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:**
Alternative Community Services Waiver Amendment
C. **Waiver Number: AR.0188**
Original Base Waiver Number: AR.0188.
D. **Amendment Number: AR.0188.R04.03**
E. **Proposed Effective Date:** *(mm/dd/yy)*
07/01/10
Approved Effective Date: 05/03/11
Approved Effective Date of Waiver being Amended: 07/01/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

To add 60 reserved capacity slots at the maximum for pervasive level of care to the Alternative Community Services (ACS) waiver for transiti
Services.

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	7A; 8
☐ Appendix A – Waiver Administration and Operation	
☑ Appendix B – Participant Access and Eligibility	3.a; 3.b and 3.c
☐ Appendix C – Participant Services	
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	

☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☑ **Appendix J – Cost-Neutrality Demonstration**	J1, J2a, J2d

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:

Add reserved capacity as priority for community transition of children in the custody of the Department of Human Services, Division of Children and Family Services.

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*):

Alternative Community Services Waiver Amendment

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.R04.03
Draft ID: AR.06.04.09

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/09
Approved Effective Date of Waiver being Amended: 07/01/09

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 the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:
  NA

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:

  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 Alternative Community Services (ACS) Waiver is to support individuals of all ages who have a developmental disability, 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 co persons from institutions to community living and also help persons to remain in a community setting.

The objectives are as follows:

1) to transition eligible persons who choose the waiver option from residential facilities into the community;

2) to provide priority services to persons who meet the pervasive level of service (imminent danger and requiring supports twenty-four hour

3) to enhance and maintain community living for all persons participating in the waiver program.

Under the organizational structure of the Department of Human Services (DHS), the Division of Medical Services (DMS) is the state Medicai Appendix A-2-b for items in interagency agreement). The Division of Developmental Disabilities Services (DDS), also within DHS, is respon services are delivered through private providers who are certified by the DDS Quality Assurance Section. The providers must first meet DD services.

All waiver services are accessed through DDS Adult Services, DDS Children's Services or the ICF/MR services intake and referral staff. The choice of waiver services or ICF/MR services. The completed application packet is transmitted to the DDS Waiver Application Unit. This uni authorized waiver positions. The DDS Waiver Application Unit is also responsible for assuring a person meets ICF/MR and Medicaid incom local DHS county offices offer choice of providers; participate in plan development of at least 10% of all waiver recipients; review and appro Specialist are subject to review and monitoring by the applicable DDS Area Manager who retains oversight responsibility. All plans at the p Review Committee. This Committee is chaired by the Waiver Program Director who retains final Committee action authority if consensus can Specialists in each area. All ACS Waiver services must be prior authorized by DDS.

The approved services can be delivered by DDS certified providers who have enrolled with DMS or by sub contracted providers who partici certified and DMS Medicaid enrolled providers to sub-contract for service delivery by local contractors, individuals, and businesses who ca services they will deliver, the counties they will serve and the maximum number of people they will serve. Providers are permitted to change that provider at the time the change is desired. Maximum capacity number will only be reduced through attrition. All services must be delive

The Person Centered Service Plan assures input not only as to what services are needed and desired but also input from the individual and t process is ever cognizant that the place of service delivery is the individual's home. Home rules such as allowance of pets, smoking vs. non-

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/MR.

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:

Arkansas secures public input into the development or revision of the waiver through standing communications with the Arkansas V
asked questions segments. In addition, a DDS waiver team, representative of providers and consumers, participates and provides inp
Arkansas Waiver Association, Arkansas Advocacy for Equal Access, Developmental Disabilities Provider Association, Community
consensus basis. It is representative of professionals, persons and families. Additional persons or groups are formed as needed to r
Waiver Association, Arkansas Advocacy for Equal Access, Developmental Disabilities Provider Association, Community Providers
DDS websites for general public comment. Subsequent to changes by DMS, DMS approves the application or amendment and subm
promulgated in accordance with the Arkansas Administrative Procedure Act. This Act allows for another opportunity for public com
Sub-Committee, the implementing regulations, policies, rules and procedures are adopted into the DMS Medical Services Manual. Th

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:	Edwards
First Name:	LeAnn
Title:	Waiver Quality Assurance Administrator/Chief Program Administrator
Agency:	Department of Human Services, Division of Medical Services
Address:	P O Box 1437, Slot S295
Address 2:	
City:	

Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 682-8359 **Ext:** ☐ **TTY**

Fax: (501) 682-2480

E-mail: leann.edwards@arkansas.gov

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

Last Name: Cromer

First Name: Carole

Title: Assistant Director of Waiver Services

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

Address: P O Box 1437, Slot N502

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 682-8689 **Ext:** ☐ **TTY**

Fax: (501) 682-8687

E-mail: carole.cromer@arkansas.gov

8. Authorizing Signature

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

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

Signature: Glenda Higgs

State Medicaid Director or Designee

Submission Date: Feb 9, 2011

Last Name: Gessow

First Name: Eugene I.

Title: Director

Agency: Arkansas Department of Human Services, Division of Medical Services

Address: PO Box 1437, Slot S-401

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 682-8292

Fax: (501) 682-1197

E-mail: eugene.gessow@arkansas.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Division of Developmental Disabilities Services

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

The Division of Medical Services (DMS) is the state Medicaid agency and has administrative authority for the waiver including the following items as outlined in the DMS/DDS interagency agreement:

1) Development and monitoring of the interagency agreement to assure that provisions specified are executed;

2) Conducts oversight of the ACS program through a DMS case record review process that allows for response to all individual and aggregate findings;

3) Reviews and approves, via Medicaid Manual promulgation process, public policy and procedures developed by DDS regarding the waiver and monitors their implementation;

4) Reimbursement of services to eligible Medicaid recipients by certified providers who are enrolled in the Medicaid Program;

5) Promulgation of the DDS ACS Waiver Provider Manual which provides the rules and regulations for participation in the Arkansas Medicaid Program;

6) Final authority on all functions related to provider participation in the Arkansas Medicaid Program;

7) Training of providers on proper procedures to follow in submitting claims (through fiscal agent, EDS);

8) Notification to providers of participative changes in the Arkansas Medicaid Program;

9) Responding to provider questions concerning submission of claims (through EDS);

10) Insure providers remain in compliance with rules and regulations required for participation in the Medicaid program;

11) Reviews provider information and makes a determination whether to enroll the provider into the Arkansas Medicaid Program;

12) Assigns each new enrolled provider a unique Medicaid provider number;

13) Notifies DDS of any providers removed from the active Medicaid provider file;

14) Establishes a mechanism to insure a specified number of service plans are reviewed by DMS or their designated representative;

15) Provides DDS with relevant information pertaining to the Medicaid program and any federal requirements governing applicable waiver programs;

16) Monitors compliance with the interagency agreement;

17) Completion and submission of CMS 372 Annual Report.

The Division of Developmental Disabilities Services (DDS), also within DHS, is responsible for operation of the waiver including the following items as outlined in the interagency agreement:

1) Development and implementation of internal, administrative policies and procedures to operate the waiver is the responsibility of DDS. DMS does not approve these internal procedures but they are reviewed to ensure there are no compliance issues with either State or Federal Regulations. The DDS develops and implements public policy and procedures. DMS approves and promulgates public policy in accordance with the state's Administrative Procedures Act;

2) Provide training to providers regarding certification requirements set forth by DDS;

3) Certification of qualified providers who request to render ACS Waiver services and provides information on certified providers to DMS;

4) Conducts certification surveys of providers in accordance with current DDS policies and procedures to verify certification status of providers;

5) Notification to DMS of any provider who DDS disqualifies and removes from the ACS Waiver Program;

6) Establishing and monitoring the person center service plan requirements that govern the provision of services;

7) Monitoring professionals who conduct the service plan development, implementation and monitoring process;

8) Coordinates the collection of data and issuances of reports through MMIS with DMS as needed to complete the CMS 372 Annual Report;

9) Provides DMS results of monitoring activities;

10) Develop and implement a Quality Assurance protocol that meets criteria as specified in the interagency agreement.

DDS is also responsible for:

1) Determining waiver participant eligibility according to DMS rules and procedures;

2) Implementing service delivery through a prior authorization process;

3) Providing technical assistance to providers and consumers on waiver requirements, policies, procedures and

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.:*
   - ◉ **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:

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:

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
Participant waiver enrollment	☑	☑
Waiver enrollment managed against approved limits	☑	☑
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☑
Rules, policies, procedures and information development governing the waiver program	☑	☑
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
The Division of Medical Services (Medicaid Agency) Quality Management Administrator meets quarterly with the Division of Developmental Disabilities Services (Operating Agency) Waiver Program Administrator.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QA Review Summary Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = The Raosoft Calculation System to determine the sample size. The system provides a statistically valic sample with a 95% confidence level and a +/-8% marg of error with a confidence interval of 8.
☐ **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:
The Division of Medical Services (Medicaid Agency) Quality Management Administrator and Division of Developmental Disabilities Services (Operating Agency) Waiver Program Administrator receive and review management reports.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Monthly, Quarterly, Semi-Annual, and Annual Reports

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

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
The semi-annual Level of Care Report identifes the number of assessments conducted, the appropriateness of the instrument used, and the remediation taken

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:
The monthly Plan of Care Report identifies the newly enrolled participants and the total waiver participant count

for comparison against approved limits.

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:
The monthly ACS Year-to-Date Financial report provides a report of actual expenditures for each waiver service.

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:
The monthly provider recertification report is reviewed and compared with data from MMIS. Effective July 1, 2009, DMS will began a record review of the provider recertification process.

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:
The Incident Database is updated at least weekly and reviewed by DMS. Serious incidents and deaths of the waiver participants are recorded, tracked and require follow up.

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:
The Division of Medical Services (Medicaid Agency) Quality Management Administrator and Division of Developmental Disabilities Services (Operating Agency) Waiver Program Administrator monitor compliance with the Interagency Agreement and for updating the Interagency Agreement, if needed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The Interagency Agreement between DMS and DDS

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **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:
The DMS QA Unit reviews waiver participant case record to assure the service plan is current, a new service plan is completed prior to the expiration of the previous plan and the service plan is updated or revised as the participant's needs change.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = The Raosoft Calculation System to determine the sample size. The
☐ **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:
Rules, policies, procedures and information governing the wavier program are submitted to the Division of Medical Services (Medicaid Agency) Quality Assurance Unit for review and approval prior to implementation. The rules, policies and procedures are distributed to stakeholders for review and comments.

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Prior to implementation	

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: prior to implementation

Performance Measure:
The Division of Medical Services (Medicaid Agency) Financial Section reviews any rate methodology established by the Division of Developmental Disabilities prior to implementation.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: As requested	

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: As requested

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

b. Methods for Remediation/Fixing Individual Problems

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

DMS prepares a monthly Summary of Case Review Findings Report for all files reviewed. The reports are summarized into quarterly and annual reports which are sent to the operating agency, DDS. In both quarterly and annual reports, DMS provides DDS with recommendations for remediation to improve the quality of operation of the waiver.

As individual service problems are discovered by DMS and reported to DDS they are corrected through notification to the applicable DDS Program Manager. The DDS Program Manager works with the applicable DDS Specialist and provider case manager to resolve the identified problems. All attempts at resolution are documented in writing and proof of correction is required. A follow up report is compiled and submitted to DMS summarizing actions taken. In the

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 a group 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 waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

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			☐
◉ Mental Retardation or Developmental Disability, or Both					
	☑	Autism	0		☑
	☑	Developmental Disability	0		☑
	☑	Mental Retardation	0		☑
○ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

Note: Mental retardation and developmental disability are both recognized as target groups. Developmental disability includes Cerel person to function as though they had mental retardation.

DDS eligibility is established by Arkansas Code Annotated, Section 20-48-101. The statute applies to the State Operated ICF/MR faci cerebral palsy, epilepsy, and autism are separate and distinct disabilities and any of these disabilities with significant adaptive behavi

Cerebral palsy is established by the results of a medical examination provided by a licensed physician.

Epilepsy is established by the results of a neurological examination provided by a licensed neurologist and/or a licensed physician.

Autism is established by the results of a team evaluation by at least a licensed psychologist or psychological examiner and speech pa

Mental retardation as established by significant intellectual limitations that exist concurrently with deficits in adaptive behavior that i approximately 70 or below as measured by a standard test designed for individual administration. Group methods of testing are unac

DDS eligibility also includes the following: Attributable to any other condition of a person found to be closely related to mental reta with mental retardation and requires treatment and services similar to those required for such persons. For persons being evaluated deficits in adaptive behavior that is manifested before the age of 22. Significant intellectual limitations are defined as a full scale intel retardation because it results in impairment of general intellectual function or adaptive behavior similar to those of persons with ment be eligible for services if the person's full scale IQ scores are approximately 70 or below the mean of a standardized test or the person' the persons required treatment.

OR

Attributable to dyslexia that causes the individual to function at the level of mental retardation (intellectual disability); and originates constitutes a substantial handicap to the person's ability to function without appropriate support services including, but not limited t and employment. When age becomes a factor in eligibility determination, under Arkansas law, such cases will be evaluated on their r authority will be the DDS Director or the DDS Assistant Director.

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

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

- ( ) **A level higher than 100% of the institutional average.**

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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

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

impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4203
Year 2	4263
Year 3	4263
Year 4	4263
Year 5	4263

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

○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	4083
Year 2	4143
Year 3	4143
Year 4	4143
Year 5	4143

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Community Transition of children in foster care	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup)*:

Community Transition of children in foster care

Purpose *(describe)*:

60 waiver openings (slots) at pervasive service level are being added and reserved for persons in foster care in the care or custody of the Department of Human Services, Division of Children and Family Services, including

Describe how the amount of reserved capacity was determined:

The reserved capacity was determined based on the need for children to live in a caring community setting; capacities determined by existing children waiting for waiver services, factored by transition to regular capacity

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	0
Year 2	60
Year 3	60
Year 4 (renewal only)	60
Year 5 (renewal only)	60

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

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

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

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

1) General Requirements: DDS policy requirements for information release, choice of community versus institution (102 choice form),and social history documents are executed.

2) Selection for participation is as follows:

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

b) In order of waiver application determination date of persons for whom waiver services are necessary to permit discharge from an institution, i.e., ICF/MR residents, Nursing Facility residents, and Arkansas State Hospital patients; or admission to or residing in a Supported Living Arrangement (group homes and apartments).

c) In order of date of Department of Human Services (DHS) custodian choice of waiver services for eligible persons in the

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

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

- ( ) **No**
- (●) **Yes**

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- (●) **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Children who are receiving Title IV-E subsidy services or funding.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. **Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. **Allowance for the needs of the waiver participant** (*select one*):

○ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

- **A percentage of the Federal poverty level**

  Specify percentage:

- **Other standard included under the State Plan**

  Specify:

- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.

- **The following formula is used to determine the needs allowance:**

  Specify:

  The maintenance needs allowances is equal to the individual's total income as determined under the post-eligibility process which includes income that is placed in a Miller trust.

- **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable (see instructions)**
- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

  Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○ **The State does not establish reasonable limits.**
○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need

waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

In an instance of "Abeyance"(as defined under "Case Management", C1), it is possible that when the the case managem either decline to deliver the case management service or provide it pro bono. When the provider cannot be reimbursed, t service delivery and, therefore, maintenance of the person's waiver slot while they are temporarily out of service for spec

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

- ○ **Directly by the Medicaid agency**
- ◉ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ○ **Other**

Specify:

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

The initial evaluation of level of care is determined by a licensed psychologist or psychiatrist or individual working under the supervision of a licensed psychologist or psychiatrist except for persons with cerebral palsy which is determined by a licensed

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

The initial determination of eligibility for both the ACS Waiver and ICF/MR requires the same type of assessments; i.e. a 703 form, areas of need, social history, and psychological assessments applicable to the category of developmental disablity (Mental Retardation, Cerebral Palsy, Epilepsy, Autism or other condition that causes a person to function as though they have a condition of mental retardation. The DDS Psychology Team is responsible for determining both initial eligibility for the ACS Waiver and initial eligibility for ICF/MR institutional care. The same criteria (as specified in "B1b" is applied for both DDS Waiver and ICF evaluations and reevaluations. According to both state statute and DDS 1035, the psychology staff uses the same criteria to determine eligibility. The criteria is based on four components: 1) a categorically qualifying diagnosis is established; 2) age of onset is established prior to age 22; 3) substantial functional limitations in activities of daily living are present; and 4) the disability and deficits are expected to continue indefinitely.

