary or their legal guardian must receive a copy of the Provider's Financial Safeguards Policies and Procedures.

1. The Provider is responsible for ensuring that each beneficiary's funds are used solely for the benefit of the beneficiary.

2. The Provider must ensure that the beneficiary is able to receive the benefit of those items/services for which they are paying. By way of illustration, if a beneficiary is paying for internet, the beneficiary should have a device with which to access the internet; if the beneficiary pays for a cell phone plan, then the beneficiary should have a functioning cell phone.

B. Access to Financial Records

Beneficiaries and their legal guardians must have access to financial records concerning the beneficiary's account/funds at all times.

C. Financial Safeguards Policy and Procedures

The Provider must implement policies that define:

1. How beneficiaries will provide informed consent for the expenditure of their funds.

2. How beneficiaries will access their financial records.

3. How beneficiary accounts/funds will be segregated and maintained for accounting purposes.

4. The safeguards and procedures in place to ensure that beneficiary funds are used only for designated and appropriate purposes.

5. How interest will be credited to the accounts of the beneficiaries, if applicable.

6. A mechanism that provides evidence that beneficiary funds were expended in the manner authorized.

D. Consent Requirements

The Provider shall obtain consent from the beneficiary or their legal guardian prior to implementing the following:

1. Limiting the amount of funds a beneficiary may expend or invest in a specific instance.

2. Designating the amount a beneficiary may expend or invest for a specific purpose.

3. Establishing time frames where a beneficiary is required to or prohibited from expending or investing their funds.

4. Delegating responsibility for expending or investing a beneficiary's funds.

E. Additional Group Residential Setting Requirements

1. **Budget Requirement**: In group living residential settings, Providers must establish an individual budget for each beneficiary. At a minimum, each budget must include a detailed breakdown of monthly personal income (SSI, family contributions, job income, etc.) and monthly personal expenses (rent, utilities, food, clothing, extra-curricular activities etc.). Providers will be monitored to ensure that the budget is being implemented properly. It is the Provider's responsibility to revise the budget with the help of the beneficiary or legal guardian if the budget does not accurately reflect the actual income and/or expenditures of the beneficiary.

2. **Record Maintenance**. It is the responsibility of the Provider to maintain records and receipts that provide verifiable evidence that each beneficiary's funds are being used solely for the benefit of the beneficiary, and are not being used for the benefit of another beneficiary residing in the same setting. Examples of such documentation might include, but are not limited to, grocery receipts, bank statements, and paid invoices.

3. Prohibition on Disproportionate Rental Payments: A beneficiary's personal resources may not be taken into account when determining how much they are required to pay in rent. In group residential settings all beneficiaries must be charged the same amount in rent each month unless there is verifiable and reasonable justification.

406. Waiver Eligibility Disqualification

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

1. When the health and safety of the beneficiary, the beneficiary's staff, or others cannot be assured.

2. When the beneficiary or legal guardian has refused or refuses to participate in the PCSP development or to permit implementation of the PCSP or any part thereof that is deemed necessary to assure health and safety.

3. When the beneficiary or legal guardian refuses to permit the on-site entry of:

    - The care coordinator or PCSP Developer to conduct scheduled/required visits,
    - Direct care staff to provide scheduled care, and
    - DHS or CMS officials acting in their role as oversight authority for compliance or audit purposes.

4. When the beneficiary applying for or receiving waiver services requires twenty-four (24) hour nursing care on a continuous basis as prescribed by a physician.

5. When the beneficiary is incarcerated or an inmate in a state or local correctional facility.

6. When the beneficiary is deemed ineligible based on a DDS Psychological Team assessment or reassessment finding that the beneficiary does not meet ICF/IID level of care.

7. When the beneficiary is ineligible based on not meeting or not complying with Medicaid eligibility requirements.

500 SERVICE PROVISION

501. Person Centered Service Plan

All CES waiver services are delivered pursuant to a person centered service plan ("**PCSP**"), which is based on the Independent Assessment and other needs assessments. The PCSP must have measurable goals and specific objectives, measure progress through data collection, and be developed, overseen, and updated through consultation with a PCSP team that must include the beneficiary.

A. Beneficiary Participation and Approval Required

The beneficiary (and, if applicable, their legal guardian) must be an active participant in the PCSP planning and revision process. The Provider must ensure that the PCSP development, planning, and update process is driven to the maximum extent possible by the beneficiary/legal guardian. Providers shall deliver services based on the choices of the beneficiary/legal guardian.

The written PCSP must be finalized and agreed to with the informed consent of the beneficiary/legal guardian in writing and signed by all individuals and Providers responsible for its implementation (see § 42 CFR 441.725 B).

B. Interim Service Plan

When a beneficiary accesses CES Waiver services for the first time, the beneficiary is issued an interim service plan ("**ISP**") for up to sixty (60) days, until the PCSP can be developed and implemented. The ISP may include care coordination and supportive living for direct case supervision. DDS staff will track the expiration dates of ISPs and ensure that a PCSP is complete before the interim plan expires.

C. Initial PCSP Development Meeting

1. **Independent Assessment**: Every beneficiary must undergo an Independent Assessment performed by the designated DDS third party vendor prior to developing a PCSP for the beneficiary. The PCSP Developer must have the results of the Independent Assessment at the initial PCSP development meeting.

    - A beneficiary must receive an Independent Assessment through the designated DDS third party vendor at least once every three (3) years.

2. **Information Gathering**: Prior to the initial PCSP development meeting, in addition to the Independent Assessment, the PCSP Developer should secure for review as part of the meeting additional information which would be beneficial to the initial PCSP development process, including, but not necessarily limited to:

    - The results of any evaluations that are specific to the needs of the beneficiary

- The results of any psychological testing during eligibility determination
- The results of any adaptive behavior assessments conducted to establish eligibility

3. **Scheduling and Attendees**: The PCSP Developer is responsible for scheduling, coordinating, and managing the PCSP development meeting, including inviting other participants, making sure that the location and the participants are acceptable to the beneficiary. Ideally this PCSP development team would consist of some combination of the beneficiary and/or their legal guardian, the beneficiary's parents or other family supports, the assigned DDS Waiver representative, professionals that conducted assessments/evaluation of beneficiary, and others who might provide support to the beneficiary.

    - If the beneficiary or their legal guardian objects to the presence of any individual at the PCSP development meeting, then the individual is not permitted to attend the PCSP development meeting.

D. PCSP Requirements

Generally, the PCSP must reflect the services and supports that are important for the beneficiary to meet the needs identified in the Independent Assessment and other needs assessments, as well as what is important to the beneficiary with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the beneficiary, the written PCSP must:

1. Identify the setting in which the beneficiary chooses to reside.

2. Reflect the beneficiary's strengths, preferences, interests, and needs.

3. Reflect the beneficiary's clinical and support needs as identified through the Independent Assessment and other needs assessments.

4. Include individually identified goals and desired outcomes for the beneficiary.

5. Reflect the services and supports (both paid and unpaid) that will assist the beneficiary to achieve identified goals, and the providers of those services and supports, including natural supports.

6. Reflect the risk factors identified through the Independent Assessment and the measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be understandable to the beneficiary, and the individuals important in supporting him or her. At a minimum, the PCSP must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

8. Identify the care coordination Provider and the individual care coordinator responsible for monitoring the PCSP.

9. Be finalized and agreed to, with the informed consent of the beneficiary in writing, and signed by all individuals and Providers responsible for the PCSP's implementation.

10. Be distributed to the beneficiary and other individuals/Providers involved in the development and implementation of the PCSP.

11. Prevent the provision of unnecessary or inappropriate services and supports.

12. Document any modifications to the PCSP that are contrary to the home and community based settings requirements (See Section 1607 for documentation requirements).

D. PCSP Reviews and Updates

1. **Annual Update**: The PCSP Developer must review and update the PCSP with the beneficiary (and anyone else the beneficiary desires to attend) at least annually. The annual PCSP update process should be very similar to the initial PCSP development process. The beneficiary selects the participants on the PCSP update team. The care coordinator secures the available and appropriate data, information, assessments, and evaluations and presents it to the PCSP Developer and PCSP update team. The PCSP Developer will then develop an updated PCSP that meets all the requirements in Section C above. The discussions and activities involved at each annual update meeting must be documented and maintained by the PCSP Developer in the beneficiary's service file. The writing should document the beneficiary's input and participation in all aspects of the review.

    2. Updates to a PCSP can occur more often than once a year, but additional updates require DDS prior authorization.

2. **Beneficiary Requested Updates**: A beneficiary must be allowed to request an update of their PCSP at any time.

502. Behavior Management Plan

A. When Behavior Management Plans Are Required

The care coordinator must develop and monitor implementation of an appropriate behavior management plan incorporating positive behavior support strategies when:

1. Three (3) or more distinct challenging behaviors occur in a three (3) month period; or[1]

[1] "*Challenging Behaviors*" behaviors defined as problematic or maladaptive by others who observe the behaviors or by the person displaying the behaviors. They are actions that:

- Come into conflict with what is generally accepted in the individual's community,
- Often isolate the person from their community, or
- Are barriers to the person living or remaining in the community, and

2. Beneficiaries are prescribed psychotropic medications for behavior; or

3. Any other time the Provider, DDS Quality Assurance, or the DDS Psychological Team believes a beneficiary's behavior warrants intervention.

A Provider of direct care services must provide training to all staff who implement a behavior management plan. Training requirements include Introduction to Behavior Management, Abuse and Neglect and any other training as necessary.

B. Behavior Management Plans Generally

All behavior management plans must:

1. Prohibit behavior modification techniques that are punishing in nature, physically painful, emotionally frightening, depriving, or that put the beneficiary at medical risk.

2. Specify what behaviors, if any, require the use of restraints, the length of time to be used, person responsible for the authorization and the use of restraints (see Section 503 below), and the methods for monitoring the beneficiary and staff.

3. Prohibit the use of medications for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition, or for the purpose of chemical restraint.

4. Prohibit the use of mechanical restraints for the purpose of limiting or controlling challenging behavior. "Mechanical restraint" means any physical apparatus or equipment that cannot be easily removed by the beneficiary, restricts the free movement or normal functioning of beneficiary, or restricts normal access to a portion or portions of the beneficiary's body.

C. Behavior Management Plan Development

Behavior management plans must be written and monitored by a qualified professional who is, at a minimum, a Qualified Developmental Disabilities Professional ("QDDP"). The care coordination Provider (with input from the supportive living Provider) will develop a beneficiary's behavior management plan. All behavior management plans must:

1. Identify the behavior/s to be decreased.

2. Identify the behavior/s to be increased.

- Vary in seriousness and intensity.

3. Identify what things should be provided or avoided in the beneficiary's environment on a daily basis to decrease the likelihood of the identified behavior/s.

4. Identify the methods that staff should use to manage behavior/s.

5. Identify the event/s that appear to trigger the behavior/s.

6. Identify what staff should do if the triggering event/s occur.

7. Identify what staff should do if the behavior/s to be increased or decreased occur.

8. Should involve the fewest interventions or strategies possible.

9. Be designed so that the rights of the individual are protected.

10. Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or put the individual at medical risk.

D. Re-Evaluation of Behavior Management Plan

All behavior management plans must be re-evaluated at least quarterly. Behavior management plans must also be re-evaluated if:

1. Distinct behaviors occur three (3) or more times within a three (3) month period, which could all take place in one day; or

2. Any time that DDS determines that re-evaluation of the behavior management plan is appropriate under the circumstances.

Each Provider is responsible for maintaining written documentation sufficient to prove that any required re-evaluation was properly requested and conducted.

E. Data Collection for Behavior Management Plan

Each Provider delivering direct care services must collect data on the behavior management plan so that the effectiveness can be evaluated. A Provider delivering direct care services is required to:

1. Develop a simple, efficient, and manageable method of logging and collecting data regarding the implementation of the behavior management plan.

2. Data collection must include the frequency, length of time of each use, the duration of use over time and the impact of the use of interventions, if applicable.

3. Review the data regularly, and send the beneficiary to the behavior management plan developer (or other assigned QDDP) for re-evaluation if the strategies are not achieving the desired results.

503. Restraints & Restrictive Intervention

A. Behavior Management Plan Required

A Provider is prohibited from using any restraints or restrictive interventions on a beneficiary unless the beneficiary has a developed and implemented behavior management plan which incorporates alternative strategies to avoid the use of restraints and restrictive interventions, and includes the use of positive behavior support strategies as an integral part of the behavior management plan (See Section 502 "Behavior Management Plans"). There is a limited exception to this requirement when the use of an emergency restraint is necessary (See Section 503 (E) "Emergency Restraint")

B. Definitions of Restraints and Interventions

1. "**Physical restraint**" or "**personal restraint**": the application of physical force without the use of any device (manually holding all or part of the body), for the purpose of restraining the free movement of a beneficiary's body. This does not include briefly holding, without undue force, a beneficiary in order to calm them, or holding a beneficiary's hand to escort them safely from one area to another.

