NOTICE OF RULE MAKING

The Director of the Division of Developmental Disabilities Services of the Department of Human Services hereby issues, for a public comment period of (30) calendar days, a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, 20-77-139, and 25-10-129.

Effective December 1, 2020, pursuant to Act 775 of 2017, the Community and Employment Supports (CES) Waiver is amended as follows:

- Six hundred (600) regular slots are being added to the CES Waiver and one hundred (100) priority slots for children in the Division of Children and Family Services (DCFS) custody.
- Cost neutrality analysis is being updated to reflect the new slots

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule on the Medicaid website at https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than **September 26, 2020.** Please note that public comments submitted in response to this notice are considered public documents.. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only will be held on September 14, 2020, at 1:00 p.m. Individuals can access this public hearing by calling 1-888-240-3210 and entering the conference code, 4527581.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6164.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501888131

Melissa Stone, Director
Division of Developmental Disabilities Services

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 waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

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

B. Program Title:
Community and Employment Support Waiver

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

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
12/01/20

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

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2. Purpose(s) of Amendment

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

The purpose of this amendment is to add additional slots to the CES (AR.0188) Waiver.

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	
☐ Appendix A Waiver Administration and Operation	
☒ Appendix B	

Component of the Approved Waiver	Subsection(s)
Participant Access and Eligibility	
☐ 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	

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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:

Adding additional slots for CES Waiver

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

1. Request Information (1 of 3)

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

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

Community and Employment Support Waiver

C. Type of Request: amendment

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

3 years **5 years**

Original Base Waiver Number: AR.0188
Draft ID: AR.006.05.05

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

Regular Waiver

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

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

☐ **Nursing Facility**

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

Not applicable.

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

☒ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

The Provider-Led Arkansas Shared Savings Entity (PASSE), a 1915(b)(1)/(b)(4) Waiver application.

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:

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

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

2. Brief Waiver Description

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

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

The goals of the CES Waiver are to support beneficiaries in all major life activities, promote community inclusion through integrated employment options and community experiences, and
provide comprehensive care coordination and service delivery under the 1915(b) PASSE Waiver Program.

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

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

All CES Waiver beneficiaries are assigned to a Provider-led Arkansas Shared Savings Entity (PASSE), which is a full-risk organized care organization responsible for providing all services to its enrolled members, except for non-emergency transportation in a capitated program, dental benefits in a capitated program, school-based services provided by school employees, skilled nursing facility services, assisted living facility services, human development center services, or waiver services provided through the ARChoices in Homecare program or the Arkansas Independent Choices program. The PASSE also provides care coordination services administratively through the § 1915(b) Waiver.

All services must be delivered based on an individual person-centered service plan (PCSP), which is based on an Independent Assessment by a third party vendor, the health questionnaire given by the PASSE care coordinator, and other psychological and functional assessments. The PCSP must have measurable goals and specific objectives, measure progress through data collection, be created by the member's PASSE care coordinator, in conjunction with the member, his or her caregivers, services providers, and other professionals.

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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

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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.

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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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:

Websites for the Arkansas Waiver Association, the Developmental Disabilities Provider Association and Arkansas Medicaid contain
information about the Waiver amendments. The information was posted to the Arkansas Medicaid Website from August 31, 2018, to September 30, 2018, and public input was invited. Additionally, letters were sent to stakeholders asking for public input on those documents. No public input was received during this time.

Other websites would have posted the information soon thereafter. DDS staff participated at provider conferences and took comments by phone and email from providers and people receiving or applying for services.

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

October 2017:
9-13: AFMC PASSE Webinars, statewide
10: Independent Assessment Informational Session, Little Rock
11: DDS Provider Information Session, Fort Smith
17: Parent Meeting, Searcy
18: Stakeholder Information Session, Hope
25: School-Based Mental Health Task Force
26: Stakeholder Information Session, Paragould
30: Stakeholder Information Session, Monticello

November 2017:
17: DDPA Conference, Little Rock

December 2017:
6: Medicaid Educational Conference

January 2018:
8: Independent Assessment Training Session
19: Facebook Live presentation, statewide

February 2018:
16: Independent Assessment Information Session, Little Rock
28: Arkansas Department of Education, Little Rock

March 2018:
27: Independent Living, Inc. Conference, Harrison

April 2018:
20: Family Bistro for Title V Families and DD Stakeholders
25: ACAAA Annual Conference, Little Rock

May 2018:
17: DDPA Conference
25: Natural Wonders Committee presentation, Little Rock

June 2018:
29: Youth Move Arkansas Conference, Jonesboro

After review and approval from CMS and Arkansas Legislative Committees, the implementing regulations, policies, rules and procedures are incorporated into the DMS Medical Services Manual. This manual is available to all providers and the general public on the Arkansas Medicaid website.