Relative to support documentation for the 703, the DDS Psychology Team considers any of the Wechsler Scales of Intelligence, the Stanford-Binet Scaled of Intelligence, the Vineland Adaptive Behavior Scales and the Adaptive Behavior Assessment Scales to be preferred assessments to use in the determination of eligibility to the ACS Waiver. It is noted that any standardized assessment of intellect and adaptive behavior (that surveys activities of daily living) deemed appropriate by the licensed professional completing the evaluation will be considered. Therefore, the four assessment instruments identified by the DDS Psychology Team as preferred would not be the only assessments accepted. As new assessments are developed the team will review for suitability to the task of determination of eligibility.

The state assures valid reliable results by requiring that assessments submitted in the application process be administered by persons licensed by an appropriate state board. The DDS Psychology Teams accepts assessments deemed appropriate by the duly licensed professional. The quality assurance is therefore two part 1) the state license and 2) the use of standardized instruments.

A DDS team composed of psychological examiners and psychologists (employed or contracted) reviews the assessments and determines if the instruments used are appropriate based upon age, mental capacity, medical condition and physical limitations. This process recognizes that while one instrument may be appropriate for a person who is an adult with no visual or hearing deficits, it is not appropriate for a child age 5 who has visual and hearing deficits. The DDS maintains records of instruments used and assures the appropriateness based on like and similar factors as afore identified. Concurrent with the assessment instrument scores and written reports, a social history and areas of needs assessment is required. In addition, a qualified mental retardation professional (QMRP - physician) assures annual level of care and prescribes waiver services to meet the individual's needs using the DDS 703 form that has been previously approved by CMS and requires physical examination and review of the plan of care. The DDS 703 is comparable to the DHS 703 utilized by the state institutions is modified to be specific to the ACS waiver) Both intelligence quotient and adaptive functioning must demonstrate significant limitations that exist concurrently with deficits in adaptive behavior that is 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. Adaptive functioning is also defined as a score of 70 or below as measured by a standard test designed for individual administration with at least 3 areas of deficit in the 8 major life activities.

At the time of each annual plan of care review, DDS notifies the waiver providers as to the anniversary date of the annual plan of care review and the anniversary date of the next full evaluation. Prior to the anniversary date, waiver providers must gather from applicable sources and submit the annual continued stay review, IQ and adaptive functional level assessments based on ages described in the next paragraph, in addition to assuring compliance for an annual re-certification of level of care as determined by the prescribing physician (QMRP)

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

All applicants are evaluated using the process described in B6d for both ICF and waiver intial evaluation process. That is; completio
Reevaluation is comparable in that all persons participating in the Waiver are re-evaluated annually for level of care using a DDS 703
as the DHS 703 in that the DDS 703 requires physician review of the plan of care and physical examination. Arkansas requires the Q
matters of appeal. This process is consistent with the requirements and process at the State operated ICFs.

For the milestone reevaluations, the waiver individual or provider obtains a psychological, IQ and adaptive assessments and submits
the DDS Psychological Team may require other instruments to be used as deemed applicable to the age, mental, medical and physical
the functional assessment; as well as, assures proof relative to age of onset and applicability of conditions. This team may require ad
certification of long term care needs by a physician. The team is the final authority for a level of care determination with the exceptior
the Waiver and ICFs.

The milestone reevaluations are conducted based on age milestones using the same process as the initial evaluation. Milestones are

1) For an individual birth to five years of age, the initial and continued stay review eligibility is based on intelligence quotient and ad
until age 5 is reached.

2) For ages five to twenty-two years, or until a person has a diploma or certificate of completion from a high school, the public or pri

3) For ages twenty-two and older (or eighteen to twenty-two if the person has a diploma or certificate of completion from a high scho
Thereafter, a current adaptive behavior assessment is required every five years. Evaluation may be required by DDS on a more freque

The annual twelve month individual plan of care revaluations are made by a physician (QMRP) who determines the continued level o
the full evaluation and the QMRP re-evaluation are required.

This process is consistent with the requirements and process at the State operated ICFs. The only difference is the age milestones in
children is one category with psychological assessments every three years whereas for ages 0-school age the Waiver process is asse

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

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

A waiver database report is generated monthly identifying any DDS eligibilities (age milestones) and annual level of care (QMRP) eva continued stay review requires certification of level of care by a licensed physician (QMRP) via 703. The report is sent to the provid assessments and prescriptions. The case manager is responsible for submitting all documents required for the annual continued stay the same information sorted by assigned DDS Specialists. These reports help assure that no aspect of level of care expires.

In addition, a waiver database report is generated monthly identifying any full (age milestones) reevaluations that are due to expire wi with the initial date established by the DDS Psychology Team who certifies eligibility. The report is sent to the provider case mana monthly waiver database report identifying the same information sorted by DDS Specialist. These reports are timely to help assure th

At each annual continued stay review, the next full review date (age milestones) is displayed on the person centered plan of care with individuals and providers in maintaining compliance. The annual twelve month individual plan of care revaluations are made by a ph years when age milestones apply for a full evaluation, both the full evaluation and the QMRP re-evaluation are required.

AGE MILESTONES ARE:

1) For an individual birth to five years of age, the initial and continued stay review eligibility is based on intelligence quotient and ad until age 5 is reached.

2) For ages five to twenty-two years, or until a person has a diploma or certificate of completion from a high school, the public or pri

3) For ages twenty-two and older (or eighteen to twenty-two if the person has a diploma or certificate of completion from a high scho Thereafter, a current adaptive behavior assessment is required every five years. Evaluation may be required by DDS on a more freque

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

The evaluation and reevaluation records are maintained by DDS field operations staff (DDS Specialist or Area Manager depending on case load assignment) in the individual case files which are located in assigned DHS county offices and by the providers in their local files. DDS Waiver Section is engaged in developing a fully electronic Person Centered Service Plan system and when fully implemented, all records will be maintained in an electronic environment with protected security and access. It is anticipated this project will be complete by July 1, 2011. This projection is based upon information technology programming to be accomplished, transition of records as continued stay reviews become due and the completion of scanning

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

      Performance Measures

      For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

      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:
      A LOC evaluation is conducted at the time of waiver admission, meaning that a vacancy exists and the applicant is released from the wait list for waiver services.

      Data Source (Select one):

Record reviews, off-site
If 'Other' is selected, specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
In accordance with the discovery process, the DDS Psychology Team compiles summaries and analysis with quarterly reports of findings and remediation.

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: Semi-annual starting July 2008

Performance Measure:
There will be consistent use of assessment instruments and technologies for 100% of all cases based on identified characteristics of age, diagnoses, medical and physical conditions.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **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:
Level of care is conducted using instruments and techniques included in the approved waiver applicable to the individual's age, diagnoses, and physical and medical conditions.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **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: Semi-Annual

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
DDS Waiver Administration staff sends sixty-day advance notice of the need for reevaluation of level of care to provider case managers, DDS Specialists and DDS Area Managers.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **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: Semi-annually

Performance Measure:
The DDS Waiver Specialist reviews and forwards to the DDS Psychology staff, full psychological assessments based on age milestones (Reference Eligibility B 6 f).

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **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: Semi-Annual

Performance Measure:
The DDS Waiver Specialists or Waiver Area Managers, as annual continued stay reviews are approved or disapproved, assure that the annual LOC (physician's certification form) has been completed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **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: Semi-Annual

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
The DDS Psychology staff reviews the assessments to determine and verify that testing and processes used are applied appropriately and according to the individual's age and conditions in order to determine participant level of care.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **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: Semi Annual

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.

A semi-annual Activity Report will be compiled listing various assessment instruments used, LOC determinations made including approvals or disapprovals, requests for additional information, accuracy of documentation and applicability

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.

Individual problems will be resolved as appeals are filed or as trends are identified.

Late or no level of care document submission: DDS designated Area Manager working with the case specific DD Specialist a prior authorization for case management reimbursement is ended and not re-initiated until the documents are submitted. Notic conducts investigation and determines if this is a single incident or if there is a pattern. When a pattern is found, a plan of co

When the cause is that of the individual or the legal representative, notice of intent to close the case within 30 days of the dat is initiated with notice of appeal rights.

If the failure deals with inability to obtain professional consultation due unavailability of credentialed professionals, DDS will

Instances of Incorrect Determinations: The DDS Psychology Team is responsible for all determinations and if a determination determination is denying eligibility, the DDS Psychology Team sends formal notification to the individual and applicable parti level of care, but not denial of services, the notice is provided to all applicable parties by the assigned DDS Specialist via the

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

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Intake and referral relative to the ACS waiver is vested within the DDS Children's Services Section for persons birth to 21 and within the DDS Quality Assurance Services Section for persons age 21 and over, inclusive of ages 18-21 if the person has graduated or been issued a certificate of high school completion. The DDS staff person explains by phone, personal visit or mail, the service options of ACS Waiver or ICF/MR to each person or their legally responsible person. The individual or legally responsible person completes the ACS 102 Choice form and selects either the ACS waiver program or ICF/MR placement. For persons residing in an ICF/MR, choice between the programs is offered annually at the time their annual program plan is due for continuance. Anyone residing in an ICF/MR can request ACS waiver services at any time by contacting the designated facility liaison. The liaison coordinates activities with the Waiver Applications Unit Administrator and assigned DDS Specialist. Annual choice is offered by the assigned DDS Specialist at the time of the individual's continued stay review. The choice form provides for minimal tracking identifiers to assure the individual maintains applicable and timely considerations regarding their choices. It also provides for supporting evidence that the options are an informed choice as attested to by the signature of the implementing DDS representative. These forms are maintained in the DDS Central Office for applicants and in the case files for waiver participants with information entered into the data base. As information

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

Individual ACS Waiver application packets including the choice form are maintained in the DDS Central Office during the application located in designated DHS county offices. A copy is also maintained by the waiver providers in their local files. Annual choices sub document storage environment with full implementation projected to be effective by July 1, 2010.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

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

DDS provides information in an alternate format once the need for accommodation is identified. Identification for need is obtained through observation, document review for diagnosis and other case related information, and self or third party notification. Awareness is provided through training, employee technical assistance, communications with provider organizations and consumer advocates, and Department of Human Services (DHS) electronic medias. A waiver handbook is available in Spanish, hardcopy and

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid ager

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Service Definition *(Scope):*

Services that assist participants in gaining access to needed waiver and other state plan services; as well as, medical, social, education available.

Case Management services include responsibility for guidance and support in all life activities including locating, coordinating and mo

1) All proposed waiver services;

2) Other state plan services;

3) Needed medical, social, educational and other publicly funded services (regardless of funding source);

4) Informal community supports needed by eligible persons and their families.

The intent of Case Management services is to enable persons to receive a full range of appropriate services in a planned, coordinated,

Case Management services are responsible for the following activities:

1) Arranging for the provision of services and additional supports;

2) Monitoring and review of services included in the individual's service plan;

3) Monitoring and review of services to assure health and safety of the participant;

4) Facilitating crisis intervention;

5) Guidance and support to obtain generic needs;

6) Case planning;

7) Needs assessment and referral for resources;

8) Monitoring to assure quality of care and case reviews which focus on the person's progress in meeting goals and objectives establis

9) Providing assistance relative to the obtaining of waiver Medicaid eligibility and ICF/MR level of care eligibility determinations;

10) Assuring the integrity of all case management Medicaid waiver billing in that the service delivered must have DDS prior authorizati

11) Assuring submission of timely (advance) and comprehensive behavior and assessment reports, continued plans of care, revisions a eligibility determinations;

12) Arranging for access to advocacy services as requested by consumers in the event that case management and direct care supervis person when the case manager and the direct care supervisor work for the same provider entity. The direct care supervisor is the perso provides supportive living services. This is separate and apart from case manager responsibilities.

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

14) Provides assistance with appeals when appeal is chosen.

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

Case Management services may not include activities or services that constitute the provision of direct services to the participant that services are furnished or they receive state plan services).

Case Management will be provided up to a maximum of a 90 day transition period for all persons who seek to voluntarily withdraw from other available services and to assure that the person's needs can be met through optional services. It also serves to assure that the pe otherwise was unduly influenced to withdraw. During this 90 day timeframe, the person remains enrolled and the case remains open. D continue to be available up and until such time as the individual finalizes their intent to withdraw.

Case management waiver services will be furnished when payment to the hospital, NF or ICF/MR is being made through private pay or hospital, nursing facility or institution (ICF) receiving treatment, they are not residing in the treatment facility. Rather, just like any non- in which they reside) is maintained. When Medicaid is not the payer for the treatment, the waiver individual can remain enrolled in the month increments with not approval beyond 1 year.

Given the nature of the population of the ACS waiver, it is sometimes necessary to place cases in abeyance to allow the case to remain purposes of behavior, physical or health treatment or stabilization. On a monthly basis, the case management provider must conduct a provider does not conduct the monitoring contact for the month, the DDS Specialist is responsible.

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

There is a maximum reimbursement limit of $117.70 per month and $1,412.40 annually for each person served for the first year of the waiv based on the operating agency's funding resources.

Service contacts have minimum requirements depending on the person's service level. They are:

1) Pervasive - minimum of one face-to-face visit and one other contact with the individual or legal representative monthly. At least on

2) Extensive - minimum of one face-to-face visit with the individual or legal representative each month. At least one visit must be made

3) Limited - minimum of one face-to-face visit with the individual or legal representative each quarter and a minimum of one contact mo individual's place of residence.

These service levels are defined in Supportive Living, C-1.

4) Abeyance - minimum of one visit or contact a month by the Case Manager or the DDS Specialist (When the DDS Specialist performs Waiver Administrative budget.). Abeyance is used when a person is temporarily (must be out of service at least one month with abey program for purposes of behavior, physical or health treatment or stabilization.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Case Management Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Certified Case Management Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DDS certification as a Case Management provider.

Certified case management providers must demonstrate evidence of the following personnel requirements:

Case management staff must meet all of the following minimum requirements prior to working with consumers:

1) Hold a Bachelor's degree in a human services field; or have two years experience as a case manager working with individuals w
manager with individuals with a developmental disability or four years experience as a case manager in a related field may be subs

OR

Have two years verifiable satisfactory experience with individuals with developmental disabilities prior to employment and is ment

Note: This standard applies to those case managers hired after October 1, 2007 via a grandfather in clause. However, there is no
(OR)standard.

2) Have satisfactorily passed a criminal background check, and adult and child maltreatment registry checks. Criminal backgroun
checks must be repeated every two years.

3) Have satisfactorily completed a drug screen in accordance with the organization's policies and procedures.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Quality Assurance

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agei

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Service Definition *(Scope)*:

Respite services are provided on a short term basis to participants unable to care for themselves due to the absence of or need for relie room & board, except when provided as part of the respite care furnished in a facility approved by the state; FFP may not be claimed fo

Receipt of respite does not necessarily preclude a participant from receiving other services on the same day. For example, a participant

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 fi supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.

Respite services may be provided through a combination of basic child care & support services required to meet the needs of a child. W setting, waiver will only pay for the support staff required by the person's developmental disability. Parents & guardians will remain res

Respite may be provided in the following locations:

1) Participant's home or private place of residence;

2) The private residence of a respite care provider;

3) Foster home;

4) Medicaid certified ICF;

5) Group home;

6) Licensed respite facility;

7) Other community residential facility approved by the state, not a private residence. Respite care may occur in a licensed or accredite

8) Licensed day care facility, licensed day care home or other lawful child care setting. Waiver will only pay for support staff required d

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Respite Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Certified Respite Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Certified ACS Respite Care Providers must demonstrate evidence of the following minimum requirements for all direct care staff pr

1) Have a high school diploma, OR

Have successfully completed a GED, and have a minimum of one year of relevant, supervised work experience with a public health

Have a minimum of two years verifiable experience with individuals with developmental disabilities that may be used in lieu of the

Have two years of verifiable successful history (defined as either employment as a paid caregiver, support staff, teacher, or as an individuals with developmental disabilities.

Note: This standard applies to all Supportive Living Services direct care staff hired after October 1, 2007 via a grandfather in claus managers meet the substitution (OR)standard.

2) Have the ability to understand written activity plans, execute instructions and document services delivered;

3) Have the ability to communicate effectively with consumers;

4) Have the ability to access emergency service systems;

5) Have the ability to access transportation services required as appropriate;

6) Have satisfactorily passed a criminal background check, and adult and child maltreatment registry checks. Criminal backgroun checks must be repeated every two years;

7) Have satisfactorily passed a drug screen prior to employment.

8) Status is deemed for providers who have CARF or equivalent certification entities.

Documentation shall be maintained for review by DDS Quality Assurance Section.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Quality Assurance

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agen

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Service Definition *(Scope):*

Supported employment services consist of intensive, ongoing supports that enable participants for whom competitive employment at o perform in a competitive work setting. Supported employment may include assisting the participant to locate a job or develop a job on b work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by p at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training requ include payment for the supervisory activities rendered as a normal part of the business setting. The employer is responsible for making employment is a collaborative service with Arkansas Rehabilitation Services (ARS). All new waiver participants receiving supported er employment and that ARS funding is accessed first.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funde Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational trai

1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program

2) Payments that are passed through to users of supported employment programs; or

3) Payments for training that is not directly related to an individual's supported employment program.