2. "**Physical Intervention**": the use of a manual technique intended to interrupt or stop a behavior from occurring.

3. "**Restrictive intervention**": procedures that restrict or limit a beneficiary's freedom of movement, restricts access to their property, prevents them from doing something they want to do, requires them to do something they do not want to do, or removes something they own or have earned. The definition would include the use of "time-out," in which a beneficiary is temporarily, for a specified period of time, removed from positive reinforcement or denied opportunity to obtain positive reinforcement for the purpose of providing the beneficiary with the opportunity to regain self-control. Under no circumstances may a beneficiary be physically prevented from leaving.

4. "**Mechanical restraint**": any physical apparatus or equipment used to limit or control a challenging behavior. This would include any apparatus or equipment that cannot be easily removed by the beneficiary, restricts the beneficiary's free movement or normal functioning, or restricts normal access to a portion or portions of the beneficiary's body.

    - ***Under no circumstances are mechanical restraints permitted to be used on a beneficiary***.

5. "**Chemical restraint**": 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.

    - ***Under no circumstances are chemical restraints permitted to be used on a beneficiary***.

6. "**Seclusion**": the involuntary confinement of a beneficiary alone in a room or an area from which the beneficiary is physically prevented from having contact with others or leaving.

    - ***Under no circumstances is seclusion permitted to be used on a beneficiary***.

C. Use of Restraints and Interventions

Permitted restraints and interventions may be used only when a challenging behavior exhibited by the beneficiary threatens the health or safety of the beneficiary or others. The use of restraints or interventions must be supported by a specific assessed need as justified in the beneficiary's PCSP, and only performed as provided in the beneficiary's behavior management plan.

1. **Required Prior Counseling**: Before a "time out," an absence from a specific social activity, or a temporary loss of personal possession is implemented, the beneficiary must first be counseled about the consequences of the behavior and the choices they can make.

2. **Direct Observation**: A beneficiary must be continuously under direct visual and auditory observation by staff members during any use of restraints or interventions.

3. **Specialized Restraint and Intervention Training**: All personnel who are involved in the use of restraints or interventions must receive training on and be qualified to perform, implement, and monitor the particular restraint or intervention as applicable. Additionally, personnel should receive training in in behavior management techniques, and abuse and neglect laws, rules, regulations and policies.

4. **Restraint and Intervention Identification**: The Provider is required to advise all staff, families, and beneficiaries on how to recognize and report the unauthorized use of a restraint or restrictive intervention.

D. Required Restraint and/or Intervention PCSP Information

Any PCSP and behavior management plan permitting the use of restraints or interventions must include the following information:

1. Identify the specific and individualized assessed need for the use of the restraint or intervention.

2. Document the positive interventions and supports used prior to any modifications to the PCSP that permits use of restraint or interventions.

3. Document the less intrusive methods of behavior modification that were attempted but did not work.

4. Include a clear description of the condition that is directly proportionate to the specific assessed need.

5. Include regular collection and review of data to measure the ongoing effectiveness of the modification to the PCSP that permitted the use of a restraint or intervention.

6. Include established time limits for periodic reviews to determine if the use of restraint or intervention is still necessary or can be terminated.

7. Include the informed consent of the beneficiary or legal guardian.

8. Include an assurance that the use of the restraint or intervention will cause no harm to the beneficiary.

E. Emergency Restraint

Personal restraints (use of staff member's body to prevent injury to the beneficiary or another person) are allowed in cases of emergency, even if a behavior management plan incorporating the use of restraints has not been developed and implemented. An "emergency" exists in the following situations:

1. The beneficiary has not responded to de-escalation or other positive behavior support strategies and the behavior continues to escalate.

2. The beneficiary is a danger to themselves or others.

3. The safety of the beneficiary and those nearby cannot be assured through positive behavior support strategies.

The care coordinator must request an interdisciplinary team meeting to revise the PCSP and implement a behavior management plan when there are more than three (3) emergency restraint incidents within a three (3) month period. It is an emergency restraint "incident" if each of the following occurred:

- A behavior was exhibited
- A restraint procedure was used
- The beneficiary was no longer thought to be dangerous
- The restraint procedure was discontinued

F. Reporting each Incident where Restraint or Intervention was Used

An incident report must be completed and submitted to DDS Quality Assurance in accordance with Section 300 herein no later than the end of the second business day following the date any restraint or restrictive intervention is administered. If the use of a restraint or restrictive intervention occurs more than three (3) times in any thirty (30) day period, permitted use of restraints and interventions must be

discussed by the PCSP development team, addressed in the PCSP, and implemented pursuant to an appropriate behavior management plan.

Any use of restraint or intervention, whether permitted or prohibited, also must be documented in the beneficiary's daily service log, maintained it their service record, and must include the following information:

1. The behavior initiating the use of restraint or intervention.
2. The length of time the restraint or intervention was administered.
3. The name of the personnel that authorized the use of the restraint or intervention.
4. The names of all individuals involved and outcomes of the use of the restraint or intervention.

504. Medication Management Plan and Medication Logs

The Provider delivering care coordination must develop a medication management plan for any beneficiary with prescribed medications. Providers delivering direct care services must maintain an accurate and up-to-date medication log for all beneficiaries to whom the Provider is responsible for administering medications, whether prescribed, pro re nata ("**PRN**"), or over-the-counter. A Provider must maintain written evidence of any beneficiary or legal guardian electing to administer all prescribed medications themselves.

A. Medication Management Plan

The care coordination Provider (with input from the supportive living Provider) must develop a medication management plan for all beneficiaries with prescribed medication/s. A medical prescription for medications, services, and level of care must be obtained annually. When medication is used to treat a specifically diagnosed mental illness, the prescribed medication must be managed by a psychiatrist who periodically provides 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. Medications may NOT be used to modify behavior in the absence of a specifically diagnosed mental illness, or for the purpose of chemical restraint.

1. Each medication management plan must include:

    - How each medication will be administered (i.e. times, doses, delivery, etc.) and charted.
    - A list of potential side effects caused by any medication/s.
    - A description of the reason each medication has been prescribed and the related symptoms.
    - The beneficiary/legal guardian's consent to the administration of the medication/s.
    - How each medication must be administered and by whom, in order to comply with the Nurse Practice Act and the Consumer Directed Care Act. This would include a list which medications may be administered by which staff.

2. For all prescribed psychotropic medications due to behaviors, the care coordination Provider shall develop and implement a behavior management plan and update as necessary (See Section 502).

3. Providers are required to provide training to direct care staff which details the specifics of the beneficiary's medical management plan, including possible side effects.

4. Direct care staff members are required to be re-trained on the medication management plan and behavior management plan (if applicable) any time medications are updated.

B. Medication Logs

1. **Prescription Medications**: Providers delivering direct care services must maintain medications logs detailing the administration of prescribed medications to the beneficiary. The prescribed medication logs must be readily available for DDS review, and document the following for each administration of a prescribed medication:

- Name and dosage of the medication administered.
- Route the medication was administered.
- Date and time the medication was administered (recorded at the time of medication administration).
- Initials of the staff administering or assisting with the administration of the medication.
- Any side effects or adverse reactions to the medication.
- Any errors in administering the medication.

2. **PRN and Over-the-Counter Medications**: Providers delivering direct care services must also maintain logs concerning the administration of PRN and over-the-counter medications. The logs for the administration of prescription PRN and over-the-counter medications must document the following:

- How often the medication is used.
- Date and time each medication was administered (recorded at the time of medication administration).
- The circumstances in which the medication is used.
- The symptom for which the medication was used.
- The effectiveness of the medication.

3. **Medication Administration Error Reporting/Charting**: Any medication administration errors occurring or discovered must be recorded in the medication log and immediately reported to a supervisor. "Medication administration errors" include, but are not limited to, the loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time or by the wrong route, the administration of the wrong medication, and the discovery of an unlocked medication lock box that is supposed to be locked at all times.
    - An incident report must be filed with DDS Quality Assurance in accordance with Section 300 for any medication administration error that caused or had the potential to cause serious injury or illness to a beneficiary.

4. **Required Oversight Documentation**: Each Provider delivering direct care services must ensure that supervisory level staff (commonly titled Direct Care Supervisor) review on at least a monthly basis all beneficiary medication logs to determine if:

    - All medications were administered accurately as prescribed.
    - The medication is effectively addressing the reason for which it was prescribed.
    - Any side effects are noted, reported, and being managed appropriately.

505. Daily Service Activity Logs

Daily service activity logs must be maintained by all Providers delivering direct care services in order to provide specific information relating to the individually identified goals and desired outcomes for the beneficiary, so that the care coordinator, PCSP Developer, and PCSP development team can measure and record the progress on each of the beneficiary's identified goals and desired outcomes. There is no required format for a daily service activity log; however, the daily service activity logs must document the following:

1. The name and sign-in/sign-out times for each direct care staff member.

2. The specific services furnished.

3. The date and actual beginning and ending time of day the services were performed.

4. Name(s) of the staff/person(s) providing the service(s).

5. The relationship of the services to the goals and objectives described in the beneficiary's individualized PCSP.

6. Daily progress notes/narrative signed and dated by the staff delivering the service(s), describing each beneficiary's progress or lack thereof with respect to each of his or her individualized goals and objectives. This would include any behavior management plan data required to be maintained pursuant to Section 502(E) above.

506. Beneficiary Service Records

A. Required Service Record Documentation

Each Provider delivering care coordination services or direct care services to a beneficiary must establish a service record for the beneficiary. At a minimum, the service record file must contain:

1. Independent Assessment
2. A copy of the PCSP
3. Behavior management plan with proper beneficiary/legal guardian approval, if applicable
4. Daily service activity logs
5. Care coordinator monthly contact reports
6. Completed forms as required by DDS, including, but not limited to, Form DHS-704, ACS/CES-703, and ACS/CES-102
7. Fully approved medication management plan and Medication logs, or signed election to self-administer medication (see Section 504), if applicable
8. Fully executed copy of lease, residency agreement, or other form of written agreement that provides protections that address eviction processes and appeals comparable to those provided under a landlord-tenant law
9. Any documentation providing additional individuals with access to a beneficiary's service record
10. Documentation required in Section 403
11. Guardianship Order, if applicable
12. Any specific documentation required by a particular CES Waiver service used by the beneficiary

B. Face Sheets

A summary document ("Face sheet") must be maintained at the front of a beneficiary's service record file, which must document the following:

1. Full name of beneficiary
2. Address, county of residence, telephone number and email address, if applicable
3. Marital status, if applicable
4. Race and gender
5. Birth date
6. Social Security number
7. Medicaid Number
8. Legal status
9. Legal guardian's name and address and relationship, if applicable
10. Name, address, telephone number and relationship of person to contact in emergency
11. Health insurance benefits and policy number
12. Primary language
13. Admission date

14. Statement of primary/secondary disability
15. Physician's name, address, and telephone number
16. Current medications with dosage and frequency, if applicable
17. All known allergies or indicate none, if applicable

Face sheets must be updated as needed and after each PCSP update. Any update to a Face Sheet must be signed and dated by the person entering the update.

C. Beneficiary Records Maintenance & Storage Retention Requirements

1. **Confidentiality**: A Provider shall maintain complete service records/files and treat all information related to beneficiaries as confidential. Access to beneficiary service files must be limited to only those staff members who have a need to know the information contained in the records of the beneficiary. The only individuals that may access a beneficiary's files and records are:

    - The beneficiary
    - The legal guardian of the beneficiary, if applicable
    - Professional staff providing direct care or care coordination services to the beneficiary
    - Authorized Provider administrative staff
    - Any other individual authorized by the beneficiary or their legal guardian

    Adult beneficiaries who are legally competent shall have the right to decide whether their family will be involved in planning and implementing their PCSP, and a signed release or document shall be present in their service record either granting permission for family involvement or declining family involvement.

2. **HIPAA Regulations**: Each Provider shall ensure that information that is used for reporting or billing shall be shared according to confidentiality guidelines that recognize applicable regulatory requirements such as the Health Insurance Portability and Accountability Act ("**HIPAA**").

3. **Electronic and Paper Records/File Maintenance**: Electronic service records are acceptable. Paper and electronic service records must be uniformly organized and easily accessible. A list of the order of the service record information shall either be present in each beneficiary's service record or provided to DDS upon request. The documents in active service records should be organized in a systematic fashion. An indexing and filing system must be maintained for all service records.

4. **Storage Location**: The location of the files/service records, and the information contained therein, must be controlled from a central location.

5. **Direct Care Staff Access**: The Provider shall ensure all direct care and care coordination staff has adequate access to the beneficiary's file/service record including, current PCSP and other pertinent information necessary to ensure the beneficiary's health, welfare, and safety (i.e., name and telephone number of physician(s), emergency contact information, insurance information, etc.).