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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: Rouse

First Name: Alexandra

Title: Director, Office of Policy Development

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

Address: P O Box 1437, Slot S295

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 508-8870 **Ext:** ☐ **TTY**

Fax: (501) 404-4619

E-mail: Alexandra.Rouse@dhs.arkansas.gov

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

Last Name: Davenport

First Name: Regina

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Title: Assistant Director for CES Waiver Services

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

Address: P O Box 1437, Slot N502

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 683-0575 **Ext:** ☐ **TTY**

Fax: (501) 682-8380

E-mail: regina.davenport@dhs.arkansas.gov

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8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Arkansas**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

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Specify the transition plan for the waiver:

While care coordination will no longer be offered as a CES Waiver service, it will be provided administratively to all CES Waiver participants through the PASSE 1915(b) Waiver. All current CES Waiver participants are currently being enrolled in a PASSE through an attribution algorithm and will begin receiving care coordination through the PASSE program prior to March 1, 2019. Clients currently on the CES Waiver Waitlist are also being enrolled in a PASSE and will begin receiving care coordination, so as those clients are placed in a CES Waiver slot, the care coordinator will continue working with them to create a PCSP under the CES Waiver.

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

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

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

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

waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

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:

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The Division of Medical Services (DMS), within the Department of Human Services (DHS), is the State Medicaid agency (SMA) and has administrative authority for the CES Waiver including the following:
1) Develop and Monitor the Interagency Agreement to ensure that provisions specified are executed;
2) Oversee the CES Waiver program through a DMS case record review process that allows for response to all individual and aggregate findings;
3) Review and approve, via Medicaid Manual promulgation process, public policies and procedures developed by DDS regarding the CES Waiver and monitoring their implementation;
4) Promulgate any applicable Medicaid Manuals that govern participation in the CES Waiver program, in accordance with the Arkansas Administrative Procedures Act;
5) Insure that a specified number of PCSPs are reviewed by DMS or their designated representative;
6) Provide to DDS relevant information pertaining to the Medicaid program and any federal requirements governing applicable waiver programs;
7) Monitor compliance with the interagency agreement; and
8) Complete and Submit the CMS 372 Annual Report.

The Division of Developmental Disabilities Services (DDS), also within DHS, is responsible for operation of the CES Waiver including the following:
1) Develop and Implement internal, administrative policies and procedures to operate the Waiver. DMS does not approve these internal procedures, but does review them to ensure there are no compliance issues with either State or Federal Regulations.
2) Develop and implement public policy and procedures;
3) Provide training to PASSE care coordinators and HCBS providers regarding provision of Waiver services and development of the PCSP;
4) Establish and monitor the person center service plan (PCSP) requirements that govern the provision of services;
5) Coordinate the collection of data and issuance of reports through MMIS with DMS as needed to complete the CMS 372 Annual Report;
6) Provide to DMS the results of all monitoring activities conducted by DDS; and
7) Develop and implement a Quality Assurance protocol that meets criteria as specified in the Interagency Agreement.

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DDS is also responsible for:
1) Determining waiver participant eligibility according to DMS rules and procedures; and
2) Providing technical assistance to PASSE care coordinators and HCBS providers, as well as consumers on CES Waiver requirements, policies, procedures and processes.

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

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

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

DMS and DDS contract with a Third Party Vendor to conduct Independent Assessments that will be used to determine the beneficiaries' service tier for the purpose of attribution to a PASSE and will generate a risk and needs report that can be used to create his or her PCSP. DDS will continue to make the ICF/IDD level of care determination and determine eligibility for services.

PASSEs provide care coordination to all enrolled members, arrange for the provision of all medically necessary services to enrolled members, certify HCBS providers, and set reimbursement rates for services provided to its enrolled members. The PASSE care coordinators will develop the PCSP for clients that determines the services the individual receives.