Transportation between the participant's place of residence and the employment site is included as a component of supported employm to providers.

Supported employment does not include sheltered workshops or other similar types of vocational services furnished in specialized facil interaction among people without disabilities. Integration requires the person to work in a place where no more than 8 persons with dis or immediate vicinity thereof.

Supported employment services may be furnished by a co-worker or other job site personnel provided that the services which are furni the pertinent qualifications to be a provider of service.

Personal assistance may be a component part of supported employment services but may not comprise the entirety of the service.

Supported employment may include services and supports that assist the participant in achieving self-employment through the operati starting up or operating a business. Assistance for self-employment may include:

1) Aiding the participant to identify potential business opportunities;

2) Assistance in the development of a business plan, including potential sources of business financing and other assistance in develo

3) Identification of the supports that are necessary for the participant to operate the business; and

4) Ongoing assistance, counseling and guidance once the business is launched.

Individuals receiving supported employment services may also receive educational, prevocational and day habilitation services. A part However, different types of non-residential habilitation services may not be billed during the same period of the day.

Supported Employment includes:

1) Activities needed to sustain paid work by waiver individuals, including supervision and training.

2) Re-Training, job retention, or job enhancement

3) Job site assessments - The job coach, after consultation with each person in supported employment, can determine on a case by cas individual's needs.

4) Job maintenance visits with the employer for purposes of obtaining, maintaining and retaining current or new employment opportun information for the twice monthly assessment may be permitted. This may take a variety of forms including telephone calls with superv to the work site.

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

Supported employment cannot exceed $3.59 per 15 minute unit with a maximum of 32 units a day for the first year. This amount includes the operating agency's funding resources. Supported Employment provided as long term support requires monitoring at a minimum of t 15 hours minimum per week in accordance with ARS regulations. Exceptions must be justified by the individual's case manager and pri (such as medical involvement) citing why the person cannot work at least 15 hours per week must be prepared in writing by the individu

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☑ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Supported Employment Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Certified Supported Employment Vendor

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

DDS Certification as a Supported Employment Provider.

Qualified providers must be currently licensed as a vendor by the Arkansas Rehabilitation Services (ARS) as a Community Rehab coaches under the provider's ARS license. Continued certification is a qualification requirement for the period the organization is be maintained on file.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Quality Assurance in conjunction with Arkansas Rehabilitation Services

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agen

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Supportive Living

Service Definition *(Scope):*

Supportive Living is an array of individually tailored services & activities to enable persons to reside successfully in their own home, w
apartments, homes of primary caregivers, leased or rented homes, or provider group homes. Supportive living services may also be prov
needed in schedules and times of service delivery. Services are approved as maximum days that can be adjusted within the annual plan

Waiver funding will not reimburse for overtime. The payments for these services exclude the costs of the person's room & board expe

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

Residential habilitation supports are to assist the person to acquire, retain or improve skills in a wide variety of areas that directly affec
the supervision & support necessary for a person to live in the community. The supports that may be provided to an eligible person in

Decision making including the identification of & response to dangerously threatening situations, making decisions & choices affectin

Money management consists of training, assistance or both in handling personal finances, making purchases & meeting personal finan

Daily living skills including habilitative training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hyg
including proper use of adaptive & assistive devices, appliances, home safety, first aid and emergency procedures;

Socialization including training, assistance or both in participation in general community activities, & establishing relationships with pe

Community integration experiences include activities intended to instruct the person in daily living & community living skills in a clinic
in clubs, etc. Community experiences include activities & supports to accomplish individual goals or learning areas including recreatio
individual needs.

Transportation to or from community integration experiences is an integral part of this service and is included in the daily rate computat
not occur. The habilitation objectives to be served by such training must be documented in the person's service plan;

Mobility including training, assistance or both aimed at enhancing movement within the person's living arrangement, mastering the use
movement within the community;

Communication including training in vocabulary building, use of augmentative communication devices &receptive and expressive lang

Behavior shaping and management includes training, assistance or both in appropriate expressions of emotions or desires, compliance,

Reinforcement of therapeutic services which consist of conducting exercises or reinforcing physical, occupational, speech & other ther

Companion & activities therapy are services and activities to provide reinforcement of habilitative training. This reinforcement is accor
person's habilitative training. Through the utilization of an animal's presence, enhancement and incentives are provided to persons to
1) Language skills;
2) Increase range of motion;
3) Socialization by developing the interpersonal relationships skills of interaction, cooperation and trust & the development of self-resp

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

The Direct Care Supervisor employed by the Supported Living provider is responsible for assuring the delivery of all supported living c
1) The coordination of all direct service workers who provide care through the direct service provider;
2) Serving as liaison between the person, parents, legal representatives, case management entity & DDS officials;
3) Coordinating schedules for both waiver & generic service categories;
4) Providing direct planning input and preparing all direct service provider segments of any initial plan of care and annual continued st
5) Assuring the integrity of all direct care service Medicaid waiver billing in that the service delivered must have DDS prior authorizatic
6) Arranging for staffing of all alternative living settings;
7) Assuring transportation as identified in person's plan of care specific to supportive living services;
8) Timely collaboration with the case management entity to obtain comprehensive behavior & assessment reports, continued plans of
waiver Medicaid eligibility determination;
9) Reviewing the person's records & environments in which services are provided by accessing appropriate professional sources to de

Health maintenance activities may be provided by a designated care aide (supportive living worker). All health maintenance activities (
feeding and breathing apparatus /devices), except injections and IV's, can be done in the home by a designated care aide, such as a wa
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
maintenance activities are available in the Arkansas Medicaid State Plan as self directed services. State Plan services must be exhauste

Persons may access both supportive living and respite on the same date as long as the two services are distinct, do not overlap and the actually provided. DDS monitors this provision through retrospective annual look behind with providers responsible to maintain adequ daily rate is established in accordance with budget neutrality wherein both supportive living and respite independently and collectively

Controls to assure payments are only made for services rendered: Controls in place include requirement by assigned staff to complete plan of care objectives; supervision of staff by the direct care supervisor with sign off on timesheets maintained weekly; audits & revie (retrospective), random attendance at planning meetings & visits to the home; DMS random audits; & oversight by the chosen and as

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Supported Living Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supportive Living

Provider Category:

Agency

Provider Type:

Certified Supported Living Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

DDS Certification as a Supportive Living Provider.

Certified Supportive Living providers must demonstrate evidence of the following personnel requirements for all direct care staff v consumers:

1) Have a high school diploma, OR

Have successfully completed a GED, and have a minimum of one year of relevant, supervised work experience with a public health

Have a minimum of two years verifiable experience with individuals with developmental disabilities that may be used in lieu of the

Have two years of verifiable successful history (defined as either employment as a paid caregiver, support staff, teacher, or as an individuals with developmental disabilities.

Note: This standard applies to all Supportive Living Services direct care staff hired after October 1, 2007 via a grandfather in claus living providers meet the substitution (OR) standard.

2) Have the ability to understand written activity plans, execute instructions and document services delivered;

3) Have the ability to communicate effectively with consumers;

4) Have the ability to access emergency service systems;

5) Have the ability to access transportation services required as appropriate;

6) Have satisfactorily passed a criminal background check, and adult and child maltreatment registry checks. Criminal backgroun checks must be repeated every two years;

7) Have satisfactorily passed a drug screen prior to employment.

8) Status is deemed for providers who have CARF or equivalent certification entities.

Documentation shall be maintained for review by DDS Quality Assurance Section.

Other Standard *(specify)*:

Verification of Provider Qualifications

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid age

Entity Responsible for Verification:

DDS Quality Assurance

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Supplies

Service Definition *(Scope)*:

Specialized medical equipment and supplies include:

1) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the prop

2) Such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant fu

3) Necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical e or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Additional supply items are covered as a waiver service when they are considered essential for home and community care. A physiciar extension of such services. A denial of extension of benefits by utilization review will be required prior to approval for waiver funding b

1) Nutritional supplements;

2) Non-prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage.

3) Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under state plan are exhau

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

When a non-prescription or prescription medication is necessary to maintain or avoid health deterioration, the $3,690.00 limit can be inc amount being deducted from the supported living array maximum allowance. All such requests must be prior approved by the DDS As

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Specialized Medical Supply Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Certified Specialized Medical Supply Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

DDS Certification as a Specialized Medical Supply provider

Appendix C: Participant Services

Other Standard *(specify)*:

C-1/C-3: Service Specification

Verification of Provider Qualifications

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid ager

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statut

Service Title:

Adaptive Equipment

Service Definition *(Scope):*

Adaptive Equipment means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, th

This service includes adaptive, therapeutic and augmentative equipment that enables a person to increase, maintain or improve their fu tools that therapists employ in the course of therapy are not included. Educational aids are not included. Adaptive equipment needs fo such as devices, controls or appliances that will enable the person to perceive, control or communicate with the environment in which t possible otherwise. Equipment may only be purchased if not available to the person from any other source. Professional consultation at a minimum but not necessarily exceed $500.00. Consultation must be conducted by a medical professional applicable as determined b when it will allow the person control of their environment, to assist the person to gain independence, or it can be demonstrated as nece socialization or educational skills. The waiver does not cover supplies. Printers may be approved for non-verbal persons. Computer d Computers may be approved for communication when there is substantial documentation that a computer will meet the needs of the pe operate the accessories included for environmental control; or to provide text-to-speech capability.

Vehicle Modifications are adaptations to an automobile or van to accommodate the special needs of the participant. Vehicle adaptation community and ensure the health, welfare and safety of the participant. Payment for permanent modification of a vehicle is based on th vehicle to which the modifications are or will be made. Transfer of any part of the purchase price of a vehicle, including preparation an reported to the Utilization Review Section of Arkansas Division of Medical Services for investigation. Reimbursement for a permanent r modification and the modifications are, for purposes of approval and reimbursement, one project and cannot be separated by plan of ca modifications may be replaced if the vehicle is stolen, damaged beyond repair as long as the damage is not through negligence of the v useful lifetime when repairs are required to make the vehicle useable, and the cost of the repairs exceeds the fair market value of the veh repairers. Vehicle value shall be determined by reference to sales listing for similar vehicles within a 200 mile radius of the beneficiary's responsible party sells or trades a permanently modified vehicle before the vehicle reaches its reasonable useful lifetime, the modificatio vehicle modification will be considered for approval. Estimated residual value shall be determined by comparing the purchase price of th at the time of sale determined as stated above. Example: A permanently modified vehicle purchased for $30,000 is sold with a value of $ the amount paid is $3,333 (33%). Vehicle modifications apply only to modifications and are not routine auto maintenance or repairs for

Exclusions: The following are specifically excluded:

1) Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individu

2) Purchase, down payment or lease of a vehicle;

3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Personal Emergency Response Systems (PERS) can be approved when it can be illustrated to be necessary to protect the health and sa institutionalization to secure help in an emergency. The person may also wear a portable "help" button to allow for mobility. The syste is activated. The response center is staffed by trained professionals. PERS services are limited to those persons who live alone or who who would otherwise require extensive routine supervision. Included in this support are assessment, purchase, installation and month

Conditions – The care and maintenance of environmental equipment, adaptive equipment and personal emergency response systems a (defined as failure to properly care for or perform routine maintenance) shall mean that the service will be denied for a minimum of two p shall mean that the aids will not ever be replaced using Waiver funding. Deterrent for non-compliance is in the form of public comment approval; monitoring is accomplished when the item is later requested again with denial if the original item is found to been sold; identi Special needs (100% state general revenue) funding is available for persons not receiving waiver services. If waiver services are not av continue but not in the home of the person who was responsible for the loss.

All adaptive equipment must be solely for the waiver individual and used only by that individual. All purchases must meet the conditi require three bids with the lowest bid with comparable quality being awarded; however, DDS authority may require 3 bids for any reque environmental modification or adaptive equipment. Therapy and educational aids are not allowable. Medicaid purchased equipment ca in the residence.

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Adaptive Equipment Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive Equipment

Provider Category:

Agency

Provider Type:

Certified Adaptive Equipment Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

DDS Certification as an Adaptive Equipment provider.

1) Certified Adaptive Equipment providers must be registered as a business entity with the office of the Arkansas Secretary of Sta

2) Review of 3 separate, different listings to determine that the provider has not been excluded as a Medicaid provider.

3) A satisfactory review of application packet, including policies and procedures, by DDS QA staff.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Quality Assurance

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agei

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statut

Service Title:

Community Transition Services

Service Definition *(Scope):*

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another directly responsible for his or her own living expenses. Waiver funds can be accessed once it has been deteremined that the waiver is t household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartn community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; and (f) nece that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service pl sources.

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

Costs for Community Transition Services furnished to individuals returning to the community from a Medicaid institutional setting thro institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If t change in condition), transitional services may be billed to Medicaid as an administrative cost.

Exclusions: Community Transition Services may not include payment for room and board; monthly rental or mortgage expense; food, r diversional/recreational purposes. Community Transition Services may not be used to pay for furnishing living arrangements that are c service they are already providing. Diversional or recreational items such as televisions, cable TV access or VCR's are not allowable.

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Community Transition Service Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

Certified Community Transition Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify)*:

Certified Community Transition Service providers must demonstrate evidence of the following personnel requirements:

Staff must meet all of the following minimum requirements prior to working with consumers:

1) Hold a Bachelor's degree in a human services field; or have two years experience in case management working with individuals management with individuals with a developmental disability or four years experience in case management in a related field may be

OR

Have two years verifiable satisfactory experience with individuals with developmental disabilities prior to employment and is ment

2) Have satisfactorily passed a criminal background check, and adult and child maltreatment registry checks. Criminal backgroun checks must be repeated every two years.

3) Have satisfactorily completed a drug screen in accordance with the organization's policies and procedures.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Quality Assurance

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agen

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statut

Service Title:

Consultation

Service Definition *(Scope)*:

Consultation services are clinical and therapeutic services which assist the individual, parents, legally responsible persons, responsible provided by professionals licensed as one of the following:

1) Dietician

2) Rehabilitation counselor

3) Psychologist

4) Psychological examiner

5) Mastered social worker

6) Professional counselor

7) Speech pathologist

8) Occupational therapist

9) Physical therapist

10) Registered nurse

11) Certified parent educator or provider trainer

12) Certified communication and environmental control specialists.

13) Recreational therapist

14) Qualified Mental Retardation Professional (QMRP)

15) Positive Behavioral Supports (PBS) Specialist.

These services are indirect in nature. The parent educator or provider trainer is authorized to provide the activities identified below in i information to document staff qualifications. Staff, who meets the certification criteria necessary for other consultation functions, may categories unless they possess the specific qualifications required to perform the other consultation activities. Use of this service for p provider indirect costs. These activities include:

1) Provision of updated psychological and adaptive behavior assessments;

2) Screening, assessing and developing therapeutic treatment plans;

3) Assisting in the design and integration of individual objectives as part of the overall individual service planning process as applicab

4) Training of direct services staff or family members in carrying out special community living services strategies identified in the perso

5) Providing information and assistance to the persons responsible for developing the person's overall service plan as applicable to th

6) Participating on the interdisciplinary team, when appropriate to the consultant's specialty;

7) Consulting with and providing information and technical assistance with other service providers or with direct service staff or family

8) Assisting direct services staff or family members to make necessary program adjustments in accordance with the person's service pl

9) Determining the appropriateness and selection of adaptive equipment to include communication devices, computers and software co

10) Training or assisting persons, direct services staff or family members in the set up and use of communication devices, computers an

11) Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment

12) Training of direct services staff or family members by a professional consultant in:

a) Activities to maintain specific behavioral management programs applicable to the person,

b) Activities to maintain speech pathology, occupational therapy or physical therapy program treatment modalities specific to the per

c) The provision of medical procedures not previously prescribed but now necessary to sustain the person in the community.

13) Training or assisting by advocacy consultants to individuals 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

15) Training and assisting persons, direct services staff or family members in proper nutrition and special dietary needs.

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

The maximum annual amount is $1,320.00 the first waiver year and is reimbursable at no more than $136.40 per hour. Based on the opera thereafter.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Consultation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consultation

Provider Category:

Individual

Provider Type:

Certified Consultation Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

DDS Certification as a Consultation provider. Credentials must match the specific consultation service to be provided. Consultat board or organization of licensing or certification as follows:

1) Psychologists: Current license as a Psychologist by the Arkansas Psychology Board.

2) Psychological Examiners: Current license as a Psychological Examiner by the Arkansas Psychology Board.

3) Mastered Social Workers: Current license as an LMSW or ACSW by the Arkansas Social Work Licensing Board.

4) Professional counselors: Current license as a counselor by the Arkansas Board.