6. **Record/File Retention**: Each Provider must retain all files/services records for five (5) years from the date of service or until all audit questions or review issues, appeals hearings, investigations or administrative or judicial litigation to which the files/services records may relate are finally concluded, whichever period is later. Failure to furnish medical records upon request may result in sanctions being imposed. Federal legislation further requires that any accounting of private healthcare information ("PHI") or HIPAA polices or complaints must be retained for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

7. **Access Sheets**: Access sheets shall be located in the front of the service record to maintain confidentiality according to 5 U.S.C. § 552a. If there is a signed release for a list of authorized persons to review the service record, only those not listed will need to sign the access sheet with date, title, reason for reviewing, and signature. If there is not a signed release for authorized persons to review, all persons must sign the access sheet whenever the service record is reviewed or any material is placed in the service record.

D. DDS Access to Beneficiary Files/Service Records

DDS shall have access to all beneficiary files/service records maintained by the Provider at any time upon demand.

507. Refusal to Serve

Providers shall not refuse services to any beneficiary unless the Provider cannot ensure the beneficiary's health, safety, or welfare. When a Provider is unable to serve a beneficiary, the Provider must notify the DDS Waiver Specialist within two (2) working days in order for choice to be offered to the beneficiary.

1. If a Provider is unable to ensure a beneficiary's health, safety, or welfare because qualified personnel are unavailable to deliver services to the beneficiary, the Provider should be able to demonstrate efforts to employ and retain qualified personnel and the results of those efforts. The documentation submitted by Provider should demonstrate:

    - Recruitment efforts
    - Retention efforts
    - Identification of any trends in personnel turnover

2. If the Provider is unable to ensure a beneficiary's health, safety, or welfare because adequate housing is not available, the Provider should develop and propose to the beneficiary alternative housing arrangements and locations within the beneficiary's resources. If the beneficiary is unable or unwilling to accept any of the proposed alternative housing arrangements or locations, the Provider shall document that the beneficiary has refused available resources and shall immediately notify the DDS Waiver Specialist.

3. The intent of this Section 507 is to prevent and prohibit Providers from implementing a selective admission policy based on the perceived "difficulty" of serving a beneficiary. Whether a Provider is refusing to serve based on legitimate beneficiary health, safety, or welfare concerns shall be determined in the sole discretion of DDS. DDS approval for refusal of services shall depend on the documented efforts made by the Provider to find housing and a determination of whether staffing can be provided by increasing the hourly rate of pay.

508. Transitioning Beneficiary

1. Corroboration and Responsibility: If it is necessary to transition a beneficiary to another Provider due to beneficiary choice, inability to serve, transition to an intermediate care facility, or any other reason, the current service Provider must fully cooperate with the care coordinator and any new service Provider in order to ensure a smooth transition process and the continuous delivery of services. The current service Provider shall remain responsible for the health, safety, and welfare of the beneficiary until the transition to the new service Provider is complete.

2. Turnover of Paperwork/Records: The current Provider must provide copies of the beneficiary's files, service records, data, and other paperwork without delay. If all copies of requested paperwork have not been provided to the care coordinator, DDS Waiver Specialist or the new Provider within thirty (30) days of the request, it is presumed to be unreasonable delay in violation of these Certification Standards.

3. Provider as Representative Payee: If the current Provider is serving as the transitioning beneficiary's representative payee (i.e. responsible for the beneficiary's finances), then within seven (7) days of the beneficiary's decision to transition the current Provider must submit the necessary paperwork to the Social Security Administration or any other necessary agency or financial institution. The current Provider is responsible for retaining written documentation evidencing that the necessary paperwork was submitted within the timeframe.

4. DDS Time-Extension: It is presumed any transition not completed within forty-five (45) calendar days from the date of the beneficiary's decision to transition is the result of undue delay by the current Provider. Notwithstanding the foregoing, a current Provider may submit written justification for any transition lasting longer than forty-five (45) calendar days to the beneficiary's DDS Waiver Specialist. DDS will determine if an extension is appropriate.

600 PROVIDER QUALIFICATIONS: SUPPORTIVE LIVING SERVICES

601. Supportive Living Responsibilities

1. Coordinating all supportive living staff that provide direct care to the beneficiary through the Provider;

2. Serving as a liaison between the beneficiary, parents, legal representatives, care coordinator and DDS representatives;

3. Coordinating schedules for both waiver and generic service categories;

4. Participating in planning and preparing the delivery of all supportive living services included in the initial PCSP and any annual or other PCSP update;

5. Assuring the integrity of all Medicaid waiver billing for all supportive living services delivered by Provider;

6. Arranging for the staffing of all alternative living settings;

7. Cooperating with the care coordinator and PCSP development team in developing a beneficiary's behavior management plan (see Section 502), if necessary, and then implementing, administering and collecting data relating to the behavior management plan;

8. Ensuring any necessary transportation is arranged for all supportive living services identified in the beneficiary's PCSP;

9. Collaborating with the care coordinator in a timely manner to obtain any Independent Assessment, comprehensive behavior and assessment reports, PCSP updates, and information and documents required for ICF/ID level of care and waiver Medicaid eligibility determination;

10. Reviewing the medication logs and daily service activity logs of the beneficiary to ensure the beneficiary is receiving appropriate services, medications and support in accordance with the PCSP and any medication management plan.

While the Provider may not staff a beneficiary on a 24/7 schedule, the Provider is responsible to ensure that sufficient staff is maintained to guarantee the health, safety, and welfare of each beneficiary, and to meet the established outcomes of the beneficiary as stated in their PCSP. Sufficiently trained staff shall be on duty at all times. Provisions shall be made for relief of supportive living staff during vacations, other relief periods and unplanned absences. Providers must have

backup plans in place to address contingencies if scheduled staff are unable, fail, or refuse to provide supportive living services.

602. Minimum Qualifications

Direct Care Staff

The Provider is responsible for the interviewing, hiring, firing, training, and scheduling of direct care staff providing supportive living services. Providers must ensure that all staff providing direct care services have one of the following:

- A high school diploma or GED;
- One (1) year of relevant, supervised work experience with a public health, human services or other community service agency; **OR**
- Two (2) years' verifiable successful experience working with individuals with developmental disabilities.

603. Medication Administration and Logs

1. Medication Administration

   Supportive living Providers must ensure that the beneficiary's medication management plan (See Section 504) incorporates measures which describe how direct care staff will administer or assist with the administration of medications. The Provider must ensure the medication management plan describes how the medication/s must be administered and by whom, in order to comply with the Nurse Practice Act and the Consumer Directed Care Act.

2. Medication Logs

   The supportive living Provider has an on-going responsibility for monitoring beneficiary medication regimens. Providers must ensure that supportive living staff are at all times aware of the medications used by the beneficiary, and are knowledgeable of potential side effects. See Section 504(B) above for the specific medication log requirements.

604. Daily Service Activity Logs

Providers must maintain daily service activity logs for each beneficiary. See Section 505 above for the specific requirements.

605. Training Requirements

1. First Aid Training: Within thirty (30) days of hiring, all supportive living staff, and any other staff of a supportive living Provider that may be required to provide emergency direct care services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

    - The course must provide a certificate of completion that can be maintained in the supportive living staff's personnel file.

    - Any services provided by a supportive living staff person prior to receiving the above described First Aid Training can only be performed in a training role, under the supervision of another supportive living staff person that has already had the required First Aid Training.

    - Training Certification must be maintained and kept up to date throughout the time any supporting living staff is providing services.

2. Beneficiary Specific Training: Prior to beginning service delivery, supportive living staff must receive the amount of individualized, beneficiary-specific training that is necessary to be able to effectively and safely provide the supportive living services required pursuant to the beneficiary's PCSP, including, but not limited to:

    - general training on beneficiary's PCSP
    - behavior management techniques/programming;
    - medication administration and management;
    - setting-specific emergency and evacuation procedures
    - appropriate and productive community integration activities; and
    - training specific to certain medical needs.

    Documentation evidencing that the necessary types and amount of beneficiary-specific training were completed must be maintained in the personnel file of the supportive living staff member at all times. This type of individualized, beneficiary-specific training shall be required each time a beneficiary's PCSP is updated, amended, or renewed.

3. Other Required Training: supportive living staff must receive appropriate training on the following topics at least once every two (2) calendar years:

    - HIPAA Policies and Procedures
    - Procedures for Incident Reporting

- Emergency and Evacuation Procedures
- Introduction to Behavior Management
- Arkansas Guardianship statutes
- Arkansas Abuse of Adult statutes
- Arkansas Child Maltreatment Act
- Nurse Practice Act
- Appeals Procedure for Individuals Served by the Program
- Beneficiary Financial Safeguards
- Community Integration Training
- Procedures for Preventing and Reporting Maltreatment of Children and Adults
- Other topics where circumstances dictate that supportive living staff should receive training to ensure the health, safety, and welfare of the beneficiary.

Documentation evidencing that training on the topics has been completed must be maintained in the personnel file of the supportive living staff member at all times.

4. DDS QA Mandated Training: DDS Quality Assurance has the ability to require a supportive living provider to conduct/administer specified training to an individual, a group, or all supportive living staff working for the Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each supportive living service staff member at all times.

700 PROVIDER QUALIFICATIONS: CARE COORDINATION SERVICES

Starting in October 2017, care coordination will begin to be phased out as a CES Waiver service. In October 2017, DHS and DDS will implement a Provider-led Managed care model for case management/care coordination where an independent third party vendor will conduct an Independent Assessment of each beneficiary for a tier determination, as well as a needs and risks assessment. Upon receiving the results of the Independent Assessment, the beneficiary will be attributed to and enrolled in a Provider-led Share Savings Entity ("**PASSE**"). Once a beneficiary is enrolled in a PASSE, care coordination services will no longer be available to the beneficiary as a CES Waiver service. Care coordination services will be performed by the PASSE under a separate home and community based services waiver.

701. Conflict Free Case Management

A Provider delivering care coordination services to a beneficiary must follow the federal conflict free case management rules.

702. Care Coordinator Minimum Qualifications

A. Care coordination Providers must require each care coordinator to meet the following minimum qualification criteria:

1. Be a Registered Nurse (R.N.), a physician, or have a bachelor's degree in a social science or health-related field; **OR**

2. Have at least one (1) year of experience working with developmentally or intellectually disabled clients or behavioral health clients;

B. Person Centered Service Plan Developer

Providers must require any supportive living staff responsible for the development of a beneficiary's PCSP ("**PSCP Developer**") to meet one of the following minimum qualification criteria:

1. A Bachelor's degree in a human services related field.

2. Two (2) or more years college credit in the field of human services, and two (2) years' experience working with individuals with developmental disabilities.

3. Two (2) or more years' experience working with individuals with developmental disabilities, and two (2) additional years of mentoring/training under a case manager.

4. Four (4) or more years' experience working as a case manager in a related field

703. <u>Care Coordination Responsibilities</u>

Care coordination services include responsibility for guidance and support in all life activities including the following:

1. Coordinating and arranging for the provision of all CES Waiver services and other state plan services;

2. Identifying and accessing needed medical, social, educational, and other publicly funded sources (regardless of funding source);

3. Identifying and accessing informal community supports needed by beneficiaries and their families;

4. Providing the beneficiary with guidance and support for their generic needs;

5. Coordinating and monitoring the implementation of all services identified on the beneficiary's PCSP, whether such services are home and community based waiver services, state plan services or generic services;

6. Coordinating with and monitoring the beneficiary's supportive living and other direct care Providers to ensure quality of care and service delivery;

7. Monitoring the beneficiary to assure their health, safety, and welfare;

8. Facilitating crisis intervention for the beneficiary;

9. Securing, scheduling, and/or conducting the beneficiary's Independent Assessment, other appropriate needs assessments, evaluations, and referrals for resources when required/necessary;

10. Providing the beneficiary with assistance in connection with continuing waiver Medicaid eligibility and obtaining ICF/IID level of care eligibility determinations;

11. Monitoring the beneficiary to ensure that the services and supports meet the needs, goals, and objectives identified in PCSP, with regard to the beneficiary's preferences for the delivery of such services and supports, and ensuring that the PCSP is revised/updated if the current services and supports are ineffective or the beneficiary's preferences change;

12. Assuring submission of timely and comprehensive behavior and assessment reports, updated PCSP, revisions to PCSP, and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;

13. Informing the beneficiary of their rights, providing support and training to each beneficiary so that they may identify attempts at exploitation, and arranging for a beneficiary to have access to advocacy services when requested;

14. Upon receipt of DDS approvals and denials, ensuring that a copy of each approval and denial is provided to the beneficiary or their legal representative;

15. Providing support and assistance with appeals when a beneficiary receives an adverse decision and desires to appeal the decision;

16. Assisting the beneficiary with transitioning between service settings or service Providers;

17. Assisting the beneficiary with selecting a primary care physician ("**PCP**") or providing a referral to a person centered medical home ("**PCMH**"), if necessary.

704. PCSP Development Responsibilities

Provider is responsible for the development of a beneficiary's person centered service plan ("**PCSP**") and ensuring the delivery of all supportive living services including the following activities:

11. Developing/updating the beneficiary's PCSP in cooperation with the beneficiary or the beneficiary's legal representative, and any other individual/s the beneficiary/legal representative wishes to have participate on the PCSP development team.