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:

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☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

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

DDS is the division in charge of operational management of the Waiver and is responsible for oversight the Independent Assessment Vendor and development of the PCSP by the PASSE care coordinators. DMS, as the State Medicaid Agency, retains authority over the CES Waiver in accordance with 42 CFR §431.10(e). DMS's Contracting Official will oversee the contract between DHS and the Third Party Independent Assessor. The Contract will have performance measures that the Vendor will be required to meet.

DMS's Office of Innovation and Delivery System Reform (IDSR), with the assistance of DDS, will have responsibility for monitoring the performance of the PASSE entities and the provision of Care Coordination, as well as the provision of all services.

Appendix A: Waiver Administration and Operation

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

The Third Party Independent Assessor must submit monthly contractor reports to DMS and DDS that include:
1. Demographics about the Beneficiaries who were assessed;
2. An activities summary, including the volume, timeliness and outcomes of all Assessments and Reassessments; and
3. A running total of the activities completed.

The Third Party Independent Assessor must submit an annual program performance report that includes:
1. An activities summary for the year, including the total number of assessments and reassessments;
2. A summary of the Third Party Contractor's timeliness in scheduling and performing assessments and reassessments;
3. A summary of findings from Beneficiary feedback research conducted by the Third Party Contractor;
4. A summary of any challenges and risks perceived by the Third Party Contractor in the year ahead and how the Third Party Contractor proposes to manage or mitigate those; and
5. Recommendations for improving the efficiency and quality of the services performed.

The PASSEs must submit quarterly reports that includes data on the quality of services provided, utilization data, and encounter data. Additionally, an External Quality Review Organization will do an annual evaluation of each PASSE in accordance with CMS regulations. These quarterly reports are described in the Concurrent 1915(b) waiver for the Provider-led Arkansas Shared Savings Entities, Section B-II-q.

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Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☒

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
AA1: Number and percent of unduplicated participants served within approved limits specified in the approved HCBS Waiver. Numerator: Number of unduplicated participants served within approved limits specified in the HCBS Waiver. Denominator: Number of approved unduplicated participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

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

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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: PASSE	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA2: Number and percentage of applicants who had an initial LOC determination completed before receipt of services. Numerator: Number of applicants who had an initial LOC determination completed before receipt of services. Denominator: Number of LOC determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC Determination Report

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

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Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

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

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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**

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

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

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Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

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

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Performance Measure:
AA4: Number and percentage of PCSPs completed in the time frame specified in the agreement with the PASSE entities. Numerator: Number of PCSPs completed in the time frame specified; Denominator: Number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE quarterly reports

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*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: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: 20% of the charts are reviewed.
	☐ **Other** Specify:	

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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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
AA5: Number and percentage of participants with delivery of at least one care coordination contact per month as specified in the PCSP. Numerator: Number of participants with delivery of at least one care coordination contact per month; Denominator: Number of participants served by the CES Waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE encounter data

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: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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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: PASSE	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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Performance Measure:
AA6: Number and percentage of providers certified and credentialed by the PASSE. Numerator: Number of provider agencies that obtained annual certification in accordance with PASSE's standards. Denominator: Number of HCBS provider agencies reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report (Validation Reviews of Provider Certification Files)

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE credentialing and certification report.

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

	Ongoing	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: PASSE	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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Performance Measure:
AA7: Number and percentage of policies developed by DDS that are reviewed and approved by the Medicaid Agency prior to implementation . Numerator: Number of policies and procedures by DDS reviewed by Medicaid before implementation; Denominator: Number of policies and procedures developed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PD/QA Request Forms

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

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

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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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Developmental Disabilities Services (the operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DDS and DMS have an Interagency Agreement for measures related to administrative authority of the CES Waiver.

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

In cases where there are problems with level of care determinations completed by a qualified evaluator, where instruments and processes were not followed as described in the waiver, or were not completed within specified time frames, additional staff training, staff counseling or disciplinary action may be part of remediation.

Similarly, remediation for PCSPs not completed in specified time frames includes completing the PCSP upon discovery, additional training for PASSE care coordinators, and possible corrective or remedial action taken against the PASSE.

Remediation to address beneficiaries not receiving at least one care coordination contact a month in accordance with the PCSP includes closing a case, conducting monitoring visits, revising a PCSP to add a service, providing training to the PASSE care coordinators, and possible corrective or remedial action against the PASSE.

Remediation associated with provider credential and certification that is not current would include additional training for the PASSE, as well as remedial or corrective action, including possible recoupment of PMPM payments.

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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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **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.