5) Speech pathologists: Current license in Speech Therapy by the Arkansas Board.

6) Occupational therapists: Current license in Occupational Therapy by the Arkansas State Medical Board.

7) Registered Nurses: Current license as a Registered Nurse by the Arkansas State Board of Nursing.

8) Certified parent educators: Current certification as a Qualified Mental Retardation Professional as specified in the DDS Quality

9) Certified communication and environmental control adaptive equipment or aids providers: Documentation as a current provide

10) QMRP as specified in the DDS Quality Assurance Licensing and Certification Standards.

11) Positive Behavior Support Specialist as certified by The Centers for Excellence that operates with federal funding under the au specialists.

12) Physical Therapists as licensed by Arkansas State Board of Physical Therapy.

13) Rehabilitation counselors with degree in Rehabilitation Counseling.

14) Dieticians with degree in nutrition.

15) Recreational Therapists with degree in Recreational Therapy.

Other Standard *(specify)*:

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agen

Verification of Provider Qualificatio

Entity Responsible for Verification:

DDS Quality Assurance

Annually

Appendix C: Participant Services
C-1/C-3: Service Specification
Other Service

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statut

Service Title:

Crisis Intervention

Service Definition *(Scope)*:

Crisis Intervention is delivered in the eligible person's place of residence or other local community site by a mobile intervention team or shall be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geogra professional. Services may be provided in a setting as determined by the nature of the crisis; i.e., residence where behavior is happenin and who are in need of non-physical intervention to maintain or re-establish a behavior management or positive programming plan.

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

The maximum rate is $127.10 per hour the first year of the waiver and based on the operating agency's funding resources the maximum r

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [x] **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Crisis Intervention Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:

Agency

Provider Type:

Certified Crisis Intervention Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

DDS Certification as a Crisis Intervention provider.

Crisis Intervention service providers must hold a current license or certification by the Arkansas Board of licensing or certificatior

1) Psychologists: Current license as a Psychologist by the Arkansas Board of Psychology.

2) Psychological Examiners: Current license as a Psychological Examiner by the Arkansas Board of Psychology.

3) Mastered social workers: Current license as an LMSW or ACSW by the Arkansas Social Work Licensing Board.

4) Professional counselors: Current license as a counselor by The Arkansas Board of Examiners in Counseling.

5) Qualified Mental Retardation Professional: as specified in the DDS Quality Assurance Licensing and Certification Standard

6) Certified Positive Behavior Supports Specialist: as certified by The Centers for Excellence that operates with federal funding un behavior support specialists.

Crisis Intervention Providers must maintain documentation of satisfactorily passing a criminal background check, and adult and cl checks must be repeated every five years and child maltreatment registry check every two years.

Crisis Intervention Providers must have satisfactorily passed a pre-employment drug screen. Documentation of the results of the

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Quality Assurance

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid ager

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statut

Service Title:

Environmental Modifications

Service Definition *(Scope):*

Environmental Modifications are modifications made to or at the home, required by the individual's plan of care, which are necessary tc institutionalization. Such environmental modifications may include the installation of ramps and grab-bars, widening of doorways, moc necessary to accommodate the medical equipment, installation of sidewalks or pads to accommodate ambulatory impairments, and hom persons who have dementia, Alzheimer's disease, other causes of memory loss or confusion as to location or decreased mental capacity

Expenses for the installation of the modification and any repairs made necessary by the installation process are allowable. Portable or d the property owner or legal designee will be considered. All services shall be provided in accordance with applicable state and local bu will be done; to scale sketch plans of the proposed modification project; identification of other specifications relative to materials, time compliance with any local building codes. Final inspection for the quality of the modification and compliance with specifications and l until the work meets specifications.

Exclusions: Outside fencing is limited to one fence per lifetime. Total parameter fencing is excluded. Excluded are those modifications benefit to the individual, such as carpeting, roof repair, central air conditioners, etc. Modifications that add to the total square footage c designed to hide the existence of the modification, or result from erosion are not allowable. Environmental modifications that are permar of current or future liability by the residential property owner. Environmental modifications may not be used to adapt living arrangemen general home repairs or modifications will not be allowable. Swimming pools (both in and out of ground) and hot tubs are not allowable

Conditions – The care and maintenance of environmental equipment is entrusted to the individual or legally responsible person for whc maintenance, shall mean the service will be denied for a minimum of two plan years. Deterrent for non-compliance is in the form of publi equipment approval; monitoring is accomplished when the item is later requested again with denial if the original item is found to been Examples: Special needs (100% state general revenue) funding is available for persons not receiving waiver services. If waiver services would continue but not in the home of the person who was responsible for the loss.

All purchases must meet the conditions for desired quality at the least expensive cost. Generally, any modifications over $1,000.00 wil may require 3 bids for any requested modification. All modifications must be completed within the plan of care year in which the modifi

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Enviornmental Modifications Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Certified Enviornmental Modifications Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

DDS Certification as an Environmental Modifications provider.

Eligible providers of environmental modification services may be agencies or individuals. Providers must be registered with the S
the State of Arkansas, as required, or other appropriate credentials to perform jobs requiring specialized skills, including but not li
1) Electrical work
2) Heating and ventilation; and
3) Plumbing work

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Quality Assurance

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid age

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statut

Service Title:

Supplemental Support

Service Definition *(Scope)*:

Supplemental Support services meet the needs of the person to improve or enable the continuance of community living. This service is
Services will be based upon demonstrated needs as identified in a person's plan of care as emergencies arise. Waiver funds will be use

Supplemental support services include:

1) Ancillary supports such as non-recurring set-up expenses for individuals for persons in the event of a disaster, crisis, emergency or
basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an
a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits f
the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses. This s
service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the serv

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

3) Activity Fees such as dues at a YMCA, Weight Watchers, etc., used for behavior reinforcement or sensory stimulation. Fees are ap
services must be prescribed and monitored by medical professionals.

Exclusions: Supplemental Support may not include payment for room and board; monthly rental or mortgage expense; food, regular util
purposes. Supplemental Support may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provi
providing. Diversional or recreational items such as televisions, cable TV access or VCR's are not allowable.

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

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

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Supplemental Support Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supplemental Support

Provider Category:

Agency

Provider Type:

Certified Supplemental Support Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Certified supplemental support providers must demonstrate evidence of:

1) Have a high school diploma, OR

Have successfully completed a GED, and have a minimum of one year of relevant, supervised work experience with a public health

Have a minimum of two years verifiable experience with individuals with developmental disabilities that may be used in lieu of the

Have two years of verifiable, successful history (defined as either employment as a paid caregiver, support staff, teacher or as an disability in their own home) with individuals with developmental disabilities.

2) Have the ability to understand written activity plans, execute instructions and document services delivered

3) Have the ability to communicate effectively with consumers

4) Have the ability to access transportation services required as appropriate

5) Have satisfactorily passed a criminal background check, and adult and child maltreatment registry checks. Criminal background checks must be repeated every two years

6) Have satisfactorily passed a drug screen prior to employment.

Documentation shall be maintained for review by DDS Quality Assurance Section

Other Standard *(specify):*

Appendix C: Participant Services

C-1: Provider Qualifications, Services Covered (2 of 2)

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Quality Assurance

Frequency of Verification:

Annually

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

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

DDS certified case management providers and DDS Specialists.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Based on DHS Policy 1080 and current ACS Waiver Certification standards, DDS requires criminal background checks for all dir
An Arkansas state criminal background check is required, and, in addition, a FBI record check is required for staff that:

1) Have not been employed in Arkansas to provide direct care to individuals with developmental disabilities within sixty calend

2) Have not lived continuously within the state of Arkansas for the past five years.

The provider may continue temporary employment of an applicant while waiting for results. If a criminal record is not found, the
Quality Assurance. If a FBI record check is made, the results are sent directly to DDS Quality Assurance and will not be sent to
Assurance will make a determination of the person's qualification or disqualification for employment and forward written determi
A.C.A. 21-15-101 et. seq. as being disqualifying offenses. A person with a disqualification determination is not eligible to work
employment of a person who has been disqualified if they provide direct care. DDS Quality Assurance staff reviews evidence o

In addition, all DDS staff are required to undergo criminal background checks. If any disqualifying criminal conviction is found, t

The Waiver provider initiates the checks and back ground investigations; the Arkansas State Police perform the criminal record
and make employment determinations based on the results.

Process for ensuring that mandatory investigations have been conducted: on-site Quality Assurance monitoring by Licensure/(

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

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A statewide central registry of cases involving allegations of abuse and maltreatment is maintained by the DHS Division of Children and Family Services (DCFS) for children and Adult Protective Services (APS). All DDS ACS certified providers must initiate a check of both the registries for children and adults for staff including spouses and any adult over the age of 18 residing in an alternative living home or group home. This check will provide documentation that the prospective employee's name and any adult family member's names do not appear on the statewide central registry. Each provider is required to adopt policies addressing what actions will be taken if an adult family member's name appears on the central registry when the individual being served is in an alternative living home or group home. If a fault record is found in either registry, the individual who received this information shall notify the Director of the program in writing so that corrective measures may be determined. When a provider is notified of a true registry finding, the provider must take corrective measures. These measures may include, but are not limited to, training, probationary employment or terminaton of employment. DDS Quality Assurance staff review evidence of central registry checks for each provider during the

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

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

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

Group homes, owned and operated by Waiver certified providers, must meet all the applicable state and federal laws and regulations. Existing group homes licensed by DDS prior to July 1, 1995 may serve groups of no more than fourteen unrelated adults, age 18 years and above, with developmental disabilities. No expansions will be approved beyond the July 1, 1995 total capacity for group homes. Group homes built after July 1, 1995 are limited to a capacity of no more than 4 unrelated adults with developmental disabilities.

The group homes are community based and located in residential areas. The homes provide access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, provide for privacy and easy access to resources and activities in the community. Each group home contains bedrooms and bathrooms that provide privacy and seclusion as desired. Individuals are allowed free use of all space within the group home with due regard for privacy, personal possessions of other residents and staff and reasonable house rules. The living and dining areas are provided with furnishings that promote the functions of daily living and social activities. Persons

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Supportive Living	☑
Supplemental Support	☑
Environmental Modifications	☐
Supported Employment	☐
Specialized Medical Supplies	☑
Adaptive Equipment	☑
Community Transition Services	☐
Case Management	☑
Crisis Intervention	☑
Consultation	☑
Respite	☑

Facility Capacity Limit:

14 beds

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑

Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Supported living arrangement apartments owned and operated by waiver providers

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Supportive Living	☑
Supplemental Support	☑
Environmental Modifications	☐
Supported Employment	☐
Specialized Medical Supplies	☑
Adaptive Equipment	☑
Community Transition Services	☐
Case Management	☑
Crisis Intervention	☑
Consultation	☑
Respite	☑

Facility Capacity Limit:

No more than 4 unrelated adults in each self contained apartment

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑

Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

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

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Payment for waiver services will not be made to the adoptive or natural parent, step-parent or legal representative or legal guardi of age or older. The employment of eligible relatives (regardless of the waiver individual's age) shall require prior approval from

Payment to relatives, other than parents of minor children, legal guardians, custodians of minors or adults, or the spouse of adul parents and step parents. For any service provider, all DDS qualifications and standards must be met before the person can be a Controls are maintained through documentation as is required for all services provided; specific to date and time of service deliv information using the NCI is analyzed annually for purposes of discovery; as is, incident reports received through the DHS auto assure the absense of undue influence in the person centered service plan.

Controls for services rendered: All care staff are required to document all services provided daily according to their work schedu care staff; case managers are responsible to periodically review with the participant any problems in care delivery and report any conduct a 100% review of service utilization for each plan of care at the time of each plan of care 12 month expiration date to iden annual provider reviews; and DMS conducts both random Quality Assurance audits and audits specific to the financial integrity

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

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

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 have access to information regarding the requirements and procedures to enroll as a waiver provider by contacting DDS Quality Assurance staff or accessing the ACS certification standards on the DDS website. Once a provider is certified by DDS, the provider may contact the Provider Enrollment Unit at Electronic Data Systems (EDS) to enroll as a Medicaid provider.

Qualified and enrolled providers are allowed to specify the maximum number of persons they can serve, the areas of the state they can serve, the services they can provide and the service levels they can serve based on staff availability. If a provider is chosen by an individual who meets the designations made by the provider, the provider cannot refuse to provide services to the person as the waiver is zero reject, except that a providers may reject a person if the provider cannot assure health and safety. In the event of rejection, it is incumbent upon the provider to prove the individual cannot be served through the waiver in compliance with the health and safety assurance. The burden of proof also requires written identification of the cause for the failure to provide health and safety supported by documentation that attests to that condition.

Before a provider can decrease the maximum number of persons they will serve, drop an existing county (area of the state they can serve), a service, or service level, the provider must identify any persons they are currently serving that would be affected. The provider will be required to continue providing services to any persons that would be affected by the changes

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**
   i. **Sub-Assurances:**

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

         Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
All prospective and continuing providers meet the required licensure, certification and other standards as specified in the approved waiver application prior to furnishing waiver services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

	☐ **Other** Specify:

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
All sub-contracted providers meet the required licensure, certification and other standards as specified in the approved waiver application prior to furnishing waiver services.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Providers will comply 100% with the training requirements as specified in the promulgated DDS Waiver Certification Standards with review process conducted annually.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

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

Individual problems with provider quality are addressed through: 1) DDS certified provider's plans of correction based on deficiencies cited during the annual on-site quality assurance monitoring visit by DDS licensure/certification staff, 2) DDS QA Investigator or Monitoring staff investigation of incidents and complaints, with interventions required by the provider for correction, 3) an array of enforcement remedies should problems continue beginning with DDS QA

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: Semi-annual

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

- (●) **No**
- ( ) **Yes**
  Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ( ) **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- (●) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [x] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

1) The annual expenditure cap for environmental modifications and adaptive equipment, collectively or individually, is $7,687.50. This amount may increase 2.5% annually. Basis for the limit: Environmental Modifications and Adaptive Equipment - the rate is prospective based on provider costs up to a maximum of $7,687.50 the first year of the renewal ($7,500.00 + 2.5% increase) with a 2.5% increase each subsequent year of the waiver renewal. The maximum was based on average consumer needs at the time of limitation setting in 1990.

2) The maximum annual allowance for Supplemental Support Services, Community Transition Services and Specialized Medical Supplies, collectively or individually, is $3,690.00 the first year of the waiver. When services are accessed in the same year, the combined maximum allowance is $3690.00 the first year of the waiver and adjusted annually by 2.5% cost of living increase each year thereafter. Basis for cost limit: Specialized Medical Supplies, Supplemental Supports and Community Transition Services - the rate is prospective based on provider costs up to a maximum of $3,690.00 ($3,600.00 + 2.5% increase) the first year of the waiver with a 2.5% increase each subsequent year of the waiver renewal. The maximum was based on average consumer needs at the time of limitation setting in 1990.

3) There is a maximum daily rate for supportive living service and respite, collectively or individually. Supportive living includes provider indirect costs for each component in the array. Individual daily rates in all levels require prior approval by DDS staff. The maximum daily rate includes a 10% growth increase the first year and 2.5% cost of living increase all subsequent years based on the operating agency's funding resources.

1) Pervasive - maximum daily rate is $391.95 ($356.32 + 10% increase for inflation) with a maximum of $143,061.75 annually.

2) Extensive - maximum daily rate is $176.00 ($160.00 + 10% increase for inflation) with a maximum of $64,240.00 annually.

3) Limited - maximum daily rate is $176.00 ($160.00 + 10% increase for inflation) with a maximum of $38,544.00 annually.

Exclusion: Waiver will not reimburse for any overtime; i.e. more than 40 hours per work week. Note: "Rate" is defined as Level of Support and is not a rate methodology.

No exceptions are made if the documentation does not support that the person is eligible for a higher limit. If the documentation supports movement then the person moves to a higher level. Once the maximum limit for Pervasive level is reached, funding sources other than Medicaid are sought to provide for the additional care needed. Once all other sources are exhausted health and safety cannot be assured and case closure proceedings are initiated and implemented.

Each prior authorization approval that identifies the limit approved is provided to the case manager who in turn

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person Centered Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [x] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- [ ] **Social Worker.**

Specify qualifications:

- [ ] **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- ( ) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- (•) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

DDS assures that participants are supported in exercising their right to free choice of providers. Participants are provided inform plan development. Choice is accomplished initially and annually (12 months as established by each individual's entry into the w individual to develop the plan. Direct oversight of the process with periodic annual evaluation is provided by the DDS Speciali annually with waiver participants to help assure that there are no systemic problems related to services or staff. In the event sys based upon the findings, will be initiated, implemented, monitored and analyzed by the DDS QA and Waiver Sections.