    - The PSCP developer is responsible for scheduling, coordinating, and managing the PCSP development/update meetings, including inviting other participants, and making sure that the location and the participants are acceptable to the beneficiary.

    - If the beneficiary objects to the presence of any individual at a PCSP development/update meeting, then that individual is not permitted to attend the PCSP development meeting.;

12. Scheduling, coordinating, and managing the PCSP annual update and any other necessary updates, including inviting other participants, making sure that the location and the participants are acceptable to the beneficiary;

705. Caseload Limit

No individual providing care coordination services is permitted to have more than fifty (50) beneficiaries on their case load at any one time.

706. Mandatory Beneficiary Contact

1. Monthly Contact: The care coordinator must stay in regular contact with each beneficiary, and must have face-to-face contact with each beneficiary at least once a month. After the initial contact, these monthly contacts can be made via video-conferencing. During each contact the care coordinator should discuss issues related to services and supports the beneficiary is supposed to be receiving pursuant to their PCSP, including, but not limited to:

    - Whether or not the beneficiary feels that their needs are being met.
    - Whether the beneficiary is satisfied with their Provider/s.
    - Inform the beneficiary they are always free to change Providers.
    - Whether there are any beneficiary health, safety, or welfare concerns.

    The care coordinator must report any service gap of thirty (30) consecutive days to the DDS Wavier Specialist assigned to the beneficiary. The report must include the reason for the gap and identify remedial action to be taken. A copy of the report must be maintained in the beneficiary's service record file.

2. 24 Hour Availability: The Provider must ensure that care coordination services are available to a beneficiary twenty-four (24) hours a day through a hotline or web-based application.

3. Crisis Contact: If the beneficiary is seen in an emergency room, urgent care clinic, or is admitted to an acute inpatient psychiatric facility, the care coordinator must follow up with the beneficiary within seven (7) days of discharge from the facility. The visit is to ensure that all discharge instructions are being followed and any follow-up appointments have been scheduled.

4. Required Documentation: The care coordinator must document all monthly contacts with the beneficiary and maintain the documentation in the beneficiary's service record file. Documentation shall include:

    a) The date and time of the contact/meeting

    b) The location of the contact/meeting

    c) The individuals present during the contact/meeting

    d) A summary of the contact/meeting

    e) Any requests by the beneficiary for change in services or new services

    f) The documentation reciting the above required details must be signed by the care coordinator and the beneficiary.

707 Request to Change Provider

A beneficiary or their legal guardian may initiate a request to change Providers by contacting (written or verbally) their care coordinator. If a request to change Provider is received by the care coordinator, the care coordinator shall forward the request to the DDS Waiver Specialist within two (2) working days of its receipt. The current service Provider will remain responsible for delivery of services until such time as the transition to the new Provider is complete. When there is a request to change Providers, the care coordinator is responsible for overseeing and facilitating the transition process, including, but not limited to the following:

- Facilitating a transitional meeting with any direct care service Provider/s;
- Collecting the beneficiary's service record file and other available information for the transitional meeting;
- Determining the effective date for transfer of service responsibilities; and
- Ensuring that the beneficiary does not suffer a lapse in services due to the change in Providers.

708. Abeyance

A. Abeyance Generally

A beneficiary's waiver status is in "abeyance" when there is a cessation of implementation of the beneficiary's PCSP while the beneficiary is temporarily placed in a licensed or certified facility for the purposes of behavior, physical, or health treatment or stabilization. The beneficiary will remain eligible for and enrolled in the CES Waiver without harm during an abeyance period. The care coordinator is responsible for requesting for a beneficiary's status to be placed into abeyance by contacting the DDS Waiver Specialist. The request for abeyance must be in writing and include all supporting evidence. Approval of a request for abeyance is made by DDS, and will be made for an initial period of up to ninety (90) days.

A beneficiary "living" in a public institution is not eligible for Medicaid or CES Waiver services, and an abeyance request cannot be granted in such circumstances. Public institutions include county jails, state and federal penitentiaries, juvenile detention centers, and other correctional or holding facilities.

B. Abeyance Extensions

The abeyance period may be extended in ninety (90) day increments for up to one (1) year total. 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.

C. Required Contact

A care coordinator must continue monitoring contact with a beneficiary whose case is in abeyance. The care coordinator must have a minimum of one (1) face-to-face visit or contact each month and

report the status to the applicable DDS Waiver Specialist. After the initial contact, these monthly contacts can be made via video-conferencing. Monthly status reports are required to be submitted to the DDS Waiver Specialist as long as the person is in abeyance.

709. Adaptive Equipment and Environmental Modifications

The care coordinator is responsible for handling adaptive equipment and environmental modification purchases for a beneficiary. Equipment may be purchased only when unable to be purchased through any other source, and all equipment must be solely for the use of the beneficiary.

1. Mandatory Consultation Threshold: When the purchase price of any single piece of equipment or single modification is $500 or greater, the care coordinator must seek an appropriate professional consultation to ensure that the equipment or modification to be purchased will meet the intended need of the beneficiary.

2. Mandatory Bidding Threshold: When any equipment or modification will be in excess of $1,000, the care coordinator must attempt to obtain at least three bids. The bids must be awarded to the lowest bid that meets the required quality level.

3. Final Inspection: Final inspection for the quality of the equipment or modification and compliance with specifications and local codes is the responsibility of the care coordinator. Payment to the supplier/contractor will be withheld until DDS receives a customer satisfaction statement signed by the care coordinator certifying that (i) the equipment/modification authorized has been delivered/completed, (ii) the beneficiary's property has been left in satisfactory condition, and (iii) any incidental damages have been repaired.

4. Required Documentation: The care coordinator must maintain in the beneficiary's service file written documentation evidencing that any required professional consultation and bidding was conducted as part of any adaptive equipment or environmental modification purchase. If a care coordinator is unable to secure three (3) bids, then the care coordinator must be able to document their efforts of the unsuccessful steps taken to secure the required three (3) bids.

7010. Training Requirements

1. First Aid Training: Within thirty (30) days of hiring, all care coordination staff, and any other staff of a care coordination provider that may be required to provide emergency services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

- The course must provide a certificate of completion that can be maintained in each care coordinator's personnel file.

- Training Certification must be maintained and kept up to date throughout the time any care coordinator is providing care coordination services.

2. Other Required Training: care coordinators must receive appropriate training on the following topics at least once every two (2) calendar years:

    - HIPAA Policies and Procedures
    - Procedures for Incident Reporting
    - Emergency and Evacuation Procedures
    - Introduction to Behavior Management
    - Arkansas Guardianship statutes
    - Arkansas Abuse of Adult statutes
    - Arkansas Child Maltreatment Act
    - Nurse Practice Act
    - Appeals Procedure for Individuals Served by the Program
    - Community Integration Training.
    - Procedures for Preventing and Reporting Maltreatment of Children and Adults
    - Other topics where circumstances dictate that care coordinators should receive training to ensure the health, safety, and welfare of the beneficiary served.

    Documentation evidencing that training on the topics listed above was completed must be maintained in the personnel file of each care coordinator at all times.

3. DDS QA Mandated Training: DDS Quality Assurance has the ability to require a care coordination Provider to conduct/administer specified training to an individual care coordinator, a group of care coordinators, or all care coordinators working for the Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each care coordinator at all times.

800 PROVIDER QUALIFICATIONS: ADAPTIVE EQUIPMENT (ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS)

801. Adaptive Equipment Units

1. The Provider must deliver professional, ongoing assistance when needed to evaluate and adjust any equipment delivered and/or to instruct the beneficiary or the beneficiary's caregiver in the use of equipment furnished.

2. The Provider must have the prior approval of DDS for any adaptive equipment items purchased and delivered. Equipment may only be covered if not available to the beneficiary from any other source.

802. Liability

1. The Provider must assume liability for equipment, supplies, warranties and must install, maintain, and/or replace any defective parts or items specified in those warranties. Replacement items or parts for adaptive equipment are not reimbursable as rental equipment.

2. The Provider must, in collaboration with the care coordinator, ascertain and recoup any third-party resource(s) available to the consumer prior to billing DDS or its designee. DDS or its designee will then pay any unpaid balance up to the lesser of the Provider's billed charge or the maximum allowable reimbursement.

803. Records of Adaptive Equipment

The Provider must submit the price for equipment and/or supplies to be purchased or rented within five (5) business days of the care coordinator's request for a bid. The Provider must maintain a record for each order. The documentation shall consist of:

1. The date the order was received and the name of the care coordinator placing the order.

2. The price quoted for the equipment and/or supplies.

3. The date the quote was submitted to the care coordinator.

The Provider must maintain a record for each beneficiary. The record must document the delivery, installation of the equipment purchased or rented, any education and/or instructions for the use of the equipment and/or supplies provided to the beneficiary, and must include documentation of delivery of item(s) to the beneficiary. The documentation shall consist of:

1. The beneficiary's signature, the signature of the beneficiary's caregiver or electronic verification of delivery.

2. The date on which the equipment and/or supplies were delivered.

900 PROVIDER QUALIFICATIONS: ENVIRONMENTAL MODIFICATION SERVICES

901. Required Credentials

Providers must be appropriately licensed and bonded in the State of Arkansas, as required, or have other appropriate credentials to perform jobs requiring specialized skills, including but not limited to:

- Electrical
- HVAC
- Plumbing
- General Contracting

All services must be completed as directed by the beneficiary's PCSP, and in accordance with all applicable state or local building codes. Environmental modifications must be made within the existing square footage of the residence.

902. Documentation

Providers must obtain and maintain the following documentation:

1. The written consent of the property owner to modify the property. When appropriate, the Provider must ensure that the owner understands that the property will be left in the modified state after the beneficiary vacates the premises.

2. An original photo of the site where modifications will be done.

3. A to-scale sketch plan of the proposed modification project.

4. Any necessary inspections, inspection reports, and permits required by federal, state and local laws either prior to commencing work or upon completion of each job to verify that the repair, modification or installation was completed. The Provider must obtain these inspections, inspection reports, and permits prior to billing for the completed job.

5. A signed and dated authorization from the beneficiary's care coordinator, or care coordinator's designee, for each job order prior to commencing work.

6. Written evidence that the Provider has informed the beneficiary and DDS or its designee of any health and/or safety risks expected during the job. The Provider is required to assist the beneficiary and care coordinator to coordinate dates and times of work to assure minimal risk of hazard to the beneficiary.

7. Obtain the beneficiary's or legal guardian's signature and the care coordinator's signature at job completion in order to certify that the work authorized has been completed, the beneficiary's property has been left in satisfactory condition, and any incidental damages have been repaired.

8. Maintain an itemized record of all expenses including materials and labor associated with the job order for a minimum of five (5) years.

903. Warranty

The Provider must furnish a warranty covering workmanship and materials with the final invoice submitted to DDS or the care coordinator. DDS will not pay any invoice that is not accompanied by a warranty.

904. Payor of Last Resort

Environmental modifications may only be purchased if not available to the beneficiary from any other source. The Provider must, in collaboration with the care coordinator, ascertain and recoup any third-party resource(s) available to the consumer prior to billing DDS or its designee. 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.

1000 PROVIDER QUALIFICATIONS: SPECIALIZED MEDICAL SUPPLIES

1001. Specialized Medical Supplies

A physician must order or document the need for all specialized medical supplies. Specialized medical supplies include:

- Items necessary for life support or to address physical conditions along with, ancillary supplies and equipment necessary for the proper functioning of such items;
- Such other durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to address participant functional limitations.
- Necessary medical items not available under the Medicaid State Plan.

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

- Nutritional supplements
- Non-prescription medications (alternative medicines not FDA approved are excluded from coverage)
- Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under the State plan are exhausted.

1002. Provider Requirements

1. The Provider must assure professional, ongoing assistance when needed to evaluate and adjust medical supplies delivered and/or to instruct the beneficiary or the beneficiary's caregiver in the use of the medical supplies furnished.
2. The Provider must have the prior approval of DDS for any medical supply items purchased and delivered.
3. The Provider must assume liability for medical supplies and must replace any defective items.
4. The Provider must, in collaboration with the care coordinator, ascertain and recoup any third-party resource(s) available to the beneficiary prior to billing DDS or its designee.

DDS or its designee will then pay any unpaid balance up to the lesser of the Provider's billed charge or the maximum allowable reimbursement.

1003. <u>Documentation</u>

The Provider must submit the price for medical supplies to be purchased or rented within five (5) business days of the care coordinator's request. The Provider must maintain a record for each order. The documentation shall consist of:

1. The date the order was received and the name of the care coordinator placing the order.

2. The price quoted for the item.

3. The date the quote was submitted to the care coordinator.

The Provider must maintain a record for each beneficiary. The record must document the delivery, installation of the item(s) purchased or rented, any education and/or instructions for the use of the equipment and/or supplies provided to the beneficiary, and must include documentation of delivery of item(s) to the beneficiary. The documentation must include:

- The beneficiary's signature, the signature of the beneficiary's caregiver or electronic verification of delivery.