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Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☒	Autism	0		☒
	☒	Developmental Disability	0		☒
	☒	Intellectual Disability	0		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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

DDS eligibility is established by Arkansas Code Annotated, Section 20-48-101. The statute applies to Intermediate Care Facilities for Intellectual or Developmental Disability (ICF/IDD) and the CES Waiver. DDS interprets a developmental disability to be (1) a categorically qualifying diagnosis and three (3) significant adaptive behavior deficits related to this diagnosis. Following are the categorically qualifying diagnoses:

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

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

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

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

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

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

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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:

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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:

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

☐ **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	4303
Year 2	4803
Year 3	4863
Year 4	4883
Year 5	5503

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.

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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	4183
Year 2	4723
Year 3	4743
Year 4	4763
Year 5	5263

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):*

Two hundred waiver openings (slots) are reserved for persons in foster care in the care or custody of the Department of Human Services, Division of Children and Family Services, including children adopted since July 1, 2010.

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 at time of reaching adulthood and upon existence of regular capacity vacancy.

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

Waiver Year	Capacity Reserved
Year 1	200
Year 2	200
Year 3	200
Year 4	200
Year 5	300

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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 eligibility determination date for persons determined to have successfully applied for the waiver, but who through administrative error were or are inadvertently omitted from the Waiver wait list.

b) In order of waiver application eligibility determination date of persons for whom waiver services are necessary to permit discharge from an institution, e.g. persons who reside in ICFs/IID, Nursing Facilities, and Arkansas State Hospital patients; or admission to or residing in a Supported Living Arrangement (group homes and apartments).

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

d) In order of waiver application determination date for all other persons.

Appendix B: Participant Access and Eligibility

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

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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:

Adults newly eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

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

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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 spend down 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 7)

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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 7)

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

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:

Other

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Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process including income that is placed in a Miller Trust.

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

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:

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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 7)

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

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 7)

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

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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-5: Post-Eligibility Treatment of Income (5 of 7)

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

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

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

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

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:

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Other

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process including income that is placed in a Miller Trust.

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

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (*select one*):

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:

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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 (6 of 7)

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

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

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

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

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. 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).

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i. Allowance for the personal needs of the waiver participant

(*select one*):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

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 formula:

Other

Specify:

The maintenance needs allowance is equal to the individual’s total income as determined under the post eligibility process including income that is placed in a Miller Trust.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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 uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

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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:

The PASSE care coordinator must monitor the member monthly, at a minimum.

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 a government agency 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.

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.

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

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

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

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

According to 42 CFR 435.1009, Ark. Code Ann. § 20-48-101 et seq. and DDS Policy 1035, Eligibility, the DDS Psychology Team uses the same criteria to determine eligibility for HCBS Waiver as for ICF/IID. The criteria are:
(1) Verification of a categorically qualifying diagnosis;
(2) Age of onset is established to be prior to age 22;
(3) Substantial functional limitations in activities of daily living (adaptive functioning deficits) are present and are as a result of the categorically qualifying diagnosis. Adaptive functioning deficits are defined as an individual's inability to function in three of the following six categories as consistently measured by standardized instruments administered by qualified professionals: Self-Care, Understanding and Use of Language, Learning, Mobility, Self-Direction, and Capacity for Independent Living; and
(4) The disability and deficits are expected to continue indefinitely.

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

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

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

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

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

impairment of general functioning similar to that of a person with an intellectual or developmental disability.

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

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

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

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

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

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.

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

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

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

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

If a beneficiary disagrees with an eligibility determination, they may appeal to the Assistant Director for CES Waiver for an administrative review of the findings. Beneficiaries may also appeal directly to the DHS Office of Appeals and Hearing, in accordance with DDS Appeals Policy 1076.

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

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:

A the Care Coordinator at the PASSE organization prepares and signs documentation annually to request from DDS annual level of care redetermination. The care coordinator must meet the qualifications set out in the 1915(b) Waiver.

DDS staff who review this annual documentation will meet QDDP qualifications or have their reviews signed by a staff person who meets QDDP qualifications.

DDS staff who perform periodic redeterminations of eligibility will meet the qualifications of a Psychological Examiner.

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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):*

The PASSE is responsible for generating a monthly report of any person whose periodic functional assessment and annual institutional level of care packet are due. Periodic functional assessment are described in B.6. d. Packets include the reports and assessments noted in this section.

The PASSE care coordinator must gather all necessary documents and submit them to DDS for the annual level of care review. CES Waiver staff then make the level of care redetermination.