Participant awareness of rights to change choice more frequently than annually is specified in the Waiver handbook that is publ participants annually. The Rights and Choice Form - #106 A will be changed from "I have the right to change providers without Change will be effective July 1, 2009.

Safeguards for controlling content of plan: DDS has a standard required MAPS and MAPS Narrative form that assures required progress, regression, or maintenance; participant input and safeguards which includes desires, scheduling and staffing; as well explanation and justification for any prior service plan underutilization. Further, DDS Specialists conduct at least 10% random p

The National Core Indicator (NCI) project is a collaboration of the National Association of State Directors for Developmental Dis to participate in the NCI program which gives annual reports from data collection process that helps to identify areas where syst of the service delivery system for waiver and provides a ranking for Arkansas; as well as, a comparison report to other states.

1) Service coordinators help me get what I need,
2) I have an advocate that speaks on my behalf,
3) I am satisfied with my personal life,
4) I have adequate transportation when I want to go somewhere,
5) I participate in integrated activities in the community,
6) I make choices about everyday lives including where I live, work, daily routines, free time, case manager, and support staff.

The DDS Quality Assurance Unit staff are responsible for identifying the sample to be surveyed, completion of the surveys and reviews the results for tracking, trending, and identification of any areas that improvement is needed in and takes necessary rem

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Information concerning participant and legal representative rights is conveyed by DDS during the intake and referral process through inclusion of waiver provision services in both written and verbal format. The DDS waiver Specialists provide the same information once the individual is processed and becomes a waiver participant. The chosen case management provider reinforces these rights and assures active participation by the individual or legal representative. DDS published a waiver handbook (a hard copy and an electronic version is available upon request, application, or through the DHS, DDS and advocacy websites) that identifies definitions of process inclusive of contact information regarding; the application process, eligibility, program choice, each service component, provider choice, and rights and responsibilities. DDS provides quarterly updates to questions and inquiries both in a hard copy and electronically on DDS and advocacy websites.

The participant invites any person of their choosing at any step in the process, as long as all rules pertaining to confidentiality and conflict of interest are met inclusive of one provider cannot participate or advocate for another provider's participant. The exception to "invite" is the chosen Case Manager. Best practices recommend that direct service providers, all other professionals associated with service delivery (such as public school, Children and Family Services, Mental Health, etc.) be invited to participate since they will have responsibility to secure or maintain services. "Other professionals" may be defined as those persons or entities who play a role in providing generic (other than Waiver) supports that help the person to reside in the community, have inclusion in the community and otherwise support the person.

The DDS Specialist; as well as, the chosen Case Manager both provides information to the waiver participant/legal representative on their rights and ability to actively engage in and direct the waiver process. As stated above, they also have

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of

assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

1) Interim or Initial Plan of Care: At the time of initial placement on the ACS Waiver and after the individual or their legal representative have chosen both case management and direct service provider entities, all persons are issued a pre-approved interim or initial plan of care (IPOC) for up to a three month period. People residing in Medicaid reimbursed facilities may receive case management the last 180 consecutive days of the institutional stay. The waiver services included in the IPOC are prior authorized by DDS. The IPOC may only include case management and supported living for direct care supervision. The IPOC is a predetermined set of services that is a precursor to full service plan development using person centered planning. It is the responsibility of the DDS Waiver Management Project Analyst to issue each IPOC when a person is initially approved for waiver services. Critical elements of date of approval and three month expiration date are entered into a DDS database with electronic transmission of the plan of care worksheets to the applicable DDS Area Manager and Specialist. The Area Manager or the assigned Specialist then electronically transmit the approved IPOC along with all documents in the existing case file to the chosen providers. The IPOC is then monitored by the Area Manager or the designated DDS Specialist to assure that the full plan of care is submitted and acted upon prior to the three month expiration time frame. Nothing herein prevents the providers from submitting and having a full service plan approved and implemented prior to the three month expiration date. The expiration date is established to assure the full service plan, addressing all needs and health and safety are in place in a timely manner. The Case Management provider may request an extension beyond the 3 months, but must justify why they have not conducted service planning as required in the person centered planning process inclusive of the individual's or their legal representative's agreement as to reasons for the untimely completion of the plan submission. An extension may be granted depending on circumstances that caused the delay.

At the time of initial placement on the waiver, the waiver participant or legal guardian is given choice of waiver or ICF, choice of case management providers, choice of direct service providers. The DDS Specialist explains that an IPOC will be issued that will cover up to three months of case management and up to three months of supportive living. The IPOC covers only these two services which allow a full person centered service plan to be conducted for the remainder of the plan year. Nothing here in requires that the full 3 months will be utilized for completion of a comprehensive plan addressing all variables. Instead the IPOC simply assures the two services are immediately available, with other services to be added as soon as they can be identified and obtained which may be earlier but no greater than three months.

2) Person Centered Service Plan:

a) A person centered service plan is developed with the individual's chosen case manager responsible to assure all issues are addressed and all parties attending participate in the process during the three month IPOC period. Participants include the chosen case manager, the individual or their legal representative. All other persons attending are at the discretion of the individual, or their legal representative and include professionals assisting with generic resources, the parents, the legal representative and any other persons the individual or legal representative want in attendance; as long as, all rules pertaining to confidentiality and conflict of interest are met. IF INVITED, The DDS Specialist attends randomly in an effort to assure an annual 10% attendance ratio or 100% attendance if the case is believed to be eligible for pervasive level of support. Mandatory attendance by the Case Manager is required as being essential to assuring a written plan of care and the meeting of all the requirements of regulation and desires of the individual or legal representative in order to assure timely and quality approval and subsequent service delivery. In all events, the participant may choose who they want to be present and if they object to the presence of any person, the objection will be honored. The case manager is further responsible to assure care coordination once the plan is developed.

b) In addition to psychological IQ and adaptive assessments, service plan development includes any applicable past social, medical, physical and mental histories, current physician evaluation, education needs (obtained external to waiver - waiver services do not include education) as determined through individual program planning, and risk assessment by the providers specific to any issues that could impact health and safety.

c) The participant is informed of available waiver services at the time of initial application, at the time choice is offered and again during this planning process. It is a shared responsibility of the case manager and direct care supervisor (at the time of care coordiation) to assure the reiteration in this plan process.

d) To assure items addressed in b) above, meet the individual's needs and preferences, a 100% review by DDS authority is conducted. Any missing elements will mean the plan in whole or in part may be denied.

e) Waiver and generic services are coordinated by the direct care supervisor with the case manager responsible to initially identify any overlaps or gaps in service implementation or need.

g) The plan is updated annually or more frequently if the participant's needs change. When service needs change it is again the case manager's responsibility to assure that revisions with justification to support the need are submitted timely for DDS prior approval.

h) The planning meetings are to be scheduled by the chosen Case Management entity at a time and location that is convenient for the waiver participant or legal representative. In many cases this will be the individual's place of residence but again, it is the option of the individual or their legal representative.

Process Summary:

The plan of care will describe the medical and other services, regardless of funding source, that the person receives, the frequency of services provided, and the provider who delivers the service inclusive of waiver services requested. The waiver services included in the plan of care will be prior authorized by DDS. A person centered service plan process will be used. This process requires meeting with the person, legally responsible person and case manager. Family members, Direct Care

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

A component requirement of the service plan meeting is that the team will identify any issues related to health and safety. In addition, a physician must examine the individual, identify treatment plans or any changes, and approve all waiver services before the service can be delivered. The Team will develop a plan and backup plan to assure all health and safety issues are addressed. Specific to safety, the team must address and access generic resources applicable to behavior and environmental hazards and any hazards known to exist within the place of residence such as securing of poisons, toxic chemicals, inflammable substances, etc. Specific to assuring medical needs are met, a medication management plan must be developed, followed and monitored when prescription drugs are part of the medical treatment plan. The plan must contain time frames for assurance of remediation. The plan must address how local authorities will be accessed in an emergency; such as, loss of electricity, fire, natural disaster, etc.; as well as, when staff may not be available for assigned duty hours.

The plan development process identifies risks and makes sure that they are addressed through backup plans and risk management agreements that are sensitive to the participant's needs and desires. The risk management agreements include agreement by the participant and their legal representative. A complete description of back up arrangements must be included in the plan. Examples of the types of back-up arrangements that could be included: A person who cannot get out of bed without staff assistance would have a back-up plan for alternate staff when their direct care staff person was absent; a person who is on a vent would have a back-up plan that included an alternate electricity source in case of power failure; a person who falls and cannot get up might have a back-up plan that included use of a personal emergency response system to alert others in case of a fall. Other types would include but not be limited to: 1) Coordination with local authorities when the person is known to have aberrant behaviors; 2) Coordination with local emergency services for evacuation in the event of natural disaster or emergency ambulance needs for transport; 3) Reasonable accommodation for identification of person's residence for ease of location when emergencies may occur; and 4) installation or application of monitoring devices when persons are known to wander or elope, etc.

DDS will not authorize or continue waiver services when:

1) The health and safety of the person, the person's caregivers, workers or others are not assured;

2) The person or the 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 person or the legally responsible person refuses to permit the on-site entry of: case managers to conduct required visits, care givers to provide scheduled care, DDS, DMS, DHS or CMS officials acting in their role as oversight authority for compliance or audit purposes;

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The DDS Specialist is responsible to explain the waiver program and service options in person or via other contact as desired by the individual or legally responsible person. Copies of the available literature are provided to the person or their legal representative. The DDS Specialist provides the participant or legally responsible person with a copy of the DDS Quality Assurance approved ACS provider list at each continued stay review or as the person may request. The DDS Specialist encourages the person or legally responsible person to visit or contact the different providers if they are not already familiar with the organizations. Annually, at the time of the individual continued stay review, the DDS Specialist will offer the participant or legally responsible person an opportunity to change choice of ICF/MR or waiver services, as well as, a choice of different providers. In the foregoing description, the DDS Specialist delivers support without any specific recommendations that could sway choice of providers. Undue influence is prohibited. Providers are prohibited from engaging in solicitation but are permitted to engage in advertisements consistent with other business practices. The Arkansas Waiver Association has developed a checklist that serves as report card that is available online for use by participants or legal representatives. In

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DDS is responsible for establishing and monitoring the person centered service plan requirements governing the provision of all ACS waiver services. The DDS Waiver Specialists are required to review and approve all plans of care or revisions thereto and to conduct a 100% retrospective review of all existing plans of care prior to approving a continued stay plan of care. In addition, the DDS Specialist attends 100% of all Pervasive Level plans of care meetings and conducts a 10% random on-site review of all other levels of care. The 10% factor is not statistically valid but rather serves as an additional component of quality review. DDS staffing levels do not permit increase of this random review.

DDS is responsible to monitor qualified professionals who conduct the service plan development, implementation and monitoring process.

DMS arranges with DDS for a specified number of service plans to be reviewed annually as specified in the interagency agreement with DMS in their role as overseer. DMS conducts a retrospective review of identified program, financial and administrative elements critical to CMS quality assurance. DMS randomly reviews plans and ensures that they have been developed in accordance with applicable policies and procedures, that plans ensure the health and welfare of the waiver recipient and that financial components or prior authorizations, billing and utilization are correct and in accordance with

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☑ **Case manager**

☐ **Other**
Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Case Manager, DDS Specialist, and DMS Quality Assurance staff are responsible for monitoring the implementation of the servic

The Case Managers are required to maintain different minimum levels of contact based on the service level for each person.

1) Pervasive - minimum of one face-to-face visit and one other contact with the individual or legal representative monthly. At least c

2) Extensive - minimum of one face-to-face visit with the individual or legal representative each month. At least one visit must be ma

3) Limited - minimum of one face-to-face visit with the individual or legal representative each quarter and a minimum of one contact m

While minimum requirements vary according to service level, the annual reimbursement rate remains constant. This constancy recog any level that may be needed due to changing participant situations.

The DDS Specialist conducts a paper and random on site review of agency and residences annually or as questions or concerns arise Management Information System (MMIS). These activities are conducted once every twelve months for each plan of care as it is ren track and trend service delivery delays; as well as, service denials, through the plans that are approved, disapproved, pended and ap base.

DDS Quality Assurance staff monitor when plans fail (such as interruption of services) through the internal incident reporting systen provide information to DMS and DDS Waiver Services as serious incidents occur. Incidents are then acted upon by the DDS Speci identified. Incidents are tracked and analyzed to identify patterns. When patterns are identified, DDS Quality Assurance notifies th

The consumer satisfaction survey under the National Core Indicator (NCI) project will address:

1) Free choice of providers;

2) If services meet the participant's needs and desires;

3) The effectiveness of the back up plans when regular plans do not meet the person's needs.

The case manager is responsible for monitoring participant access to waiver and non-waiver services that are included in the service those responsible for identification will forward monitoring results to the applicable Quality Assurance Program Administrator. This directly with the issue by remedying whatever problem is impacting the plan of care. Actions taken must be documented in the case The direct care supervisor is responsible for assuring that activities are recorded as they occur and are consistent with goals and obj

Quality monitoring activities are vested with the DDS Quality Assurance Section who performs 10% random review of all waiver case approximately 350 consumers each year during the NCI process. Further, this sample is supplemented by virtue of investigations, co entities. All plans of care are reviewed and approved by DDS Waiver staff.

b. **Monitoring Safeguards.** *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The DDS Appeals Policy 1076 is provided to all participants along with information as to the ability to file a service concern with to the petitioner except when anonymous petitions are filed. The petitioner receives notice of investigation. In addition, service implemented a requirement for participants to identify the reason they request a change of providers. As this information is coll identifies dissatisfaction with the provider, referral will be made to the DDS Quality Assurance licensing and certification section

In accordance with requirements to monitor service plan implementation and participant health and welfare when the case manag are met through:
1) Individual choice options to at any time choose seperate case management and other service providers,
2) Sampled participation in the NCI satisfaction surveys with results tracked and analyzed for any needed corrective action,
3) 100% participant survey by DD Specialists with results tracked and analyzed for any needed corrective action
4) Participant awareness of rights that include the right to file concerns is conducted with each participant at least once during e corrective action taken as indicated.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**
   i. **Sub-Assurances:**

      a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

      Performance Measures

      For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

      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:
      The person centered plan of care process, inclusive of meeting individual needs and assuring health and safety, is monitored via a comprehensive data collection system for tracking and trending, on-site reviews and 100% plan of care review that is analyzed by DDS specialists, area managers and waiver administrators with corrective action taken 100% of the time when deficiencies are identified.

      Data Source (Select one):
      Record reviews, off-site
      If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **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: semi-annual

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
The state monitors development in accordance with its policies and procedures and takes appropriate action when inadequacies are identified. Plans are revised at least annually or as warranted, and are delivered as proscribed in the plan as to scope, amount, duration and frequency. It is reviewed 100% of the time by the DDS Specialist or Area Manager.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Sixty day advance notice of need for a continued stay review is forwarded to the applicable Case Managers, DDS Specialists and DDS Area Managers with retrospective review conducted 100% of the time by DDS Specialists to assure annual update inclusive of identification of any need that should have been addressed as a revision.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
The DDS Specialist reviews MMIS payments and the prior year's plan for each participant to assure services were delivered in the type, scope, amount, duration and frequency of the approved plan. This review is conducted annually as the continued stay review is submitted for approval.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Annually at the 60 day notice of the continued stay review, each participant is given a rights and choice form to designate ICF/MR or waiver services, as well as choice of certified providers.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **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: semi annual

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

b. Methods for Remediation/Fixing Individual Problems

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

As individual problems are discovered, the DDS authority works directly with the case manager to ensure additional documentation and justification is provided prior to approval of any requests. In addition, the DDS authority conducts retrospective review to determine if services were delivered as approved and when justification is absent future requests are altered to match utilization. When eligibilities or critical timeframes are not met, the DDS authority acts to end the prior authorization and deny applicable provider reimbursement. Any action necessitating cancellation

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: semi-annual

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- Yes. The State requests that this waiver be considered for Independence Plus designation.
- No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the

choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

It is initially the responsibility of the DDS Intake and Referral Specialist to inform the person or the legally responsible representative of appeal rights specific to application intake policies and procedures:

1) As Waiver services are requested; and

2) When initial choice of home and community based services as an alternative to institutional care is offered.

It is the responsibility of the Quality Assurance Assistant Director to inform the person or the legally responsible representative of appeal rights specific to applicant or program denial of ICF/MR Level of Care or Medicaid Income Eligibility. This responsibility stands alone relative to eligibility determinations and coordinates determinations with the DDS Waiver Applications Unit Administrator to assure knowledge of actions.

It is the responsibility of the Waiver Applications Unit Administrator to inform the person or the legally responsible representative of appeal rights specific to closure of an application case for failure of the person or the legal representative to comply with requests for required application assessment information. Copy of official letters is made to the Quality Assurance Psychology Team member (s) who made the determination. When the determination is favorable to the applicant and a vacancy exists, this entity coordinates release of the information to the applicable Waiver Area Manager via electronic uploading of "shared" files.