- The date on which the equipment and/or supplies were delivered.

1100 PROVIDER QUALIFICATIONS: CONSULTATION SERVICES

1101. Licensed Professionals

Providers will be responsible for maintaining the necessary information to document staff qualifications. Selected staff or contract individuals may not provide training unless they possess the specific qualifications required. Consultant services are indirect in nature.

1102. Qualifications

Providers must ensure that any individual providing consultation has current credentials which correspond to the specific area of consultation they provide. Providers must be able to provide evidence that the following professionals providing consultation services through the Provider hold a current license or certification by the following licensing or certification board or organization:

1. Psychologists: hold a current license from the Arkansas Psychology Board as a Psychologist

2. Psychological examiners: hold a current license from the Arkansas Psychology Board as a Psychological Examiner

3. Mastered social workers: hold a current license as an LMSW or ACSW by the Arkansas Social Work Licensing Board

4. Professional counselors: hold a current license as a counselor by the Arkansas Board of Examiners in Counseling

5. Speech pathologists: hold a current license in Speech Therapy by the Arkansas Board of Audiology and Speech Language Pathology

6. Occupational therapists: hold a current license in Occupational Therapy by the Arkansas State Medical Board.

7. Physical Therapy: hold a current license in Physical Therapy by the Arkansas Board of Physical Therapy.

8. Registered Nurses: hold a current license as a Registered Nurse by the Arkansas Board of Nursing.

9. Certified parent educators: meet the qualifications of a Qualified Developmental Disabilities Professional as defined in 42 C.F.R. Subsection 483.430(a)

10. Certified communication and environmental control adaptive equipment/aids providers: be currently enrolled as a provider of Durable Medical Equipment with the Arkansas Medicaid Program.

11. Qualified Developmental Disabilities Professional: meet the qualifications defined in 42 C.F.R. Subsection 483.430(a)

12. Dietician: hold a degree in nutrition.

13. Behavior Support Specialist: certified through our Center of Excellence University of Arkansas Partners for Inclusive Communities

14. Rehabilitation counselors: hold a masters degree in Rehabilitation Counseling.

15. Recreational Therapist: hold a degree in Recreational Therapy.

16. Behavior Analyst: hold a certification by the Behavior Analyst Certification Board as defined in A.C.A. § 23-99-418.

1103 Documentation

The Provider must maintain a record of every consultation service provided for each beneficiary. The documentation shall consist of:

1. The date the consult was provided and the name of the care coordinator requesting the consult.

2. The consultation service provided.

3. A detailed narrative regarding the content of each consulting session.

1200 PROVIDER QUALIFICATIONS: RESPITE SERVICES

1201. Minimum Qualifications

Providers must ensure that each staff member providing respite services has one of the following:

- A GED or high school diploma;
- One (1) year of relevant, supervised work experience with a public health, human services or other community service agency; **OR**
- Two (2) years' verifiable successful experience working with individuals with developmental disabilities

1202. Approved Settings

Respite may be provided in the following locations:

1. Beneficiary's home or private place of residence
2. Private residence of a Respite care Provider
3. Foster home
4. Medicaid certified intermediate care facility
5. Group home
6. Licensed respite facility
7. Licensed or accredited residential mental health facility
8. Licensed day care facility or other lawful child care setting

When respite is provided in a Medicaid certified ICF/ID, licensed respite facility, or licensed residential mental health facility, the time of the stay may not exceed thirty (30) consecutive days.

1203. Physical Environment

Providers must ensure the physical environments of facilities where respite services are provided are compatible with the services being provided and the needs of beneficiary and staff. The Provider shall provide an accessible and safe environment and be in compliance with U.S.C. § 12101 *et. seq*. "American with Disabilities Act of 1990." The environment must be appropriate and cannot jeopardize the health, safety, or welfare of beneficiaries.

1204. Training Requirements

A. First Aid Training

Within thirty (30) days of hiring, all respite staff, and any other employees that may be required to provide respite services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

- The course must provide a certificate of completion that can be maintained in the staff's personnel file.

- Any services provided by respite staff prior to receiving the above described First Aid Training can only be performed in a trainee role, under the supervision of another staff person that has already received the required First Aid Training.

- Training Certification must be maintained and kept up to date throughout the time any respite service Provider is providing services.

B. Beneficiary Specific Training

Prior to beginning service delivery, respite staff must receive the amount of individualized, beneficiary-specific training required to demonstrate the skills and techniques necessary to implement the individual Person-Centered Service Plan for each individual for whom they are responsible. Training must focus on skills and competencies directed toward the beneficiaries developmental, behavioral, and health needs. Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of beneficiaries. The Provider must ensure that the necessary amount of beneficiary-specific training was completed and written documentation evidencing training must be maintained in the staff member's personnel file at all times.

C. Other Required Training

Respite Services staff must receive appropriate training on the following topics at least once every two (2) calendar years:

- HIPAA Policies and Procedures
- Procedures for Incident Reporting
- Emergency and Evacuation Procedures
- Introduction to Behavior Management
- Arkansas Guardianship statutes
- Arkansas Abuse of Adult statutes

- Arkansas Child Maltreatment Act
- Nurse Practice Act
- Appeals Procedure for Individuals Served by the Program
- Community Integration Training.
- Procedures for Preventing and Reporting Maltreatment of Children and Adults
- Other topics where circumstances dictate that respite staff should receive training to ensure the health, safety, and welfare of the beneficiary served.

Documentation evidencing that training on the topics listed above was completed must be maintained in the staff member's personnel file at all times.

D. DDS QA Mandated Training

DDS Quality Assurance has the ability to require a respite services Provider to conduct/administer specified training to an individual, group, or all staff working for the Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each Respite Services staff member at all times.

1300 PROVIDER QUALIFICATIONS: CRISIS INTERVENTION SERVICES

1301. Provider Assurances

Providers must be able to initiate services on-site within two (2) hours of request. Documentation for crisis intervention services must, at a minimum, include the time of the request, the name of the individual making the request, the time of arrival on-site, a summary of the intervention services provided, any recommendations for changes in the behavior plan or recommendations in change in medications, the time intervention services were discontinued, the signature of the Provider, and the signature of the care coordinator/caregiver as appropriate.

1302. Qualifications

Each professional staff member providing crisis intervention services must hold a current license/certification through their respective state Board of licensing/certification as follows:

1. Psychologists: hold a current license from the Arkansas Psychology Board as a Psychologist

2. Psychological examiners: hold a current license from the Arkansas Psychology Board as a Psychological Examiner

3. Mastered social workers: hold a current license as an LMSW or ACSW by the Arkansas Social Work Licensing Board

4. Professional counselors: hold a current license as a counselor by the Arkansas Board of Examiners in Counseling

5. Qualified Developmental Disabilities Professional: meet the qualifications defined in 42 C.F.R. Subsection 483.430(a)

6. Behavior Support Specialist: certified through our Center of Excellence University of Arkansas Partners for Inclusive Communities

1303. Incident Reporting

Providers must adhere to Incident Report Standards found in Section 300 of this manual.

1400 PROVIDER QUALIFICATIONS: SUPPORTED EMPLOYMENT

Supported Employment is a tailored array of services that offers ongoing support to beneficiaries to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for beneficiaries for whom competitive employment has not traditionally occurred, and who need ongoing supports to maintain their employment.

1401. Supported Employment Supports

A. Discovery/Career Planning Services

1. **Services Included**: discovery/career planning services consist of the Provider gathering information about the beneficiary's interests, strengths, skills, the types of supports that are most effective, and the types of environments and activities where the beneficiary is at his or her best. The following activities may be a component of Discovery/Career planning services:

    - Review of the beneficiary'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 beneficiary's interest in and aptitude for a particular type of job
    - Employment preparation (i.e. resume development)
    - Benefits counseling
    - Business plan development for self-employment
    - Volunteerism

2. **Individual Career Profile**: discovery/career planning services should result in the development of an Individual Career Profile for the beneficiary, which includes specific recommendations regarding the beneficiary's employment support needs, preferences, abilities, and characteristic of optimal work environment.

3. **Required Documentation**: the Provider must produce and maintain the following documents in the beneficiary's service record to demonstrate compliance in the delivery of discovery/career planning services:

    - Completed Individual Career Profile

- Record of progress notes/narratives detailing information gathering process and steps taken by Provider in developing the beneficiary's Individual Career Profile

B. Employment Path Services

1. **Services Included**: employment path service activities 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, both verbal and nonverbal, and time management. The beneficiary's employment path service activities must be designed to support employment goals, and can replace non-work services.

2. **Part of PCSP**: beneficiaries receiving employment path services must have goals related to employment in integrated community settings in their person centered service plan ("**PCSP**").

3. **Limits**: employment path services are time-limited and require prior authorization for the first twelve (12) months. One re-authorization of up to an additional twelve (12) months is possible, but only if the beneficiary is also receiving job development services, which indicates the beneficiary is actively seeking employment.

4. **Required Documentation**: the Provider must produce and maintain the following documents in the beneficiary's service record to demonstrate compliance with delivery of employment path services:

    - Beneficiary's PCSP
    - Detailed progress notes/narratives
    - An Arkansas Rehabilitation Services ("**ARS**") referral letter for beneficiary

C. Employment Supports Services

Employment supports services consist of two (2) primary components: (i) job development and (ii) job coaching.

1. **Job Development**: individualized services that are specific in nature to obtaining a 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 thirty (30) days after job development services commence. The Job Development Plan must at a minimum specify:

    - The short and long term employment goals, target wages, task hours, and special conditions that apply to the worksite for that beneficiary.

- The jobs that will be developed and/or description of customized tasks that will be negotiated with potential employers.

- An initial list of employer contacts and plan for how many employers will be contacted each week.

- 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 job coaching services may include, but are not limited to, the following:

    - Complete job duty and task analysis.
    - Assist the beneficiary in learning to do the job by the least intrusive method.
    - Develop compensatory strategies, if needed, to cue beneficiary to complete job.
    - Analyze work environment during initial training/learning of the job.
    - Make determinations regarding modifications or assistive technology.

    This service may also be utilized when the beneficiary chooses self-employment. Activities such as assisting the beneficiary 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.

3. **Required Documentation**: the Provider must produce and maintain the following documents in the beneficiary's service record to demonstrate compliance and delivery of employment support services:

    a) Job development

        1. Job Development Plan
        2. Beneficiary's remuneration statement

    b) *Job coaching*: the Provider must develop a fading Job Coaching Plan to be completed within twelve (12) months. Additional authorizations of Employment Supports Job Coaching with no additional fading gains will require additional documentation of level of need for service.

D. Employment Supports Extended Services

1. **Services Included**: 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 beneficiary's personal and career planning goals. This service allows for the continued monitoring of the employment outcome through maintenance of regular contact with the beneficiary and employer. Activities allowed under this service must include, but are not limited to, a minimum of one (1) contact per quarter with the employer.

2. **Required Documentation**: The Provider must maintain the following documents to demonstrate compliance and delivery of this service:

    - ARS letter of closure.
    - Beneficiary's remuneration statement.
    - Beneficiary's work schedule, if available.
    - Detailed documentation of the topics and issues discussed during all Beneficiary and employer meetings/contacts.

1402. Minimum Qualifications

Providers must be currently licensed as a vendor by ARS as a Community Rehabilitation Program. Supported employment services must be provided by certified job coaches under the Provider's ARS license. Continued certification is a qualification requirement for the period the Provider is certified to provide supported employment services. Providers must maintain documentation of certification on file.

1403. Required Training

1. First Aid Training: Within thirty (30) days of hiring, all supported employment staff shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

    - The course must provide a certificate of completion that can be maintained in the supported employment staff's personnel file.

    - Any services provided by a supported employment staff person prior to receiving the above described First Aid Training can only be performed in a training role, under the supervision of another supported employment staff person that has already completed the required First Aid Training.

    - Training Certification must be maintained and kept up to date throughout the time any supported employment staff person is providing supported employment services.

2. Beneficiary Specific Training: Prior to beginning service delivery, supported employment staff must receive the amount of individualized, beneficiary-specific training that is necessary to be able to effectively and safely provide the supported employment services required pursuant to the beneficiary's PCSP, Individual Career Profile, and/or Job Development Plan, including, but not limited to:

    - general training on beneficiary's PCSP
    - behavior management techniques/programming;
    - medication administration and management;
    - setting-specific emergency and evacuation procedures
    - appropriate and productive community integration activities; and
    - training specific to certain medical needs.

    Documentation evidencing that the necessary types and amount of beneficiary-specific training were completed must be maintained in the personnel file of the supported employment staff member at all times. This type of individualized, beneficiary-specific training shall be required each time a beneficiary's PCSP is updated, amended, or renewed.