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:

At DDS, all records are maintained in an electronic environment with protected security and access. This system includes level of care records. All electronic records are housed by the Department of Information Systems in the state designated storage medium. The responsibility for day to day operations remains with DDS.

The PASSE's will also be responsible for maintaining all level of care documentation for assigned beneficiaries in a secure manner that is compliant with HIPAA.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
LOC A1: Number and percentage of applicants for whom an application packet is completed and submitted timely to the DDS psychology team for an LOC initial determination. Numerator: Number of applicants for whom an application packet is completed and submitted timely to the DDS psychology team for an LOC initial determination; Denominator: Number of application packets submitted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Intake and Referral Report of Timely Application Submissions

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

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

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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:

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Performance Measure:
LOC A2: Number and percentage of applicants who had an initial LOC determination completed before receipt of services. Numerator: Number of applicants who had an initial LOC determination completed before receipt of services; Denominator: Number of initial LOC determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual File Review

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

		Sample Confidence Interval = 95% with a +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Quarterly QA Report

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

Specify:		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:

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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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
LOC C1: Number and percentage of participants for whom the appropriate process and instruments were used to determine initial eligibility. Numerator: Number of participants' packets with appropriate process and instruments used to determine initial eligibility; Denominator: Number of participant's packets reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **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:

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

b. Methods for Remediation/Fixing Individual Problems

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

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

(LOC A2) The system in place for new applicants to enter the CES waiver program does not allow for services to be delivered prior to an initial determination of Level of Care.

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

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:

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c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

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

Beneficiaries may change individual service providers within their PASSE network, at anytime, by contacting their PASSE care coordinator. Individuals do have a choice of their PASSE. All beneficiaries are auto-assigned to a PASSE and given 90 days to change that PASSE for any reason. Every year, the beneficiary will have an open enrollment period, where they can change their PASSE for any reason. And, at any time, a beneficiary may change their PASSE for cause (as described in 42 CFR 438.56(d)(2)).

The PASSE must have transition supports in place to assist individuals in transitioning between an ICF/IID and HCBS services.

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

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

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

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

The PASSEs are also required to offer all material in English and Spanish and provide translations or other assistance as requested or needed.

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	**Caregiver 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**		

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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 agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Caregiver Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

Sub-Category 2:

09 Caregiver Support	09012 respite, in-home

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Caregiver respite services are provided on a short term basis to members unable to care for themselves due to the absence of or need for relief to the non-paid primary caregiver. Caregiver respite services do not include room and board charges.

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

When caregiver respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Caregiver respite should not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Caregiver 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.

Respite may be provided in the following locations:

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

2) The private residence of a respite care provider;

3) Foster home;

4) Licensed respite facility; or

5) Other community residential facility approved by the member's PASSE, not a private residence. Respite care may occur in a licensed or accredited residential mental health facility.

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

N/A

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	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Caregiver Respite

Provider Category:

Agency

Provider Type:

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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Other Standard *(specify):*

Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Cannot be on the National or State Excluded Provider List.
Individuals who perform respite services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry checks, and
1) Have a high school diploma,
2) Have at least one year of experience working with persons with developmental disabilities or behavioral health diagnoses;
3) Be certified to perform CPR and first aid; and
4) Have training in use of behavioral support plans and de-escalation techniques.

Verification of Provider Qualifications

Entity Responsible for Verification:

PASSE

Frequency of Verification:

Annually. Proof of credentialing must be submitted to DMS.

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 agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category	Sub-Category
Category 1: 03 Supported Employment	**Sub-Category 1:** 03010 job development
Category 2: 03 Supported Employment	**Sub-Category 2:** 03021 ongoing supported employment, individual
Category 3: 03 Supported Employment	**Sub-Category 3:** 03022 ongoing supported employment, group
Category 4: 03 Supported Employment	**Sub-Category 4:** 03030 career planning

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Service Definition *(Scope):*

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

Supported Employment array consist of the following supports:

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

2) Employment Path-Members receiving Employment Path services must have goals related to employment in integrated community settings in their Person Centered Support Plan (PCSP). Service activities must be designed to support such employment goals. Employment Path services can replace non-work services. Activities under Employment Path should develop and teach soft skills utilized in integrated employment which include but are not limited to following directions, attending to tasks, problem solving skills and strategies, mobility training, effective and appropriate communication-verbal and nonverbal, and time management.
The ideal documentation for this service is the PCSP, progress notes, and a Arkansas Rehabilitation Services Referral.