When the applicant is determined to meet eligibility criteria, a vacant Waiver position exists, and the individual is participating in the Waiver program, it is the responsibility of the DDS Waiver Area Manager or the assigned DDS Waiver Specialist to inform the person or the legally responsible person of appeal rights specific to:

1) Continued choice for institutional or community based services;

2) Provider choice;

3) Service denials;

4) Chosen providers non-acceptance of the case;

5) Case closure.

Participant awareness of rights to change choice more frequently than annually is specified in the Waiver handbook that is published on the DDS and Arkansas Waiver Association websites,the promulgated Medicaid provider manual and is specified on the form that is given to the participants annually. The Rights and Choice Form - #106 A will be changed from "I have the right to change providers without fear of retaliation" to read, "I have the right to change providers at any time I may choose without fear of retaliation". Change will be effective July 1, 2009. Awareness is also accomplished one on one as needs or concerns are made known and through surveys conducted by the DDS Quality Assurance Section.

Thereafter, the Case Manager provides re-education at each annual continued stay review and provides support at any time a service request is denied. The individual or the legal representative may file an appeal or may authorize the case manager to file an appeal on behalf of the individual.

When any adverse action occurs, including reduction, suspension or termination of waiver services, written notice is provided to the individual, the legally responsible person and the provider in accordance with DDS Policy 1076. A copy of the policy is enclosed with the notice to the individual or the legal representative. The notice with the enclosure is sent both through regular and certified mail. A copy of the notice is also forwarded to the individual's chosen case manager - if applicable. Distribution may be electronic when secure electronic transmission is available. This policy provides for DDS resolution by the applicable DDS Assistant Director or designee and specifies, "If a participant is not satisfied with the result of the administrative review a fair hearing may be requested". Within ten working days of receiving the results of the administrative review, which may be conducted in a face-to-face meeting, based on the record or via teleconference, an appeal may be filed with the Office of Chief Counsel (OCC), Office of Appeals and Hearings.

Requests for fair hearing shall include:

1) The name, address, and telephone number of the person filing the appeal;

2) The relationship of the person who is filing the appeal to the individual requesting or receiving waiver services;

3) The decision that is being appealed;

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

DDS operates a service concern process whereby individuals can file concerns that are specific to waiver providers and the delivery of services. This concern process is administered by the DDS Quality Assurance Section. Concerns may be presented in writing or verbal and anonymous concerns are allowed. In anonymous concerns, follow up with the person filing the concern is not possible. All known petitioners are provided with notice of investigation.

DDS hired an ombudsman and is developing partnerships with pertinent developmental disability agencies across the state to familiarize advocates with this opportunity. Activities that are part of the Ombudsman program include providing families with information on DDS programs and client rights; providing outreach to clients, families, facilities and other entities concerned about DDS services; and making presentation at conferences and workshops.

DDS informs participants that the use of the DDS dispute mechanism is optional to direct a request for a fair hearing with the Office of Chief Counsel, Office of Appeals and Hearings via an "Alert" that accompanies adverse actions or upon request for the participant for any reason.

Participants are informed that use of a dispute mechanism is not a substitute for a fair hearing. DDS will by September 1, 2009 add and implement the following statement to the annual 106 choice and rights form and also to any notices of service denial: "The DDS Appeals Policy (dispute resolution process) is not a pre-requisite for a fair hearing".

The timeframes for resolution of any service concerns that are presented about waiver providers and/or delivery of waiver services is as follows:

As soon as complaint is received at DDS, it is reviewed and prioritized. DDS Policy 1010 requires that investigations begin within 24 hours (next business day) from time of receipt.

Within five working days from start of the investigation, if telephone contact with complainant is required and cannot be made and complainant is known, a certified letter is sent to the complainant with return receipt requested and a return call to DDS within three working days of receipt of letter.

Within ten working days of receipt of report, review team gathers information. If timely contact cannot be made with the concerned parties, the process may be extended an additional ten working days.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants

may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Incidents to be reported include:

1) Adult abuse, maltreatment, and exploitation ACA 5-28-102;

2) Child maltreatment and severe maltreatment ACA 12-12-503;

3) Disturbance, meaning any situation in which a DHS client, employee or member of the general public engage in threatening or disr

4) Serious or significant injuries;

5) Incidents which include:

a) Significant injury or death;

b) Serious injury to a person;

c) Threatened or attempted suicide of a person in DHS custody;

d) arrest or conviction of a person in DHS custody or a DHS employee while on duty;

e) Any situation where the location of any person in DHS custody is unknown and cannot be determined within two hours;

f) Any crime committed at a DHS office, institution or facility;

g) Any communicable disease resulting in quarantine or closing of a DHS facility;

h) Any condition or event that prevents the delivery of DHS services for more than two hours.

DHS Policy 1090 and DDS Service Policy 3004-I identify that if the incident involves adult abuse, maltreatment or exploitation or child child abuse hotline.

Any employee of DHS, a DHS contracted facility, institution, or hospital is a mandated reporter of suspected child or adult abuse or r second business day following the incident. The DHS Communications Director must be notified by phone within one hour of occu filed with the Division Director or designee (specific to DDS the designee is the Quality Assurance Investigator) and the DHS Client Incident Report form DHS 1910.

The DHS Chief Counsel must be notified within one hour of occurrence, regardless of the hour, for incidents of:

1) Suicide;

2) Death from adult abuse, maltreatment or exploitation;

3) Death from child maltreatment or severe maltreatment; or

4) Serious injury.

Information requested on DHS Form 1910 that is not available at the time of the initial report must be submitted as a follow up or final hotlines may also be a criminal offense under Arkansas law. DHS policy does not supersede investigations by DDS.

As incident reports are received pertaining to waiver services, DDS Quality Assurance section notifies the DDS Waiver Program Dire

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Participants or legally responsible persons will be provided training and information on abuse and neglect through the Arkansas Guide to Services for Children with Disabilities and the Arkansas Guide to Services for Adults with Disabilities, The DDS Waiver Handbook, DDS website, advocacy websites and by the individual's case manager and DDS Waiver Specialist. All DHS contract facilities, institutions or hospitals are required to receive training on procedures of preventing and reporting alleged maltreatment of children or adults, and procedures for incident reporting. Training is offered by the DDS Quality Assurance staff as needed and upon request by a qualified provider or other group. In addition, DDS Certification Standards require all staff receive training on incident reporting as a part of the provider's annual up-date training.

Information and training on the waiver application is provided to waiver participants through the Arkansas Waiver

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The focal point for incident management is Arkansas is the Department of Human Services, Division of Aging Adult Protective Services (APS) for adults and the Division of Children and Family Services (DCFS) for children. APS and DCFS works under legislative mandates regarding acceptance of reports, investigations, substantiation and resolution of incidents of abuse, neglect and exploitation of adults and children. All waiver staff, providers and their staff and anyone receiving reimbursement for working with a Medicaid participant are identified in the law at Arkansas Code Annotated 12-12-1708 (a) (1) as mandatory reports. Mandatory reporters are required by law to report incidents immediately. All reports are logged into the IRIS database, from which some information is shared between DDS and APS/DCFS. Refer to b above for details on IRIS reporting. DDS uses the IRIS database to monitor critical incidents for participants in the ACS Waiver program. At each continued stay review, the DDS Specialists are required to do a review of all incident reports related to the waiver participant and to address any concerns.

APS has jurisdiction to investigate all cases of suspected maltreatment of an endangered or impaired adult. If at any point during intake or the investigative process an APS staff member believes a crime has been committed, the staff member is responsible for making a report to the law enforcement agency holding jurisdiction in the person's county or city of residence. Written information of the report is forwarded to law enforcement within 24 hours of filing the report. When a report indicates the person is in immediate need of assistance, the referral will be treated as an emergency, is reported to 911, and the person is seen by APS within 24 hours. If immediate assistance is not indicated, the initial face to face interview is unannounced and is conducted within three working dates from the date the report was filed with APS. If for any reason the three day requirement cannot be met, the APS staff must notify their Field Manager prior to the third day to request an extension for the initial visit. As per ACA § 12-12-1711(b)(1) The investigation shall be completed and an investigative determination entered within sixty (60) days. Based on information provided in the Case Summary Report and the recommendation of the APS staff, the APS Field Manager shall determine that the allegations are unfounded, founded or incomplete. If founded, the case summary report must contain details of how the APS staff met their responsibility to protect the person and to remedy the circumstances found to exist. Founded reports are maintained for five years. Incomplete reports are placed on inactive status for one year and at the end of the year are expunged. APS communicates with DDS as needed on all appropriate and relevant information related to ACS Waiver participants. The DHS Client Advocate reviews all incidents in the IRIS database and generates reports. All relevant information about ACS Waiver participants is reviewed by DDS waiver staff.

The Arkansas Child Maltreatment Hotline must accept reports of alleged maltreatment. If the nature of a child maltreatment report (Priority I or II) suggests that a child is in immediate risk, the investigation will begin immediately or as soon as possible. DCFS has jurisdiction to investigate all cases of child maltreatment in conjunction with Arkansas State Police Crimes Against Children Division (CACD) who is responsible to assess most Priority I allegations of child maltreatment. DCFS is responsible for ensuring the health and safety of the children even in the primary responsibility for the investigation belongs to CACD. The County Supervisor/designee assigns the report to a Family Service Worker(s) or a Unit Group who will conduct the assessment when the report is received in the CHRIS county in-box. The Family Service Worker will begin the Child Maltreatment Assessment immediately and no later than 24 hours after receipt of report by the Hotline, if severe maltreatment (Priority I) is indicated. All other Child Maltreatment Assessments must being within 72 hours of the report. A Health and Safety Assessment is completed in conjunction with the Child Maltreatment Assessment. An investigative determination shall be made within thirty days. If the circumstances of the child present an immediate danger of severe maltreatment, the Family Service Worker will take the child into protective custody for up to 72 hours.

The DDS Quality Assurance Investigator reviews and evaluates all incident reports to ensure correct procedures and time frames are followed. In the event DHS provider staff have failed to notify proper authorities such as the Adult Protective Services Hotline, Child Abuse Hotline, or the police department, the DDS Quality Assurance Investigator will ensure the notifications are made immediately. If an incident warrants investigation, the DDS Quality Assurance Investigator will investigate and submit findings of the review. The DDS Quality Assurance Investigator notifies the DHS entity involved. The entity is required to submit a plan of correction to the DDS Quality Assurance Program Evaluator Supervisor, and the DDS Quality Assurance staff perform necessary follow-up to monitor progress toward compliance.

Incidents involving people receiving waiver services will be tracked with analysis using an automated electronic reporting system. Incidents may be reviewed by the Waiver Program Director and Area Managers. The Waiver Program Director assures applicable distribution to the DDS Area Manager and DDS Specialist. The Specialist or Manager determines follow up outside the purview of DDS Quality Assurance and takes action when specific waiver issues are identified that need to be corrected.

Deaths and critical incidents are reported as received by the DDS Quality Assurance section to the DMS Quality Assurance.

DDS, in collaboration with DMS, implemented a DDS Community Provider Mortality Review Committee, under the guidance of

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Incident report logs are maintained by the DDS Quality Assurance section. Information for the logs is obtained from the IRIS incident reporting system. The information is collected from each provider who must report in accordance with DHS and DDS policy. The information in the IRIS system is extrapolated by the DDS Quality Assurance Investigator into an Excel spreadsheet and placed on an electronic "Share Point" intra DHS information system. Oversight is then performed through weekly review by the Medicaid lead agency (Division of Medical Services) and DDS Quality Assurance Assistant Director who access the Share Point reports. Follow up is conducted by QA when necessity is indicated by the DMS. Respective agreements are obtained and utilized when the matter is specific to either the Adult Protective (included in legislation) or Child Protective Agency. The interagency collaborations provide for the sharing of information inclusive of conclusions with both the Medicaid and Operating agencies. These agencies use the findings to conduct follow up when indicated, up to and inclusive of Death review that is performed by a DDS Mortality Review Committee. Health and Welfare are maintained by the DDS certified providers who are responsible for alternate placement or other actions when the individual is harmed but death has not occurred. In addition these providers are responsible to take applicable action with staff up to and inclusive of staff replacements in a timely manner consistent with the return of any individual who may have been hospitalized or otherwise out of service receiving treatment. DDS QA oversight includes Immediate Intervention Plans with specified dates for follow up and review depending upon the criticality of the incident or event.

Waiver participants and their services are monitored by DHS DDS Quality Assurance. Waiver participants receive services through qualified and certified providers. Therefore, all information previously stated in Appendix G 1 (c) also applies to the waiver participants. Through the National Core Indicators (NCI) project, DDS Quality Assurance staff gathers information from waiver participants and their families regarding health and safety issues including any critical incidents or events that affect waiver participants. Information obtained from the NCI project, as well as information from the Adult and Child Protection investigative agencies are used for tracking, trending, analyzing and remediation.

The timeframes are:

As soon as complaint is received at DDS, it is reviewed and prioritized.

Within five working days from start of the investigation, if telephone contact with complainant is required and cannot be made and complainant is known, a certified letter is sent to the complainant with return receipt requested and a return call to DDS within three working days of receipt of letter.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

◉ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A consumer who has become agitated or disruptive may be separated from a group or activity to allow the person to calm but the person may not be involuntarily secluded as a form of punishment.

Personal restraints (use of a staff member's body to prevent injury to the consumer or another person) is allowed under emergency (an emergency exists when: 1) the consumer has not responded to de-escalation techniques and continues to escalate behavior, 2) the consumer is a danger to self or others, or 3) the safety of the consumer and those nearby cannot be assured through positive reinforcers. If use of personal restraint occurs frequently (defined as more than 3 times per month), use should be discussed by the interdisciplinary team and addressed in the consumer's plan of care. When emergency procedures are implemented, plan of care revisions to include 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.

Mechanical restraints fall under the same requirements as the use of any type of personal or physical restraint in that it may only be used in emergency circumstances that places the person served or others at serious threat of violence or risk of injury if no intervention occurs. If emergency procedures are used more than three times in six months, the interdisciplinary team must meet to revise the plan of care.

DDS Standards require that providers will not allow maltreatment or corporal punishment of individuals. Provider's policies and procedures must state that corporal punishment 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 based on 20 U.S.C. 14000 et. seq.; ACA 12-12-501, ACA 12-12-515, ACA 5-28-101, ACA 5-29-109. Providers must develop a written behavior management policy to ensure rights of individuals. The policy is incorporated by an interdisciplinary team in programming. The policy must include a provision for alternative methods to avoid the use of restraints and seclusions. This shall include all types of positive approaches to behavior management prior to and in conjunction with more restrictive programmatic techniques such as positive reinforcement, differential

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DDS is responsible for monitoring and overseeing the use of restrictive interventions via an incident report tha tmust be submitted no later than the end of the 2nd business day following the incident. The providers are required to develop and implement a written administrative policy and procedures to protect all individual rights. Policy, procedures, individual consumer files, and on-site visits are reviewed annually by DDS Quality Assurance staff. When a verbal or written complaint or service concern arises, the DDS Quality Assurance Program Evaluator Supervisor will assure that a review is conducted to gather information, review records, contact entity to visit, observe and conduct private confidential interviews with complainant, service recipients, and provider personnel. A written report will be submitted to the DDS Quality Assurance Program Evaluator Supervisor within fifteen working days of completion of the complaint investigation. This time frame may be extended for justifiable cause, as approved by the DDS Director or designee. The DDS Quality Assurance Program Evaluator Supervisor will notify entities involved of the results of the review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Quality Assurance staff monitors the time frames for completion of the plan of correction and makes periodic on-site monitoring visits to assure compliance. Failure to complete corrective action measures may result in the provider being placed on provisional status or revocation of certification.

The use of mechanical restraints must be reported to DDS QA Section by providers. These events are monitored

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i

and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

DDS Standards require the use of a behavior management plan for all individual's whose behavior may warrant intervention. The plan must specify what behavior will constitute use of restrictive interventions, the length of time, who authorizes, and methods for monitoring the individual. When the behavior management plan is implemented, use must be documented in the individual's case record to include the initiating behavior, length of time, name of authorizing authority, names of all individuals involved, and the outcome of the event. Review of all behavior management plans is required as part of the annual person centered plan process; as well as, during quarterly progress reporting. All initial behavior modification plans and any subsequent modifications to the plan require the approval of the individual or legally responsible person.

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, regulations and policies. They must also be qualified to perform develop, implement, monitor or provide direct intervention as is applicable to the behavior management role.