3. Other Required Training: supported employment staff must receive appropriate training on the following topics at least once every two (2) calendar years:

    - HIPAA Policies and Procedures
    - Procedures for Incident Reporting
    - Emergency and Evacuation Procedures
    - Identifying Unsafe Environmental Factors
    - Introduction to Behavior Management
    - Arkansas Guardianship statutes
    - Arkansas Abuse of Adult statutes
    - Arkansas Child Maltreatment Act
    - Nurse Practice Act
    - Procedures for Preventing and Reporting Maltreatment of Children and Adults
    - Other topics where circumstances dictate that supported employment staff should receive training to ensure the health, safety, and welfare of the beneficiary served.

    Documentation evidencing that training on the topics listed above was completed must be maintained in the personnel file of the supported employment staff member at all times.

4. DDS QA Mandated Training: DDS Quality Assurance has the ability to require a supported employment provider to conduct/administer specified training to an individual, a group, or all supported employment staff working for Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each supported employment service staff member at all times.

1500 PROVIDER QUALIFICATIONS: SUPPLEMENTAL SUPPORT SERVICES

1501. Qualifications

The Provider must require all staff that coordinate the expenditure of supplemental support funds to have at least one of the following qualifications/experience:

1. A Bachelor's degree in a human services field.

2. Two (2) years college credit and two (2) years' experience working with persons with developmental disabilities.

3. Two (2) years of verified experience working with persons with a developmental disability and have been mentored by a case manager for two (2) additional years.

4. Four (4) years of experience as a case manager in a related field.

1502. Supplemental Supports

A. Permissible Supplemental Supports

1. Ancillary supports such as non-recurring set-up expenses for beneficiaries in the event of a disaster, crisis, emergency or life threatening situation. Allowable expenses are those necessary to enable a beneficiary to establish a basic household 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. This service is furnished only to the extent that it is reasonable and necessary as determined through the beneficiary's PCSP development process, clearly identified in the beneficiary's PCSP, and the beneficiary is unable to meet such expenses, or when the services cannot be obtained from other sources.

2. Drug and alcohol screening in accordance with the beneficiary's treatment plan.

3. Activity fees such as dues at a YMCA, Weight Watchers, etc., used for behavior reinforcement or sensory stimulation. Fees are approved for the beneficiary only and for such time as to abate the life threatening condition. The services must be prescribed and monitored by medical professionals.

B. Exclusions

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

1503. Provider of Last Resort

Supplemental support services can be accessed only as a last resort. A lack of other available resources must be documented and proven prior to a beneficiary receiving supplemental support services.

1600 PROVIDER QUALIFICATIONS: COMMUNITY LIVING-RESIDENTIAL SETTINGS

1601. Accessibility Requirements

Provider owned/leased/rented residential settings must be fully accessible by the beneficiary, compatible with the services being provided to the beneficiary, and compatible with the needs of each beneficiary and their staff, as provided in the beneficiary's PCSP. Each Provider owned/leased/rented residential facility must be in compliance with U.S.C. § 12101 et. seq. "American with Disabilities Act of 1990," and 29 U.S.C. §§ 706 (8), 794 – 794(b) "Disability Rights of 1964."

1602. Regulatory Approvals

All water, food service, and sewage disposal systems must have the required approval of local, state, and federal regulatory agencies, as applicable.

1603. Safe and Comfortable Environment

The Provider must ensure that each Provider owned/leased/rented residential settings provide a safe and comfortable environment tailored towards the needs of the beneficiary/ies, as provided for in their PCSP/s. This shall include, but not be limited to:

1. All Provider owned/leased/rented residential settings must meet all local and state building codes, regulations and laws.

2. The temperature must be maintained within a normal comfort range for the climate.

3. The interior and exterior of the residential setting must be maintained in a sanitary and repaired condition.

4. The residential setting must be free of offensive odors.

5. The residential setting must be maintained free of infestations of insects and rodents.

6. All materials, equipment, and supplies must be stored and maintained in a safe condition. Cleaning fluids and detergents must be stored in original containers with labels describing contents.

1604. Emergency and Evacuation Procedures

The Provider must establish emergency procedures which include detailed actions to be taken in the event of emergency and promote safety. Details of emergency plans and procedures must be in written form, and shall be available and communicated to all members of the staff and other supervisory personnel.

A. There shall be written emergency procedures for:

1. Fires.
2. Natural disasters.
3. Utility failures
4. Medical emergencies
5. Safety during violent or other threatening situations

Additionally, the emergency procedures must satisfy the requirements of applicable authorities, and contain practices appropriate for the locale (example: nuclear evacuations for those living near a nuclear plant).

B. The Provider shall maintain an emergency alarm system for each type of drill (fire and tornado).

C. Beneficiaries, as appropriate, must be educated and trained about emergency and evacuation procedures.

D. Evacuation procedures must address:

1. When evacuation is appropriate.
2. Complete evacuation from the physical facility.
3. The safety of evacuees.
4. Accounting for all persons involved.
5. Temporary shelter, when applicable.
6. Identification of essential services.
7. Continuation of essential services.
8. Emergency phone numbers.
9. Notification of the appropriate emergency authorities.

E. In group living environments, evacuation routes must be posted in conspicuous places.

1605. Safety Equipment

Providers must maintain the following items in each setting in which beneficiaries reside:

1. Functioning smoke detectors, heat sensors, carbon monoxide detectors and/or sprinklers
2. Functioning fire extinguishers
3. Functioning flash light
4. Functioning hot water heater
5. Emergency contact numbers (i.e. law enforcement, poison control etc.)
6. First-Aid kit

1606. Required Independence and Integration

Beneficiaries must be safe and secure in their homes and communities, taking into account their informed and expressed choices. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.

A. Providers must take reasonable steps to ensure that beneficiaries are safe and secure in their homes and communities, taking into account the beneficiary's informed and expressed choices.

B. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.

C. Beneficiaries shall be allowed free use of all space within the group living setting/alternative living site with due regard for privacy, personal possessions of other residents/staff, and reasonable house rules.

D. Settings must be able to provide beneficiaries access to community resources and be located in a safe and accessible location. Beneficiaries must have access to the community in which they are being served. The site shall assure adequate/normal interaction with the community as a group AND as an individual.

    - This can be achieved through transportation or through local community resources.

E. The living and dining areas must be provided with normalized furnishings for the usual functions of daily living and social activities.

F. The kitchen shall have equipment, utensils, and supplies to properly store, prepare, and serve three (3) meals a day. Beneficiaries must have access to food at any time. Any modification to this requirement must be based on an assessed need and documented in the beneficiary's PCSP.

G. Bedroom areas are required to meet the following:

    1. Shall be arranged so that privacy is assured for beneficiaries. Sole access to these rooms cannot be through a bathroom or other bedrooms. Bedrooms must be equipped with a functioning lock with only appropriate staff having keys.

    2. Beneficiaries must have a choice of roommate when shared by one or more individuals. The Provider must actively address the need to designate space for privacy and individual beneficiary interests.

    3. Physical arrangements shall be compatible with the physical needs of the individuals.

4. Each beneficiary shall have an individual bed. Each bed must have a clean, adequate, comfortable mattress.

    a. Beds are of suitable dimensions to accommodate the beneficiary who is using it. Mattresses must be waterproof as necessary.

    b. Each beneficiary must have a suitable pillow, pillowcase, sheets, blanket, and spread.

    c. Bedding must be appropriate to the season and beneficiary's personal preferences. Bed linens must be replaced with clean linens at least weekly.

5. Bedroom furnishings for beneficiaries shall include shelf space, individual chest or dresser space, and a mirror. An enclosed closet space adequate for the belongings of each beneficiary must be provided.

6. Eighty (80) square feet per beneficiary in multi-sleeping rooms; one hundred (100) square feet in single bedrooms.

H. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

I. Bathroom areas are required to meet the following criteria:

    1. Sole access may not be through another beneficiary's bedroom. Commodes, tubs, and showers used by beneficiaries must provide for individual privacy.

    2. A minimum of one commode and sink is provided for every four (4) beneficiaries. Lavatories and commode fixtures are designed and installed in an accessible manner so that they are usable by the beneficiaries living in the residential setting.

    3. A minimum of one tub or shower is provided for every eight (8) beneficiaries.

    4. Must be well ventilated by natural or mechanical methods.

1607. Home and Community Based Services (HCBS) Settings Requirements

All providers must meet the Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the rule is 42 CFR 441.301(c) (4)-(5). All Provider owned/leased/rented residential settings must have the following characteristics:

1. Be chosen by the beneficiary 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.

    a. Choice must be identified/included in the beneficiary's PCSP.

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

2. Ensure a beneficiary's rights of privacy, dignity and respect and freedom from coercion and restraint.

3. Must optimize, but 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.

4. Facilitate beneficiary choice regarding services and supports and who provides them.

5. The setting must be integrated in and support full access to the greater community by the beneficiary, including the opportunity 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 CES Waiver services.

6. The unit or dwelling must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary 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.

7. Each beneficiary has privacy in their sleeping or living unit, which must include the following:

    i. Units have entrance doors lockable by the beneficiary, with only appropriate staff having keys to doors.
    ii. Beneficiaries sharing units have a choice of roommates in that setting.
    iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

8. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.

9. Beneficiaries are able to have visitors of their choosing at any time.

10. The setting is physically accessible to the beneficiary.

11. Any modification of the additional conditions specified in items 6 through 10 above must be supported by a specific assessed need and justified in the beneficiary's PCSP. The following requirements must be documented in the beneficiary's PCSP:

    i. Identify a specific and individualized assessed need.
    ii. Document the positive interventions and supports used prior to any modifications to the PCSP.
    iii. Document less intrusive methods of meeting the need that have been tried but did not work.
    iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
    v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
    vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    vii. Include the informed consent of the beneficiary.
    viii. Include an assurance that interventions and supports will cause no harm to the beneficiary.

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Community and Employment Support Waiver

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

D. Amendment Number:AR.0188.R05.02

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

10/01/17

Approved Effective Date: 10/01/17
Approved Effective Date of Waiver being Amended: 09/01/16

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment is to incorporate the following changes:

1.To require all Waiver participants be attributed to a Provider-led Arkansas Shared Savings Entity (PASSE) to receive care coordination after receiving an Independent Assessment by a Third Party Vendor that will establish their service intensity need and be used to develop the Person Centered Service Plan (PCSP).

2.To change the service definition of case management and to rename it care coordination. Care coordination is a broader service than case management and will be offered to all beneficiaries attributed to a PASSE. So that there is a seamless transition into the PASSE, care coordination will be offered as a Waiver service until a beneficiary is attributed, at which time care coordination will be delivered by the PASSE.

3. To add Person-Centered Service Plan (PCSP) Development as a component of the Care Coordination Service. The PCSP Developer will be responsible for developing and implementing the PCSP.

4. To change the supported employment service definition.

5. To clarify the use of restrictive interventions and restraints in our waiver. Nothing was changed or added to these requirements.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ **Waiver Application**	2, Attachment 1
☑ **Appendix A – Waiver Administration and Operation**	A-3, A-5, A-6, A-7
☑ **Appendix B – Participant Access and Eligibility**	B-6-a, B-6-f
☑ **Appendix C – Participant Services**	C1/C3, C-4-a
☑ **Appendix D – Participant Centered Service Planning and Delivery**	D-1-a, D-1-d
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☑ **Appendix G – Participant Safeguards**	G-2-a
☐ **Appendix H**	
☑ **Appendix I – Financial Accountability**	I-2-a
☑ **Appendix J – Cost-Neutrality Demonstration**	

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

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

Specify:
Require all Waiver participants to enroll in a PASSE for care coordination services after receiving an independent assessment by a third party vendor that will determine service intensity need and be used to develop the PCSP.

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

1. Request Information (1 of 3)

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

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

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: AR.0188
Waiver Number:AR.0188.R05.02
Draft ID: AR.006.05.02

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:
Not applicable.

1. Request Information (3 of 3)

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

○ **Not applicable**

◉ **Applicable**
Check the applicable authority or authorities:

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

☑ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:
The Arkansas Provider Led Care Coordination Program (PCCM Entity). A Waiver Application will be submitted simultaneously with this Waiver Amendment.
Specify the §1915(b) authorities under which this program operates *(check each that applies):*

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

☐ **§1915(b)(2) (central broker)**

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

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

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

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

All waiver beneficiaries are attributed to a Provider-led Arkansas Shared Savings Entity (PASSE) that provides care coordination services administratively through the § 1915(b) Waiver.

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

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

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

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

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

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

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

Websites for the Arkansas Waiver Association, the Developmental Disabilities Provider Association and Arkansas Medicaid contain
information about the Waiver amendments. The information was posted to the Arkansas Medicaid Website from July 13, 2017, to August 11, 2017. Other websites would have posted the information soon thereafter. DDS staff participated at provider conferences and took comments by phone

and email from providers and people receiving or applying for services.
DDS conducted a formal public comment period, with a public hearing held on August 8, 2017, at 4:30 p.m. Written comments were received and considered by DDS, and oral comments were made at the public hearing. Public comments are located in the section title Optional, along with DDS's responses.