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Employment supports consists of two primary components-Job development and Job Coaching.
Employment Supports-Job Development services are individualized services that are specific in nature to obtaining certain employment opportunity. The initial outcome of Job Development Services is a Job Development Plan to be incorporated with the Individual Career Profile. The Job development plan should specify at a minimum the short and long term employment goals, target wages, tasks hours and special conditions that apply to the worksite for that member; jobs that will be developed and/or a description of customized tasks that will be negotiated with potential employers; initial list of employer contacts and plan for how many employers will be contacted each week; conditions for use of on-site job coaching.
The ideal documentation for this service is the Job Development Plan and participant’s remuneration statement.

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

This service may also be utilized when the member chooses self-employment. Activities such as assisting the member to identify potential business opportunities, assisting in the development of business plan, as well as other activities in developing and launching a business. Medicaid Waiver funds may not be used to defray expenses associated with starting or operating a self-employment business such as capital expenses, advertising, hiring and training of employees.
Ideally, the provider will develop a fading plan for this service to be achieved within 12 months to 24 months.

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

Transportation between the member's place of residence and the employment site is included as a component of supported employment services when there is no other resource for transportation available.

The service provider must maintain the following documents to demonstrate compliance and delivery of this service- any job development plan or transition plan for job supports, remuneration statement (paycheck stub) and member's work schedule.

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

Must be documented in the PCSP.

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	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

DRAFT

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:

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Cannot be on the National or State Excluded Provider List.
Individuals who perform supported employment services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

PASSE

Frequency of Verification:

Annually. Proof of credentialing must be submitted to DMS.

Appendix C: Participant Services

C-1/C-3: Service Specification

DRAFT

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Supportive Living

HCBS Taxonomy:

Category	Sub-Category
02 Round-the-Clock Services	02031 in-home residential habilitation
02 Round-the-Clock Services	02011 group living, residential habilitation
04 Day Services	04010 prevocational services
04 Day Services	04020 day habilitation

Service Definition *(Scope):*

Supportive living is an array of individually tailored services and activities to enable members to reside successfully in their own home, with family or in an alternative living setting (apartment, or provider owned group home). Supportive living services must be provided in an integrated community setting.

Supportive living includes care, supervision, and activities that directly relate to active treatment goals and objectives set forth in the member's PCSP. It excludes room and board expenses, including general maintenance, upkeep, or improvement to the home.

Supportive living supervision and activities are meant to assist the member to acquire, retain, or improve skills in a wide variety of areas that directly affect the person's ability to reside as independently as possible in the community. The habilitation objective to be served by each activity should be documented in the member's PCSP. Examples of supervision and activities that may be provided as part of supportive living include:

1) Decision making, including the identification of and response to dangerously threatening situations, making decisions and choices affecting the member's life, and initiating changes in living arrangements or life activities;
2) Money management, including training, assistance or both in handling personal finances, making purchase and meeting personal financial obligations;
3) Daily living skills, including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, administration of medication (to the extent permitted by state law), proper use of adaptive and assistive devices and household appliances, training on home safety, first aid, and emergency procedures;
4) Socialization, including training and assistance in participating in general community activities and establishing relationships with peers. Activity training includes assisting the member to continue to participate in an ongoing basis;
5) Community integration experiences, including activities intended to instruct the member in daily living and community living in integrated settings, such as shopping, church attendance, sports, and participation sports.
6) Mobility, including training and assistance aimed at enhancing movement within the member's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel or movement within the community;
7) Communication, including training in vocabulary building, use of augmentative communication devices, and receptive and expressive language;
8) Behavior shaping and management, including training and assistance in appropriate expression of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors;
9) Reinforcement of therapeutic services, including conducting exercises reinforcing physical, occupational, speech, behavioral or other therapeutic programs;
10) Companion activities and therapies, or the use of animals as modalities to motivate members to meet functional goals established for the member's habilitative training, including language skills, increased range of motion, socialization, and the development of self-respect, self-esteem, responsibility, confidence, an assertiveness; and
11) Health maintenance activities, which include tasks that members would otherwise do for themselves or have a family member do, with the exception of injections and IV medication administration.

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

All units must be documented in the member's PCSP.

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	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

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:

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DRAFT

Other Standard *(specify):*

The Provider must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not be on the National or State Excluded Provider List.