Restrictive interventions include: 1) absence from a specific social activity, or 2) temporary loss of a personal possession. These interventions might be implemented to deal with aggressive or disruptive behaviors related to the activity or possession. Staff/consumers/families are trained by providers to recognize and report unauthorized

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DDS QA is responsible for monitoring and overseeing the use of restrictive interventions. The providers are required to develop and implement a written administrative policy and procedures to protect all individual rights. Policy, procedures, individual consumer files, and on-site visits are reviewed annually by DDS Quality Assurance staff. When a verbal or written complaint or service concern arises, the DDS Quality Assurance Program Evaluator Supervisor will assure that a review is conducted to gather information, review records, contact entity to visit, observe and conduct private confidential interviews with complainant, service recipients, and provider personnel. A written report will be submitted to the DDS Quality Assurance Program Evaluator Supervisor within fifteen working days of completion of the complaint investigation. This time frame may be extended for justifiable cause, as approved by the DDS Director or designee. The DDS Quality Assurance Program Evaluator Supervisor will notify entities involved of the results of the review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Quality Assurance staff monitors the time frames for completion of the plan of correction and makes periodic on-site monitoring visits to assure compliance. Failure to complete corrective action measures may result in the provider being placed on provisional status or revocation of certification.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The supportive living direct care supervisor has on-going responsibility for monitoring participant medication regimens. While the supportive living provider may not actually staff a person on a 24/7 schedule, the provider is responsible around the clock to assure that the plan of care identified and addressed all needs with other supports as necessary to assure the health and welfare of the participant. The direct care supervisor reviews the person's records and environments in which services are provided by accessing applicable professional sources to determine whether the person is receiving appropriate support in the management of medication.

Minimum components with monitoring activities for methods, frequency and effectiveness include:

1) Staff at all times are aware of the medications being used by the person;

2) Staff are make knowledgeable through the communication of potential side effects of the medications by the prescribing physician or nurse and pharmacist at the time medications are ordered;

3) All medications consumed are prescribed or approved by the person's physician or other health care practitioner;

4) The person or legally responsible person are informed by the prescribing physician about the nature and effect of medications being consumed, and consent to consumption of those medications prior to consumption;

5) Staff are implementing the service providers policies and procedures as to medication management, appropriate to the person's needs as monitored by the direct care support supervisor in accordance with acceptable personnel policies and practices and by the case manager at least monthly;

6) If psychotropic medications are used for behavior, the direct care support supervisor and case manager are responsible to assure an appropriate positive behavior programming is present and in use with programming review at least monthly;

7) The consumption of medications is monitored at least monthly by the direct care supervisor. Toxicology screenings are conducted on a frequency as determined by the prescribing physician with case manager oversight at least monthly to ensure they are accurately consumed and prescribed;

8) Any administration of medication or other nursing tasks or activities are performed in accordance with the Arkansas Nurse Practice and Consumer Directed Care Acts as monitored by the direct care supervisor in accordance with acceptable personnel practices and by the case manager at least monthly;

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The responsibility for ensuring that participant medications are managed appropriately is delegated to the direct care supervisor. The provider is required to have procedures and policies in place regarding medication management. Annually, DDS Quality Assurance staff conducts a review of the providers policies, procedures and consumer files. Items reviewed include, but are not limited to, locked medication storage and medication logs. Any time there is a reported incident or concern; DDS Quality Assurance staff will investigate, follow up as needed, and when indicated, make referrals to the Arkansas State Board of Nursing.

The provider is required to complete a medication management plan that is submitted for DDS Specialist review at least annually when medications are prescribed by the attending physician.

Prescription drugs are a state plan Medicaid service. The prescribing of prescription drugs is monitored by DMS Drug Utilization Review (DUR) Committee and the DUR Board. Monitoring includes checking number of medications prescribed and possible contraindications of use.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. **Medication Administration by Waiver Providers**

i. **Provider Administration of Medications.** *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Arkansas Nurse Practice Act as amended applies to all programs which administer medications. The act does not require a provider or their employees to perform any specific tasks, nor does it require a nurse to delegate tasks. Providers may at their discretion elect not to allow staff to perform any health maintenance activity.

The training and education that non-medical waiver providers must have in order to administer medications to participants who cannot self-administer is determined and provided by the nurse or nurse consultant when nurse delegation is occurring, or by the physician when consumer directed care applies. Frequency of follow up is also

iii. Medication Error Reporting. *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Medication errors that (1) cause serious injury or have the potential to cause serious injury, or (2) cause serious illness or have the potential to cause serious illness must be reported to DDS Quality Assurance Section or (3) trends that indicate the need for planning and intervention. Other, less serious medication errors are reported and investigated internally by the provider. Reporting may include State protective agencies and the nursing board.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record omission, over dosage and under dosage of prescribed medicines, clerical omission, charting omission, falsification of records, and theft of medication.

(c) Specify the types of medication errors that providers must *report* to the State:

Medication errors that (1) cause serious injury or have the potential to cause serious injury, or (2) cause serious illness or have the potential to cause serious illness must be reported to DDS Quality Assurance Section and (3) trends that indicate the need for planning and intervention. Other, less serious medication errors are reported and investigated internally by the provider. Reporting may include State protective agencies and the nursing board.

- ○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DDS Quality Assurance section follows up on reports of serious medication errors as they are reported.

DDS Quality Assurance monitors any problems with medication administration annually through record and on-site inspection. As warranted, follow-up is conducted and any re-training or corrective action plans are monitored by the Quality Assurance staff through on-site inspections and review of documentation provided. If the provider does not enter into compliance or complete the corrective action plan within the specified time frames, DDS may place the provider on provisional status or remove them from the list of qualifying providers. The proposed incident reporting and tracking system will include a component to track medication errors and the data collected will be used in tracking and trending these types of incidents and the development of statewide performance outcomes.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
The DDS Quality Assurance Section reviews 100% all written and verbal concerns regardless of reporting source as the reports are received and conducts investigation and remedy in accordance with DDS Policy 1010 within 35 days from concern receipt.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **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:
The DDS Quality Assurance Section conducts 100% review of all allegations of abuse, neglect and exploitation with referral to and collaboration with the applicable Arkansas protective agency 100% of the time. As a result of the legal investigation and review, administrative/corrective action is taken for 100% compliance with the findings and outcomes.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☑ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **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:
DDS Q A requires an immediate intervention plan from the DDS certified provider with remedy up to & inclusive of revocation of DDS certification based on seriousness of the substantiation. Based on trending, specific training unique to the situation, annual training in the form of awareness and prevention; and awareness via power point presentation on the DDS and AWA Websites are accomplished.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **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:
The DDS Waiver Program Section conducts review of all initial and continued stay reviews (12 month) plans of care for the identification or omission of risk factors that may impede health and safety in the community; with action in the form of follow up, inclusive of plan of care denial, pending correction.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

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

Incidents: Incidents reported to the Waiver Section staff or any other source are referred to the Quality Assurance Licensing Section for follow up and corrective action at that Section's discretion in accordance with standards to include referral to external agencies when abuse, neglect or exploitation are alleged. In addition, Waiver staff monitors the issue to assure corrective action is taken; and if not, the process as described in Risk Assessment is employed.

All incident reports are tracked through the Quality Assurance reporting system with patterns identified that may be systemic and have the need for further remediation. Based upon an allegation being one on one specific or systematic, corrective action in the form of training/retraining up to and inclusive of decertification of the DDS Certified provider is taken. In addition training and awareness are published via the DDS and AWA websites.

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 Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The applicable DDS section (Quality Assurance Services and Waiver Services) is responsible to identify critical data elements and perform data collection as specified in the Quality Improvement Strategy for tracking, trending, discovery, analysis, and remediation for compliance with the ACS Waiver and CMS requirements. The DDS is engaged in on-going information technology projects to automate data collection into an integrated data base to be available for the extraction of reports to facilitate the identification and analysis process. Each respective DDS section is responsible to assure data entry as the system capability is expanded and extrapolation of reports. The DDS Waiver Services is responsible to assure overall development and completion of the project by working directly with the information technology systems analyst and programmers.

Processes employed to review findings, establish priorities, develop strategies and assess effectiveness of current

system:

1) Roles and Responsibilities - DMS remains responsible for the administration and oversight of all Medicaid waivers, including those operated by other divisions. To facilitate this responsibility, DMS has a Waiver Quality Assurance Administrator who plays a major role for DMS in QMS development, implementation, and monitoring for each 1915(c) HCBS waiver. The Waiver QA Administrator works closely with the operating agencies and serves as primary liaison with CMS regarding the waivers. This position serves to centralize responsibility and accountability for the waiver with DMS, and also provides leadership in promoting and improving quality in 1915(c) HCBS waivers. The Waiver QA Administrator reports to the DMS Assistant Director, and together they keep the DMS Director informed of waiver concerns and activities.

The DDS Assistant Director of Waiver Services is responsible for the day-to-day operation of the waiver program. This includes helping design, develop and implement the QMS for the waiver. The DDS Assistant Director directly supervises the Program Director and the Waiver Administrators. The Program Director supervises the Area Program Managers who in turn supervise the DDS Specialists that have direct contact and interaction with waiver participants. In addition this position is responsible for internal and external training functions and activities. One Waiver Administrator supervises the Waiver Coordinators who perform monitoring, reporting and policy functions; and recommend, design, track and analyze systems. One supervises the Waiver technical support unit (prior authorization creation and distribution) and manages internal operations (procedures) and information technology advances to include design and implementation. One supervises the Waiver application unit to include processing for release to vacant waiver positions. In addition this position manages all of the business and personnel functions and activities for the entire Section.

The DDS Area Program Managers perform case/chart reviews on 10% of all active participants annually, as well as other ongoing discovery activities. The results of these activities are reported monthly to the DDS Program Administrator, who also periodically performs chart reviews and other discovery activities. The QMS matrix provides information on the chart reviews and other discovery activities, including who is responsible, what data and information is used; frequency and what reports are generated.

The DDS Specialists participate in on-site multi-agency planning reviews (MAPS) for a minimum of 10% of all active participants annually, and must visit on-site prior to approving all initial Pervasive Level of Care requests. Adverse findings are reported to the Waiver Program Director as reviews are conducted with corrective action to be taken by the applicable authority depending upon what the adverse finding may be. Adverse findings of service concerns are reflected in quality assurance reviews and in reports of denial of services that may occur.

The DMS Waiver Quality Assurance Unit will review a valid sample of participant records annually. This unit will review for compliance with key assurances including level of care, plans of care, qualified providers, health and welfare, and financial accountability. The DMS Wavier Quality Assurance Unit will report findings to the DMS Waiver QA Administrator and Assistant Director. The DMS Waiver QA Administrator will share review results with the DDS Assistant Director and Waiver Administrator, and will advise on and track any necessary remediation and improvement.

2) Processes to Establish Priorities and Develop Strategies for Remediation & Improvement -
The DDS Waiver Program Director and Waiver Administrators share reports with the DMS Waiver QA Administrator and discuss the findings of the reports and any issues or concerns. Priorities are established and strategies are developed for any necessary remediation and improvement. DDS personnel are responsible to track remediation and improvement results and report findings to their Assistant Directors/Director. When the DMS Waiver Quality Assurance reviews and reports are added to the discovery process, the annual results will determine prioritization as well as needed remediation and improvement.

When major issues are identified that impact one or more of the assurances, the DDS Waiver Assistant Director and DMS Waiver QA Administrator will inform the DDS and DMS Directors and Assistant Directors and seek their input on prioritization and remediation.

The purpose of the QMS matrix was to at a glance identify activities for compliance with the 6 major CMS assurances whereby identified parties can keep track of their specific responsibilities with the goal being to be in compliance with the assurance requirements. The matrix was developed with the technical assistance of the CMS technical advisors who recommended the design. It is now applied throughout this waiver document where applicable but remains as an at a glance document. For any of the quality indicators that are found to be deficient, determinations by the applicable responsible party result in individual corrective actions with providers or DDS staff or system change when or if the discoveries result in systemic problems. The matrix is now replaced with the quality improvement strategy.

3) Compilation and Communication of Quality Management Information - At the end of each waiver year, the DMS QA Administrator will compile a QMS annual report based on discovery findings from DDS, DMS Quality Assurance, and the CMS 372 report. The annual QMS report will include key information relevant to each assurance, information about participation in and cost of the waiver based on the CMS 372 report and information on any key findings, including

status of remediation and improvement activities. The DMS QA Administrator will make the report available to DDS and DMS administration.

4) Periodic Evaluation and Revision of the QMS - It is anticipated that the QMS will undergo a good deal of revision during the first year or two of implementation as more is learned about effective discovery methods, remediation solutions and program improvement techniques. The DMS Waiver QA Administrator and the DDS Assistant Director will use the last quarterly meeting each waiver year to review and discuss the QMS and to make any necessary changes. If the QMS is revised as a result of this annual review, the DMS Waiver QA Administrator will send the revised QMS to CMS.

Each services section has distinct responsibilities within the Quality Management Strategy for Unit functions. They are:

1) Quality Assurance Services section:

a) Provider Qualifications, capacity and capabilities

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

DDS employs a lead information technology developer. Weekly and monthly meetings to review progress, develop new elements and components, and test system changes are established and on-going. The weekly meetings involve local participation in current programming activities with participation of the assigned Northrop-Grumman consultant, the DDS Waiver Information Technology lead, the DDS Waiver Policy Administrator and others as may be appropriate depending on the issue for discussion and review that week. Monthly meetings among the consultants, the DHS Office

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DDS and DMS will review the Quality Improvement Strategy annually. Review consists of analyzing reports and progress toward stated initiatives, resolution of individual and systematic issues found through discovery and notating of desired outcomes. When change in the strategy is indicated, a collaborative effort between DMS and DDS is set in motion to complete a revision to the Quality Management Strategy that may include changes for submission as an

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All providers who receive a total of $100,000 up to $500,000 in state funding are required to submit a GAS audit annually. Providers wh audit of the provider's financial statements. All audits are reviewed by the Department of Human Services, Office of Chief Counsel (OC will notify the funding division. The funding division (in this case DDS) defers the notifications to the DDS Quality Assurance Services

Waiver programs and providers must use the Medicaid Management Information System (MMIS) for billing and payment. The Divisio System (data warehouse for reporting). The Division of Developmental Disabilities Services (DDS) is responsible for identifying neces needed in MMIS. DMS is responsible to determine priority for programming changes requested of Electronic Data Systems to include d random financial audits for billing practices and utilization.

DDS is responsible for reviewing billing claims activity for each provider with DDS Specialists conducting a 100% post payment financi prior approved waiver services for the plan of care being reviewed. This audit occurs prior to approval of all new continued plans of ca questioned, a referral is made to the DMS Program Integrity for onsite resolution.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Percentage of claims paid in accordance with the reimbursement methodology specified in the approved waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of actual billing and payments from the Medicaid Management Information System (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 = DMS Audit uses the Raosoft Calculation System to determine the
☐ **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.

The DDS Specialist review provider billing for each waiver individual at the end of each plan of care year and uses the current yeaar as a baseline for the next year's plan approval unless the provider justification for underutilization is

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 DDS Specialist notifies the waiver provider of any variance from the plan of care approvals or discrepancy in billing and requests correction or adjustment in cases where the provider may need to make restitution to the state's Medicaid agency. Any finding that involves the possibility of restitution is reported to the state's Medicaid agency, Program Integrity section, for review, investigation and collection activities. In all events, the DDS Specialist documents the

ii. Remediation Data Aggregation

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

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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

○ **No**

◉ **Yes**

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

The DDS is developing and enhancing a DDS tracking system to include documenting variances for the purpose of identifying systemic issues that are reported to both the DDS Quality Assurance section for provider certification compliance and the Division of Medical Services, Program Integrity section for Medicaid enrollment compliance. Speed of completion is dependent upon securing above base level funding. With addition funding for above base line capability

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Case Management - The monthly rate for case management is prospective based on provider costs up to a maximum of $117.70 the first year of the waiver ($107.00 + 10% increase) with a 2.5% increase in the unit rate for each subsequent year of the waiver renewal if the operating agency has available funding.

Supportive Living - The daily rate for pervasive level is prospective based on provider costs up to a maximum of $391.95 the first year of the renewal ($356.32 +10% increase)with a 2.5% increase each subsequent year of the waiver renewal if the operating agency has funding available. The $356.32 rate was based on the extensive level care maximum rate of $160.00 plus a companion program, Community Integration, which used state general revenue to augment waiver services. The daily maximum for the Community Integration program is $196.32. With the exception of Pervasive Level of Care, as described above, the maximum is based on comparison costs with ICF/MR facilities at the time of limitation setting in 1990. There has been no change in rate setting since that date. The daily rate for supportive living for all other levels of support is prospective based on provider costs up to a maximum of $176.00 the first year of the waiver renewal ($160.00 a day plus a 10% increase) with a 2.5% increase each subsequent year of the waiver renewal if funding is available to the operating agency.