Prior to the formal public comment period, meetings were organized and held for participants and their families to ask any
questions and make any comments. The following meetings were held where the DDS director or her designated Assistant Director spoke regarding these amendments:

January
18th Presentation to Senate Public Health
30th Presentation to Black Caucus

February
14th Meeting with Lainey Morrow with Medicaid Saves Lives
24th Provider Meeting at Easter Seals

March
29th Public Hearing at Little Rock Public Library, Transformation Track A and Track B
29th Public Meeting for families and consumers at ICM

April
3rd St. Vincent Hospital, Transformation Presentation
6th Open Horizons Conference
6th Livestream Presentation with families and consumers at Arkansas Support Network
10th St. Vincent Hospital, Transformation Presentation
11th Public Meeting for families and consumers at Easter Seals
17th St. Vincent Hospital, Transformation Presentation
24th St. Vincent Hospital, Transformation Presentation

May
4th Waiver Meeting with Waiver providers
9th Town Hall Meeting in Russellville
24th Meeting with Lainey Morrow with Medicaid Saves Lives

June
5th Meeting with Lainey Morrow
21st Town Hall Meeting, Springdale

July
12th AWA Conference
14th AWA Conference
19th Staff and Provider Meeting to discuss Transformation
25th Town Hall Meeting, Fort Smith

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 is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121)

and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Nye

First Name: Bradford

Title: Director, Office of Policy Development

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

Address: P O Box 1437, Slot S295

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

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

Fax: (501) 404-4619

E-mail: Brad.Nye@dhs.arkansas.gov

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

Last Name: Davenport

First Name: Regina

Title: Assistant Director for ACS Waiver Services

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

Address: P O Box 1437, Slot N502

Address 2:

City:	Little Rock
State:	**Arkansas**
Zip:	72203-1437
Phone:	(501) 683-0575 **Ext:** ☐ **TTY**
Fax:	(501) 682-8380
E-mail:	regina.davenport@dhs.arkansas.gov

8. Authorizing Signature

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

Signature:	Elizabeth Pitman
	State Medicaid Director or Designee
Submission Date:	Sep 14, 2017

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:	Divsion 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:** ☐ **TTY**

Fax:

(501) 682-6836

E-mail:

Dawn.Stehle@dhs.arkansas.gov

Attachments

Attachment #1: Transition Plan

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

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

This Waiver Amendment will operate concurrently with the § 1915(b) Arkansas Provider Led Care Coordination Program. Under these concurrent waivers, every participant will be enrolled in a Provider-Led Arkansas Shared Savings Entity (PASSE) and receive care coordination services administratively through the PASSE in which they are attributed.

Beginning on February 1, 2018 participants will be attributed to a PASSE. We anticipate attributing all Waiver participants in accordance with the following schedule:

Feb.	1400
Mar.	300
Apr.	300
May	400
Jun.	400
Jul.	400
Aug.	400
Sep.	400
Nov.	403

Any clients who were not assessed in this time period will be assessed in December, 2018. The CES Waiver care coordination service will no longer be available to Waiver participants once they are attributed to a PASSE and begin receiving care coordination through the PASSE. The state will cease offering the CES Waiver care coordination service as of January 1, 2019.

The State is scheduled to begin an independent functional assessment beginning October 1, 2017. Clients who have been deemed to meet Institutional Level of Care criteria will undergo an independent assessment to establish a service Tier that will be utilized when developing and approving the Person Centered Service Plan (PCSP). Results of the Independent Assessment will begin dictating the participant's level of service tier beginning on January 1, 2019.

Current participants will be transferred from their current level into a tier as follows:
1) Participants now classified as pervasive will be classified as Tier 3, until they undergo an Independent Assessment.

2) Participants now classified as limited or extensive will be classified as Tier 2, until they undergo an Independent Assessment.

For those participants receiving Supported Employment Services, the following two components will no longer be paid for as Supported Employment Waiver Services:

(1) Supported Employment Services furnished by a co-worker or job site personnel; and

(2) Personal Assistance.

Participants may still receive comparable services, however. Specifically, the supported employment vendor may enter into support agreements that allow for onsite employees to provide supported employment services; and participants may access personal care (a comparable service to personal assistance) as a state plan service.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State of Arkansas submitted and received final approval, 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://humanservices.arkansas.gov/daas/Pages/HCBS-Settings-Home.aspx.

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 - Community and Employment Support (CES) 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 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 CES 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 care coordination and direct service providers. The chosen PCSP developer assesses the person’s needs and wants and facilitates the development of the person-centered plan, which is approved by DDS staff. DDS CES Waiver staff will monitor services through random CES visits (minimum 10% per staff caseload). The care coordinator implements the PCSP. In addition, as part of the DDS certification process, DDS Licensure and Certification staff monitors services in the person’s home. DDS CES Waiver staff and DDS Licensure and Certification staff have been trained on the CMS Final Rule. Information on the HCBS Settings rule will be included in annual training opportunities for DDS CES Waiver staff and DDS Licensure and Certification staff.

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)].

Description of State Assessment of Current Level of Compliance

Review of State Policies and Procedures

DDS staff have reviewed and identified policies, provider manual, and certification requirement changes needed to comply with the federal HCBS settings regulations. The following documents were reviewed and a detailed policy crosswalk is included in this STP : DDS Certification Standards for CES Waiver Services, Medicaid Manual for DDS CES Waiver, and the ACS Waiver renewal application. Each of these documents will be amended to comport with the federal requirements. DDS anticipates the necessary revisions to be completed by October of 2017.

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

An inter-divisional HCBS Settings working group has met regularly since 2014 and will continue to meet during the implementation of the STP. The working group consists of representatives from DAAS, DDS, and Division of Medical Services (DMS) within the Arkansas Department of Human Services. The working group initially met to review the new regulations and develop the initial STP and corresponding timeline. The group has met with external stakeholders to discuss the new regulations.

DDS recognizes that group homes and provider owned or controlled apartments may be at risk for not meeting the full extent of regulations because the participant receiving services resides in and receives services in a home, group home, or apartment owned by the provider. The State considers DDS Staff Homes to have elements of provider-owned or controlled settings, and as such will plan to assess, validate, and remediate these as needed to assure full compliance with the HCBS Settings rule.

Provider self-assessment

To assess compliance with the new HCBS settings requirements, the inter-divisional HCBS Settings working group developed a residential provider self-assessment survey. The survey was developed using the exploratory questions provided in the CMS HCBS Toolkit. Each residential provider has completed and returned a self-study to DDS. The self-assessment survey served 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. DDS used the self–study as a means to notify providers of the new federal regulations and prepare them for possible changes in how they provide services. Survey responses were validated through on-site visits. The residential provider self-assessment is an integral part of the HCBS compliance process. The information gathered from this survey allows the State to provide tailored technical assistance to DDS providers as they move into compliance with the HCBS settings rule.

Validation of self-assessment (site visits).

Staff employed by DAAS, DDS, and DMS were assigned to regional site visit teams. Employees with a background in survey/data collection, auditing, and fieldwork were chosen to serve as reviewers and assigned to a regional site visit team. The aforementioned site visit teams conducted on-site visits on 100% of residential provider owned or controlled apartments and group homes. Random samples of beneficiaries within each site were selected for a beneficiary survey during the site visit. The residential provider owned or controlled group home and apartment site visits were completed in July 2016. The site visits followed a standard process including a brief introduction with setting administrators/staff, initial rounds with administrators/staff using the Residential Site Review Survey, request for supporting documentation, interviews with beneficiaries using the Beneficiary Survey, and an exit summary with administrators/staff.

Upon completion of the initial site visits and review of supporting documents provided by the provider, notes from the site review team member were summarized in a standardized report.A cover letter and the corresponding report were mailed to each provider following the on-site visit. The letter summarized the visit, noted areas needing clarification that were observed and documented, requested clarification of provider policies and procedures and/or a corrective action plan, and provided a deadline with which to comply with the requested action(s). DHS has provided technical assistance to providers throughout this time period.

Ongoing Assessment of Settings

Regularly scheduled on-site visits completed by the DDS Licensure and Certification unit, that oversees HCBS regulatory

requirements, will occur to ensure HCBS Settings compliance. DDS expects every residential setting to receive a visit at least once every three years, in addition to the current random home visit procedure (minimum 10% per staff caseload) of DDS Licensure and Certification unit. These visits will include a site survey and beneficiary experience surveys with a select number of Medicaid beneficiaries. DDS CES Waiver staff and DDS Licensure and Certification staff have been trained on the HCBS Settings rule. Information on the HCBS Settings rule will be included in annual training opportunities for DDS CES Waiver staff and DDS Licensure and Certification staff. Ongoing training for providers on the HCBS Settings rule will be provided through annual meetings of provider membership organizations and via updates to the Arkansas HCBS website.

Settings found to be out of compliance with the new regulations during these routine reviews will be required to submit and have approved a corrective action plan which includes a timeframe for its completion. Failure to complete that plan may jeopardize the agency's certification and participation in the waiver program. Providers who wish to appeal our findings can follow the appeal rights process described in DDS Policy 1076 Appeals.

Remediation

The inter-divisional HCBS Settings working group developed and conducted provider trainings as well as provided tailored technical assistance to partially compliant and non-compliant providers. In order to achieve initial compliance, DDS conducted multiple regional training opportunities for providers, beneficiaries, and advocates to discuss reoccurring themes from provider-initiated technical assistance phone calls, appropriate remediation strategies, heightened scrutiny, and ongoing compliance.

During the first half of 2017, the HCBS site review subcommittee along with the HCBS Settings working group will monitor provider compliance efforts through corrective action plans and follow-up site visits. Some corrective action plans may only require a desk audit, meaning the site visit and beneficiary surveys did not highlight any non-compliance issues. However, the provider policies may not reflect the true intent of the HCBS Settings rule and as such will need to undergo revisions to become compliant with the HCBS Settings rule. However, follow-up site visits will be conducted with all providers submitting substantive corrective action plans that require a change in procedure or reflect a culture change within that setting to ensure that providers are implementing the corrective actions outlined in the plan.

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.

Based on the accumulation of findings, the inter-divisional HCBS Settings working group will make a determination on which settings represent a home and community-based setting and should be submitted to CMS for review. The inter-divisional HCBS Settings working group will pay particular attention to beneficiary rights and community integration (as documented in the site survey, beneficiary surveys, provider site visit report and provider-initiated corrective actions) to ensure that the settings submitted to CMS for review reflect the qualities of an HCBS Setting and overcome the presumption of an institutional setting. The HCBS Settings working group will finalize the list of settings to be published for public comment prior to submission to CMS for heightened scrutiny review.

In cases where the State asks for heightened scrutiny by CMS for certain settings, the inter-divisional HCBS Settings working group will provide CMS with documentation (including site visit reports, site-specific assessment tools/results, corrective action plans or remediation strategies implemented by the provider/setting, information received during public comment period, information from external stakeholders, information received from the provider/setting, person-centered service plans, etc.) in an effort to demonstrate that the setting does not have the qualities of an institution and that it does have the qualities of a home and community-based setting.

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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The following comments were received during the public comment period:

We received several comments regarding the requirement that PASSE care coordinators not be affiliated with the Waiver participant's direct service providers.

We responded as follows: Based on public comment, DHS has clarified that it is the responsibility of the PASSE to comply with Conflict Free Case Management rules.

Comment: This [PASSE Manual] does not match the CES Waiver for DD which says that "contact" must be made monthly, but "face-to-face" must be made at least quarterly. Please clarify if "face-to-face" can be telemedicine.

Response: Within the context of care coordination, we have clarified that the use of video conferencing for the purpose of required contacts is allowable after the initial face-to-face visit. Telemedicine is still allowable under the Medicaid State plan in order to deliver a medical service.

Comment: Regarding conflict free case management, who is the care coordinator? What is the role of the direct care supervisor? Are they care coordinators? What separates the current case manager from the future care coordinator?

Response: Under the PASSE care coordination model, all case management/care coordination activities will be done by the PASSE care coordinator. To ensure continuity of service and consistency, we have changed the definition of case management in the CES waiver and changed the name of it to care coordination. The current case managers will provide care coordination as it is defined in the CES waiver to their clients until such time as those clients are attributed to a PASSE. Then the PASSE will take over providing care coordination.

Comment: How is the eligibility determination discussed in [PASSE Manual] different from the independent assessment, and/or is this a prior authorization?

Response: [This] describes what functions a care coordinator will be required to perform for a DD Waiver client. One of those functions in assisting with the ICF/IID Level of care
redetermination every year. A DD Waiver client will only have to undergo the Independent Assessment (IA) once every three (3) years unless there is a change in condition and another IA is requested. The IA will not be used to determine whether a client is eligible to receive waiver services that will be determined by DDS's intake and eligibility unit. The IA is a functional assessment that helps determine the individual client's service need.

Comment: Please clarify 'current state,' 'future state,' and changes for 1) care coordination staffing including case managers, direct care supervisor (DCS), 2) related fees for the services, and 3)responsibility for plan of care between current providers such as DD waiver case management, DCSs and PASSEs.