Individuals who perform supportive living services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry checks, and
1) Have a high school diploma, GED or equivalent,
2) Have at least one year of experience working with persons with developmental disabilities or behavioral health diagnoses;
3) Be certified to perform CPR and first aid; and
4) Have training in use of behavioral support plans and de-escalation techniques.

Verification of Provider Qualifications

Entity Responsible for Verification:

PASSE

Frequency of Verification:

Annually, proof of verification must be submitted to DMS.

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 agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11060 prescription drugs
Category 3:	**Sub-Category 3:**
17 Other Services	17990 other
Category 4:	**Sub-Category 4:**

DRAFT

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 proper functioning of such items;

2) Such other durable and non-durable medical equipment not available under the State plan that is necessary to address the member's functional limitations and has been deemed medically necessary by the prescribing physician;

3) Necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the member. All items shall meet applicable standards of manufacture, design and installation. The most cost effective item should be considered first.

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

1) Nutritional supplements;

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

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

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

Must be documented in the member's PCSP.

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	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

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

DRAFT

Provider Category:

Agency

Provider Type:

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.

Verification of Provider Qualifications

Entity Responsible for Verification:

PASSE

Frequency of Verification:

Annually. Proof of credentialing must be submitted to DMS.

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 agency or the operating agency (if applicable).

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 statute.

Service Title:

Adaptive Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

DRAFT

Service Definition *(Scope):*

Adaptive equipment is a piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of members, whether commercially purchased, modified, or customized. The adaptive equipment services include adaptive, therapeutic, or augmentative equipment that enables a member to increase, maintain, or improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Consultation by a medical professional must be conducted to ensure the adaptive equipment will meet the needs of the member.

Adaptive equipment includes enabling technology, such as safe home modifications, that empower members to gain independence through customizable technologies that allow them to safely perform activities of daily living without assistance while still providing monitoring and response for those members, as needed. Enabling technology allows members to be proactive about their daily schedule and integrates member choice.

Adaptive equipment also includes Personal Emergency Response Systems (PERS), which is a stationary or portable electronic device used in the member's place of residence and that enables the member to secure help in an emergency. The system is connected to a response center staffed by trained professionals who respond to activation of the device. PERS services may include the assessment, purchase, installation, and monthly rental fee.

Computer equipment, including software, can be included as adaptive equipment. Specifically, computer equipment includes equipment that allows the member increased control of their environment, to gain independence, or to protect their health and safety.

Vehicle modification are also included as adaptive equipment. Vehicle modifications are adaptions to an automobile or van to accommodate the special needs of the member. The purpose of vehicle modifications is to enable the member to integrate more fully into the community and to ensure the health, safety, and welfare of the member. Vehicle modifications exclude: adaptations or modifications to the vehicle that are of general utility and not of direct medical or habilitative benefit to the member; purchase, down payment, monthly car payment or lease payment; or regularly scheduled maintenance of the vehicle.

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

Must be documented in the member's PCSP.

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	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

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:

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.

Verification of Provider Qualifications

Entity Responsible for Verification:

PASSE

DRAFT

Frequency of Verification:

Annually. Proof of credentialing must be submitted to DMS.

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 agency or the operating agency (if applicable).

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 statute.

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Community Transition Services are non-recurring set-up expenses for members who are transitioning from an institutional or provider-operated living arrangement, such as an ICF or group home, to a living arrangement in a private residence where the member or his or her guardian is directly responsible for his or her own living expenses.

Community Transition service activities include those necessary to enable a member to establish a basic household, not including room and board, and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the member's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses.

Community Transition Services should not include payment for room and board; monthly rental or mortgage expense; regular food expenses, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

DRAFT

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

Must be documented in the member's PCSP.

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	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

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:

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.
Individuals who perform community transition services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry checks, and hold a current Arkansas license or certification from the appropriate licensing or certification organization, if applicable (i.e., to provide pest control services the individual or company must be appropriately licensed). Additionally,
--have a high school diploma, GED, or the equivalent, and
--at least one year of experience with developmental disability populations.

DRAFT

Verification of Provider Qualifications

Entity Responsible for Verification:

PASSE

Frequency of Verification:

Annually. Proof of credentialing must be provided to DMS.

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 agency or the operating agency (if applicable).

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 statute.