Respite Care - prospective based on provider costs with the same maximum daily amounts as shown for supportive living.

Environmental Modifications - the rate is prospective based on provider costs up to a maximum of $7,687.50 the first year of the renewal ($7,500.00 + 2.5% increase) with a 2.5% increase each subsequent year of the waiver renewal if funding is available to the operating agency.

Adaptive Equipment - the rate is prospective based on provider costs up to a maximum of $7,687.50 the first year of the renewal ($7,500.00 + 2.5% increase) with a 2.5% increase each subsequent year of the waiver renewal if funding is available to the operating agency. The maximum was based on average consumer needs at the time of limitation setting in 1990.

Specialized Medical Supplies - the rate is prospective based on provider costs up to a maximum of $3,690.00 ($3,600.00 + 2.5% increase) the first year of the waiver with a 2.5% increase each subsequent year of the waiver renewal if funding is available to the operating agency. The maximum was based on average consumer needs at the time of limitation setting in 1990.

Supplemental Supports - the rate is prospective based on provider costs up to a maximum of $3,690.00 ($3,600.00 + 2.5% increase) the first year of the waiver with a 2.5% increase each subsequent year of the waiver renewal if funding is available to the operating agency. The maximum was based on average consumer needs at the time of limitation setting in 1990.

Consultation - based on prevailing labor market rates and inability to access the services utilizing the former methodology which was outdated as established in 1989. Services will be based on up to the same maximum as crisis intervention since some of the same qualifications are required for staff. The maximum rate will be $136.40 for the first year of the waiver and an additional with a 2.5% increase each subsequent year of the waiver renewal if funding is available to the operating agency.

Crisis Intervention - the rate is prospective based on provider costs in 1998 for a maximum rate of $127.10 ($124.00 + 2.5% increase) the first year of the waiver and with a 2.5% increase each subsequent year of the waiver renewal if funding is available to the operating agency.

Supported Employment - the rate is based on prevailing state rate of established for non waiver programs at the time of rate setting in 1990 with a maximum rate of $3.59 for a 15 minute unit of service ($3.50 + a 2.5% increase) the first year of the waiver and with a 2.5% increase each subsequent year of the waiver renewal if funding is available to the operating agency.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers bill directly through the state Medicaid Management Information System (MMIS). DDS approved plans of care include the approval of a prior authorization that is entered into MMIS specifying the approved provider, approved service, annual approved dollar amount for the service and beginning and ending dates in which the service is to be delivered. The provider is sent a copy of the approved plan and the prior authorization for billing. Once the provider has delivered an approved service, they can bill through MMIS. MMIS will verify that a prior authorization is on file for the person and service

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify**

their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Services are identified in the plan of care with prior authorizations electronically entered into the MMIS. The MMIS contains billing edits which prevent unauthorized services from being paid. MMIS will verify that a prior authorization is on file for the person and service and that funding is available in the prior authorization to pay the bill. The provider is required to maintain daily progress notes of services provided, time sheets, payroll, sub-contracts (if using Organized Health Care Delivery System), vendor purchase orders and payments to support and justify the billing. The provider direct care support services supervisor is responsible to assure that services are delivered in accordance with the plan of care prior to when billing for the service occurs. This activity includes review of daily case notes by the workers who deliver the services. The provider case manager is responsible to perform oversight of this service delivery. In all services outside the scope of supported living, the case manager is responsible to assure that the items or services are delivered prior to billing. DDS QA reviews provider payroll and service delivery documentations annually. In addition to the QA activities, the MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. Waiver staff verifies annually services were provided according to the service plan through a monthly on site, based on random case sampling, that assures a 10% on site case review annually and a 100% off site case review annually. All waiver claims are processed through the MMIS, using all applicable edits and audits, to assure claims are processed appropriately, timely, and compared to the Medicaid maximum allowable amount and individual prior authorization. Providers are required to report all gaps in services and failure to do so may result in sanctions relative to their certification standing. Collectively, these activities are effective for timely remediation to resolve any problems in delivery of services. Remediation is effected via adjustments in the future billing, as allowable under the 365 day Medicaid billing authorization when or if new billing may be required, and via sanctions as may be indicated by the QA findings.

The DDS Specialist does a 100% review of billing on MMIS annually before the next plan of care is approved.

DMS Quality Assurance conducts random financial utilization samplings. Audit results are forwarded to the applicable DDS Area Manager who responds to all findings until resolution is obtained.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency,

economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

To help assure timely, efficient and quality services to meet the identified needs of all persons, the DDS has established a management providers. Providers are not required to contract with an OHCDS, it is an optional program. The delivery c providers to serve all locations in the State of Arkansas. Within the state of Arkansas there are numerous economically services to people with developmental disabilities. This situation is further exacerbated by the current economic dilemm

The option of OHCDS is available to any current or future provider through a written agreement between DDS and the pr Medicaid regulations and provides that the OHCDS provider assumes all liability for contract non-compliance. The OH(also have a written contract that sets forth specifications and assurances that work will be completed timely and with qua supplemental support and specialized medical supplies.

Monitoring activities are vested with the DDS Quality Assurance Licensure section will include a review of all OHCDS w are reviewed and approved by waiver staff.

Any willing qualified provider may apply to become an ACS waiver provider by contacting the DDS Licensure Unit. A c The applicant then applies with the DMS through their fiscal agent, Electronic Data Systems, to become an ACS waiver p provider.

Methods for assuring participants have a free choice of qualified providers are:

1) The DDS Specialist provides comprehensive lists of all qualified waiver providers to each individual or the legal repre

2) Changes in the providers listings are updated annually with the individual or the legal representative at each continue

3) The Case Management entity is responsible to assist the individual or the legal representative in locating qualified loc

4) A retrospective review is conducted annually by the DDS Specialist;

5) A satisfaction survey is conducted in accordance with National Core Indicators annually by the DDS Quality Assurar

Methods for assuring providers meet applicable qualifications: Policy requires the OHCDS provider to have a written an all applicable provider qualifications to include local codes or other requirements. Qualification requirements will be incl

When OHCDS is used, the enrolled provider is required to have a duly executed sub-contract in place and must review a approved services. The enrolled provider is held responsible for ensuring that services were delivered and proper docu

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Developmental Disabilities Services receives some state funding that is used for Medicad waiver match. The money is transferred to DMS through an interagency agreement.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Supplemental Security Income (SSI)/personal accounts are used to cover room and board costs and are maintained separately from waiver reimbursements. Providers are prohibited from including room and board as any part of waiver direct/indirect expense formulations with the following exceptions.

Federal financial participation (FFP) may not be claimed for the cost of room and board except when provided as a part of respite care furnished in a facility approved by the state. FFP may not be claimed for room and board when respite is provided

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	36897.05	12711.48	49608.53	72031.16	1664.54	73695.70	24087.17
2	42631.95	13166.58	55798.53	74591.44	1724.13	76315.57	20517.04
3	45824.44	13637.99	59462.43	77262.03	1785.86	79047.89	19585.46
4	49274.55	14126.27	63400.82	80028.24	1849.80	81878.04	18477.22
5	52998.95	14632.03	67630.98	82893.48	1916.03	84809.51	17178.53

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	4203	4203
Year 2	4263	4263
Year 3	4263	4263
Year 4	4263	4263
Year 5	4263	4263

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The estimate is based on the actual prior year experience from the FY 08 372 report for the ACS HCBS Waiver. The average is based on total sum of waiver covered days divided by the total unduplicated count of persons.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Case Management, Supportive Living, Supplemental Support, Environmental Modifications, Supported Employment, Specialized Medical Supplies, Adaptive Equipment, Crisis Intervention and Respite - the basis for the estimates was utilization as identified in the FY 08 372 Report; inclusive of number of people receiving each service and unit of service received. Year 1 of the estimates includes a 10% growth adjustment factor and each year thereafter includes a 2.5% cost of living adjustment which may be provided if funding is available to the operating agency.

Consultation - the rate is based on provider studies that identify the inability to obtain necessary consultation services due to restrictive hourly rates for each consultation component. To alleviate this situation and provide for flexibility when determining consultation needs, DDS is establishing a yearly and maximum hourly service rate. The annual rate is based upon an average of current labor markets for specialties identified. The $3,600.00 yearly maximum is based on statistical trends of ICF/MR eligibility expiration; pervasive level needs pended, environmental modifications pended

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was computed based on CMS-372 report. This report contains actual data from the previous year. Prescription drug costs associated with dual eligible participants are not contained in this report.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on factor G in the draft FY 08 372 report plus a percent of the increase in factor G from the FY 07 372 report to the FY 08 372 report.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on factor G' in the FY 08 372 report plus a percent of the increase in factor G' from the FY 07 372 report to FY 08 372 report.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and

populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**5842745.70**
Transitional case management	month	215	3.00	117.70	**75916.50**	
Case Management	month	4083	12.00	117.70	**5766829.20**	
Respite Total:						**1211931.36**
Respite	day	527	12.00	191.64	**1211931.36**	
Supported Employment Total:						**630561.96**
Supported Employment	15 minutes	84	2091.00	3.59	**630561.96**	
Supportive Living Total:						**145084403.76**
Supportive Living	day	4062	356.00	100.33	**145084403.76**	
Specialized Medical Supplies Total:						**223190.40**
Specialized Medical Supplies	month	335	12.00	55.52	**223190.40**	
Adaptive Equipment Total:						**958277.98**
Personal Emergency System Service Fee	month	22	12.00	35.00	**9240.00**	
Adaptive Equipment	package	254	1.00	3736.37	**949037.98**	
Community Transition Services Total:						**286344.00**
Community Transition Services	package	194	1.00	1476.00	**286344.00**	
Consultation Total:						**192470.40**
Consultation	hour	163	18.00	65.60	**192470.40**	
Crisis Intervention Total:						**10668.00**
Crisis Intervention	hour	21	4.00	127.00	**10668.00**	
Environmental Modifications Total:						**546208.84**
Environmental Modifications	package	139	1.00	3929.56	**546208.84**	
Supplemental Support Total:						**91512.00**
Supplemental Support	month	62	6.00	246.00	**91512.00**	
				GRAND TOTAL:		**155078314.40**
				Total Estimated Unduplicated Participants:		**4203**
				Factor D (Divide total by number of participants):		**36897.05**
				Average Length of Stay on the Waiver:		356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**6042254.40**
Transitional case management	month	123	3.00	120.64	**44516.16**	
Case Management	month	4143	12.00	120.64	**5997738.24**	
Respite Total:						**1327784.40**
Respite	day	535	12.00	206.82	**1327784.40**	
Supported Employment Total:						**695829.12**
Supported Employment	15 minutes	84	2251.00	3.68	**695829.12**	
Supportive Living Total:						**171293337.36**
Supportive Living	day	4122	356.00	116.73	**171293337.36**	
Specialized Medical Supplies Total:						**247899.96**
Specialized Medical Supplies	month	363	12.00	56.91	**247899.96**	
Adaptive Equipment Total:						**1043692.50**
Personal Emergency System Service Fee	month	23	12.00	35.00	**9660.00**	
Adaptive Equipment	package	270	1.00	3829.75	**1034032.50**	
Community Transition Services Total:						**177754.50**
Community Transition Services	paackage	105	1.00	1692.90	**177754.50**	
Consultation Total:						**216831.60**
Consultation	hour	170	18.00	70.86	**216831.60**	
Crisis Intervention Total:						**11985.76**
Crisis Intervention	hour	23	4.00	130.28	**11985.76**	
Environmental Modifications Total:						**575975.40**
Environmental Modifications	package	143	1.00	4027.80	**575975.40**	
Supplemental Support Total:						**106652.70**
Supplemental Support	month	63	6.00	282.15	**106652.70**	
				GRAND TOTAL:		**181739997.70**
				Total Estimated Unduplicated Participants:		**4263**
				Factor D (Divide total by number of participants):		**42631.95**
				Average Length of Stay on the Waiver:		356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**6193511.10**
Transitional case management	month	123	3.00	123.66	**45630.54**	
Case Management	month	4143	12.00	123.66	**6147880.56**	
Respite Total:						**1435062.60**
Respite	day	535	12.00	223.53	**1435062.60**	
Supported Employment Total:						**752748.36**
Supported Employment	15 minutes	84	2377.00	3.77	**752748.36**	
Supportive Living Total:						**184544248.32**
Supportive Living	day	4122	356.00	125.76	**184544248.32**	
Specialized Medical Supplies Total:						**254085.48**
Specialized Medical Supplies	month	363	12.00	58.33	**254085.48**	
Adaptive Equipment Total:						**1069550.40**
Personal Emergency System Service Fee	month	23	12.00	35.00	**9660.00**	
Adaptive Equipment	package	270	1.00	3925.52	**1059890.40**	
Community Transition Services Total:						**162823.50**
Community Transition Services	paackage	105	1.00	1550.70	**162823.50**	
Consultation Total:						**234151.20**
Consultation	hour	170	18.00	76.52	**234151.20**	
Crisis Intervention Total:						**15357.10**
Crisis Intervention	hour	23	5.00	133.54	**15357.10**	
Environmental Modifications Total:						**590375.50**
Environmental Modifications	package	143	1.00	4128.50	**590375.50**	
Supplemental Support Total:						**97694.10**
Supplemental	month				**97694.10**	

Support		63	6.00	258.45		
		G				195349607.66
		Total Estimated Unduplicated Participants:				4263
		Factor D (Divide total by number of participants):				45824.44
		Average Length of Stay on the Waiver:				356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**6348273.75**
Transitional case management	month	123	3.00	126.75	**46770.75**	
Case Management	month	4143	12.00	126.75	**6301503.00**	
Respite Total:						**1549852.20**
Respite	day	535	12.00	241.41	**1549852.20**	
Supported Employment Total:						**810275.76**
Supported Employment	15 minutes	84	2499.00	3.86	**810275.76**	
Supportive Living Total:						**198851710.32**
Supportive Living	day	4122	356.00	135.51	**198851710.32**	
Specialized Medical Supplies Total:						**260445.24**
Specialized Medical Supplies	month	363	12.00	59.79	**260445.24**	
Adaptive Equipment Total:						**1096048.20**
Personal Emergency System Service Fee	month	23	12.00	35.00	**9660.00**	
Adaptive Equipment	package	270	1.00	4023.66	**1086388.20**	
Community Transition Services Total:						**166893.30**
Community Transition Services	paackage	105	1.00	1589.46	**166893.30**	
Consultation Total:						**252878.40**
Consultation	hour	170	18.00	82.64	**252878.40**	
Crisis Intervention Total:						**15742.35**
Crisis Intervention	hour	23	5.00	136.89	**15742.35**	
Environmental Modifications						**605134.53**

Total:						
Environmental Modifications	package	143	1.00	4231.71	**605134.53**	
Supplemental Support Total:						**100135.98**
Supplemental Support	month	63	6.00	264.91	**100135.98**	
				GRAND TOTAL:		**210057390.03**
				Total Estimated Unduplicated Participants:		**4263**
				Factor D (Divide total by number of participants):		**49274.55**
				Average Length of Stay on the Waiver:		356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**6507043.20**
Transitional case management	month	123	3.00	129.92	**47940.48**	
Case Management	month	4143	12.00	129.92	**6459102.72**	
Respite Total:						**1673822.40**
Respite	day	535	12.00	260.72	**1673822.40**	
Supported Employment Total:						**876506.40**
Supported Employment	15 minutes	84	2635.00	3.96	**876506.40**	
Supportive Living Total:						**214303769.28**
Supportive Living	day	4122	356.00	146.04	**214303769.28**	
Specialized Medical Supplies Total:						**266935.68**
Specialized Medical Supplies	month	363	12.00	61.28	**266935.68**	
Adaptive Equipment Total:						**1123207.50**
Personal Emergency System Service Fee	Month	23	12.00	35.00	**9660.00**	
Adaptive Equipment	package	270	1.00	4124.25	**1113547.50**	
Community Transition Services Total:						**171063.90**
Community Transition Services	paackage	105	1.00	1629.18	**171063.90**	
Consultation Total:						**273135.60**
Consultation	hour	170	18.00	89.26	**273135.60**	
Crisis Intervention						

Total:						**16135.65**
Crisis Intervention	hour	23	5.00	140.31	**16135.65**	
Environmental Modifications Total:						**620262.50**
Environmental Modifications	package	143	1.00	4337.50	**620262.50**	
Supplemental Support Total:						**102638.34**
Supplemental Support	month	63	6.00	271.53	**102638.34**	
				GRAND TOTAL:		**225934520.45**
				Total Estimated Unduplicated Participants:		**4263**
				Factor D (Divide total by number of participants):		**52998.95**
				Average Length of Stay on the Waiver:		356