Response: Under the PASSE care coordination model, all case management/care coordination activities will be done by the PASSE care coordinator. To ensure continuity of service and consistency, we have changed the definition of case management in the CES waiver and changed the name of it to care coordination. The current case managers will provide care coordination as it is defined in the CES waiver to their clients until such time as those clients are attributed to a PASSE. Then the PASSE will take over providing care coordination.

Comment: Who will manage things like my child's pullups and meds? I manage them at present time and do not want someone else to take over. Will I be able to continue to manage these things?

Response: Yes, you will be able to continue to manage those things. The independent assessment will look at what is currently taking place to determine service needs. If you are currently meeting your child's needs the independent assessment will note that and that will be considered when forming the person centered service plan (PCSP).

Comment: Can the assessment find someone who is pervasive not eligible for Waiver?

Response: No, the Independent Assessment is a functional needs assessment and is separate from the eligibility determination.

So, the assessment will be used to determine the intensity of services a Waiver client needs, not to make them eligible or non-eligible for Waiver.

Comment: Will the plan of care, with goals (outcomes) be the responsibility of the providers or the care coordinators? If it is done by the care coordinators, how does provider have input on the needs of the client if don't agree with goals set (or not) by care coordinator, we think the client needs?

Response: In Phase I, the development of the Person Centered Service Plan (PCSP) will stay the same as it has been in the past.

Comment: If a consumer is pervasive level of care with inclusive opportunities for independence, how will that affect the change within the PASSE?

Response: Under the PASSE model, individuals currently classified as Pervasive level of care are until they are assessed being assigned Tier 2 which is the highest level of need (24 hour paid services and supports). This does not negate the ability for services and supports being provided in inclusive settings that offer maximum opportunities for independence.

Comment: Arkansas Medicaid is pushing supported employment. How is DDS proposing to actually provide licensing, training, and money to providers in order to serve our clients in this way? We're in a small town, have taken client with 20+ years dishwasher experience to apply several times for this job, last time, employer said had 200 people applying for 1 dishwasher job.

Response: DDS continues to promote supported employment options for individuals with disabilities. As part of our initiatives, DDS has worked with providers on a voluntary basis to provide assistance as providers transformed service delivery system in the employment arena. This assistance has included technical assistance through Consultants knowledgeable in the field who work directly with providers in their communities to develop provider/community specific planning; Inter/intra agency agreements to stabilize funding for Supported Employment and other activities. Through the implementation of the revised SE definition, greater flexibility in utilization of funding to better need employment support needs are being offered.

Comment: Do you get another Plan of Care development fee of $90.00 for revisions?

Response: Yes, with an approved Prior Authorization.

Comment: Who approves the plan of care?

Response: In Phase I, DDS will continue to approve.

Comment: The maximum of $90.00 per plan development is not enough money.

Response: Thank you for your comment.

Comment: Define specialty providers. The entire paragraph is confusing regarding care coordination. The whole 14 month transition time is confusing. Will care coordinators be only employed by the PASSE?

Response: As clients are attributed to a PASSE (if they are DD clients receiving services through the 1915(c) Waiver) the client will only receive care coordination under the PASSE. It will take approximately 14 months to completely transition all DD and BH clients into the PASSE model.

Comment: Will providers be allowed to subcontract with the PASSE with care coordinators?

Response: It will be the decision of each PASSE entity to determine the financial relationship with the care coordinators.

Comment: Why is lease supposed to be in the person centered file?

Response: The final rule for HCBS settings requires that individuals in residential settings have a lease, residency agreement or other form of written agreement that document protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. A copy of this document should be maintained in the individual's file for annual licensure review.

Comment: Why is rent expected to be one set fee among all? Consumers receive different amounts, why should one that gets $750 a month have to have a rule that they will pay the same as the one that receives $1200. When they can't afford anything extra as it is now.

Response: DDS does not set rates for rent.

Comment; Who issues the Interim Service Plan?

Response: DDS will continue to approve interim plans of care.

Comment: Seems like the PSCP Developer does a lot. Who employs the PSCP, how are they reimbursed with all the time and work for which they are completing? Looks like this person gets all the leg work completed and the care coordinator just comes by to collect the completed work or monitor the work. Providers will be doing as much as they are now and more with reimbursement reductions. How?

Response: We disagree and believe the role of the care coordinator under the PASSE model will work in coordination with the supportive living provider and PCSP developer.

Comment: This section deals with the requirements for a beneficiary's Person Centered Service Plan (PCSP). It states that "The beneficiary (or, if applicable, their legal guardian) must be an active participant in the PCSP planning and revision process." DRA would like this language revised to state "The beneficiary (and, if applicable, their legal guardian)..." This will ensure that the beneficiary always is considered a participant, even if they have a guardian. The language as written suggests that a beneficiary with a guardian may not be an active participant. Even a beneficiary with a guardian should have the right and opportunity to be an active participant in this process, which the suggested amended
language supports more clearly.

Comment: This section contains the language: "If the beneficiary or their legal guardian objects to the presence of any individual at the PCSP development meeting, then the individual is not permitted to attend...." DRA recommends that language be included to address situations where the beneficiary and guardian's wishes are in conflict. For example, the following language could be included: "If the wishes of the beneficiary or guardian are in conflict as to persons attending the meeting, the preferences of the beneficiary will be given primary consideration and take precedence where there is no compelling health and safety reason."

Response: DDS asserts that items regarding guardians will depend on the specifics listed in the actual guardianship order. Because of this, no blanket responses to these comments can be made.

Comment: This section states that Providers shall not refuse service to beneficiaries unless they cannot ensure the beneficiary's health, safety, or welfare. The stated intent of this policy is "to prevent and prohibit Providers from implementing a selective admission policy based on the perceived 'difficulty' of serving a beneficiary." Determining whether or not a Provider's refusal to serve is legitimate is left to the discretion of DDS. The section contains no mention of consequences for a Provider in the event that it is determined that they are refusing beneficiaries in violation of this policy. DRA requests that this section be amended to contain sanctions against Providers who violate this policy, and addressing what
actions will be taken by DDS in the event that a Provider demonstrates a pattern of improperly refusing to serve beneficiaries.

Response: Currently, Waiver Providers cannot refuse to continue to serve unless they cannot maintain health and safety.

Comment: This section discusses the required contact by a care coordinator with a beneficiary while their waiver status is in abeyance. We are concerned about the issue of in-person contact with the beneficiary. When a beneficiary is in the community, the standards require that a care coordinator make monthly contact with the beneficiary, with at least one in-person visit per quarter. However, under the standards, during the period of abeyance when a beneficiary is placed in a licensed or certified facility for up to 90 days (with possible renewal), the care coordinator is required to only "have a minimum of one (1) visit or contact each month...." This section does not require any in-person contact as currently written. The language of the abeyance section should be changed to clearly state that even though the beneficiary is institutionalized; the care coordinator is still required to make quarterly in-person visits.

Response: This was the intent and the policy has been clarified to reflect your statement above.

Comment: The draft CES Manual prohibits care coordination by case direct care providers, and it also says that providers may do so as long as they implement certain firewalls, which is the process used today. It is not clear if this language was intended or not, but the firewalls are similar to what we propose under “Solutions.” The draft CES Manual fails to provide a clear distinction between the direct care and care provider and the care coordinator, creating overlapping and confusing responsibilities. The draft CES Manual reflects the difficulty in trying to separate functions that should not be separated. One glaring example is that it states that the direct care provider is to provide a “PCSP Developer” to
develop and implement the person-centered service plan (PCSP), but the Care Coordination section says the person-centered

service plan is the responsibility of the care coordinator.
Other examples: Under 213.000 Supported Living (which is delivered by the direct service provider), the draft Manual charges the direct care provider with the following responsibilities: C.2 “Serving as liaison between the beneficiary, parents, legal representatives, care coordinator entity and DDS officials.” --Isn’t this care coordination?

Response: We respectfully disagree.

Comment: "Coordinating schedules for both waiver and generic service categories.” – Yet Care Coordination Services Section 220.000 says the care coordinator is responsible for “coordinating and arranging all CES waiver services and other state plan services.” It also says the care coordinator is responsible for “generic needs.” [...] “…determine whether the person is receiving appropriate support in the management of medication.” – Yet, the Care Coordination section lists “Medication management plan” as a care coordinator responsibility. (It also says the care coordinator is responsible for “Coordination of …medication management.” Does this have some meaning different than the direct care providers’
“support in the management of medication”?)

Response: The role of the care coordinator will be to work closely with all service providers, including the supportive living provider if applicable to ensure appropriate services and supports are being provided to the beneficiary.

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

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

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that

division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

The Division of Medical Services (DMS), within the Department of Human Services (DHS), is the State Medicaid agency 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;
10) Provide to DMS the results of monitoring activities;
11 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. DHS Program Integrity through the Office of Medicaid Inspector General (OMIG) 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.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
   - (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
     Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
     DMS and DDS contract with a Third Party Vendor to conduct Independent Assessments that will be used to determine the beneficiaries' service tier for the purpose of attribution to a PASSE and will generate a risk and needs report that can be used to create his or her PCSP.
   - ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

   - (●) **Not applicable**
   - ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
     Check each that applies:
     - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

       Specify the nature of these agencies and complete items A-5 and A-6:
     - [ ] **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
DDS is the division in charge of operational management of the Waiver and is responsible for oversight 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 Independent Assessor. The Contract will have performance measures that the Vendor will be required to meet.

   DMS's PASSE Certification Unit will have responsibility for monitoring the performance of the PASSE entities and the provision of Care Coordination.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Third Party Independent Assessor must submit monthly contractor reports to DMS and DDS that include:
1. Demographics about the Beneficiaries who were assessed;
2. An activities summary, including the volume, timeliness and outcomes of all Assessments and Reassessments; and
3. A running total of the activities completed.

   The Third Party Independent Assessor must submit an annual program performance report that includes:
1. An activities summary for the year, including the total number of assessments and reassessments;
2. A summary of the Third Party Contractor's timeliness in scheduling and performing assessments and reassessments;
3. A summary of findings from Beneficiary feedback research conducted by the Third Party Contractor;
4. A summary of any challenges and risks perceived by the Third Party Contractor in the year ahead and how the Third Party Contractor proposes to manage or mitigate those; and
5. Recommendations for improving the efficiency and quality of the services performed.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☑	☑	☐
Waiver enrollment managed against approved limits	☑	☑	☐
Waiver expenditures managed against approved levels	☑	☑	☑
Level of care evaluation	☑	☑	☐
Review of Participant service plans	☑	☑	☐
Prior authorization of waiver services	☑	☑	☐

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Utilization management	☑	☑	☐
Qualified provider enrollment	☑	☑	☐
Execution of Medicaid provider agreements	☑	☐	☐
Establishment of a statewide rate methodology	☑	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐
Quality assurance and quality improvement activities	☑	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
AA2: Number and percentage of applicants who had an initial LOC determination completed before receipt of services. Numerator: Number of applicants who had an initial LOC determination completed before receipt of services. Denominator: Number of LOC determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC Determination Report

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
AA4: Number and percentage of PCSPs completed in the time frame specified in the agreement with the Medicaid Agency. Numerator: Number of PCSPs completed in the time frame specified; Denominator: Number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Quarterly QA Report (Validation Chart Reviews)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: DMS reviews 20% of the charts reviewed by DDS during Individual File Reviews, as a validation review.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
AA5: Number and percentage of participants with delivery of at least one HCBS Waiver service per month as specified in the PCSP. Numerator: Number of participants with delivery of at least one HCBS Waiver service per month; Denominator: Number of participants served.

Data Source (Select one):
Other
If 'Other' is selected, specify:
No Waiver Service Report

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
	☐ **Weekly**	☑ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/-5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
AA7: Number and percentage of policies developed by DDS that are reviewed and approved by the Medicaid Agency prior to implementation . Numerator: Number of policies and procedures by DDS reviewed by Medicaid before implementation; Denominator: Number of policies and procedures developed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PD/QA Request Forms

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 Services Report (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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
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
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
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 Profiles (Validation Review)

		Sampling Approach*(check each that applies):*

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Developmental Disabilities Services (the operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DDS and DMS have an Interagency Agreement for measures related to administrative authority of the HCBS Waiver.

In cases where the numbers of unduplicated beneficiaries 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, as part of the Interagency Agreement. In cases where policy or procedures were not reviewed and approved by DMS, remediation includes DMS reviewing the policy upon discovery, and approving or removing the policy.

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

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

Remediation associated with provider certifications that are not current according to the DDS/DMS agreement 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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**
○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☑	Autism	0		☑
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

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

DDS eligibility is established by Arkansas Code Annotated, Section 20-48-101. The statute applies to Intermediate Care Facilities for Intellectual or Developmental Disability (ICF/IDD) and the HCBS Waiver. DDS interprets a developmental disability to be (1) a categorically qualifying diagnosis and three (3) significant adaptive behavior deficits related to this diagnosis. Following are the categorically qualifying diagnoses:

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

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

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

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

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

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c*.
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*.

  The limit specified by the State is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:
  - ( ) **Other**

    Specify:
- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that