Service Title:

Consultation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

DRAFT

Consultation services are clinical and therapeutic services which assist the individual, parents, legally responsible persons, responsible individuals and service providers in carrying out the member's PCSP. Consultation activities are provided by professionals licensed as one of the following:

1) Psychologist

2) Psychological Examiner

3) Licensed Clinical Social Worker

4) Professional counselor

5) Speech pathologist

6) Occupational therapist

7) Registered Nurse

8) Certified parent educator or provider trainer

9) Certified communication and environmental control specialist

10) Qualified Developmental Disabled Professional (QDDP)

11) Positive Behavior Support (PBS) Specialist

12) Physical therapist

13) Rehabilitation counselor

14) Dietitian

15) Recreational Therapist

16) Board Certified Behavior Analyst (BCBA)

DRAFT

These services are direct in nature. The PASSE will be responsible for maintaining the necessary information to document staff qualifications. Staff, who meets the certification criteria necessary for other consultation functions, may also provide these activities. These activities include, but are not limited to:

1) Provision of updated psychological and adaptive behavior assessments;

2) Screening, assessing and developing therapeutic treatment plans;

3) Assisting in the design and integration of individual objectives as part of the overall individual service planning process as applicable to the consultation specialty;

4) Training of direct services staff or family members in carrying out special community living services strategies identified in the member's PCSP as applicable to the consultation specialty;

5) Providing information and assistance to the persons responsible for developing the member's PCSP as applicable to the consultation specialty;

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

7) Consulting with and providing information and technical assistance with other service providers or with direct service staff or family members in carrying out the member's PCSP specific to the consultant's specialty;

8) Assisting direct services staff or family members to make necessary program adjustments in accordance with the member's PCSP and applicable to the consultant's specialty;

9) Determining the appropriateness and selection of adaptive equipment to include communication devices, computers and software consistent with the consultant's specialty;

10) Training or assisting members, direct services staff or family members in the set up and use of communication devices, computers and software consistent with the consultant's specialty;

11) Screening, assessing and developing positive behavior support plans; assisting staff in implementation, monitoring, reassessment and plan modification consistent with the consultant's specialty;

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

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

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

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

13) Training or assisting by advocacy consultants to members and family members on how to self-advocate.

14) Rehabilitation Counseling for the purposes of supported employment supports.

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

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

Must be documented in the member's PCSP.

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
Individual	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultation

Provider Category:

Individual

Provider Type:

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.
Individuals who perform consultation services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry checks, and hold a current Arkansas license or certification from the appropriate licensing or certification organization, if applicable (i.e., a physical therapist must be licensed by the Arkansas State Board of Physical Therapy).

DRAFT

Verification of Provider Qualifications

Entity Responsible for Verification:

PASSE

Frequency of Verification:

Annually. Proof of credentialing must be submitted to DMS.

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 agency or the operating agency (if applicable).

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 statute.

Service Title:

Crisis Intervention

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Crisis Intervention is delivered in the member's place of residence or other local community site by a mobile intervention team or professional. Intervention shall be available 24 hours a day, 365 days a year. Intervention services shall be targeted to provide technical assistance and training in the areas of behavior already identified. Services are limited to a geographic area conducive to rapid intervention as defined by the provider responsible to deploy the team or professional. Services may be provided in a setting as determined by the nature of the crisis; i.e., residence where behavior is happening, neutral ground, local clinic or school setting, etc., for persons participating in the Waiver program and who are in need of non-physical intervention to maintain or re-establish a behavior management or positive programming plan.

DRAFT

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

N/A

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	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

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:

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.
Individuals who perform Crisis Intervention for the PASSE must be a Masters or Doctoral level clinician, an Advanced Practice Nurse, or a Physician.

DRAFT

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 agency or the operating agency (if applicable).

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 statute.

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1: 14 Equipment, Technology, and Modifications

Sub-Category 1: 14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Modifications made to the member's place of residence that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence and without which, the member would require institutionalization. Examples of environmental modifications include the installation of wheelchair ramps, widening doorways, modification of bathroom facilities, installation of specialized electrical and plumbing systems to accommodate medical equipment, installation of sidewalks or pads, and fencing to ensure non-elopement, wandering or straying of members with decreased mental capacity or aberrant behaviors.

Exclusions include modifications or repairs to the home which are of general utility and not for a specific medical or habilitative benefit; modifications or improvements which are of an aesthetic value only; and modifications that add to the total square footage of the home.

Environmental modifications that are permanent fixtures to rental property require written authorization and release of current or future liability from the property owner.

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

Must be documented on the member's PCSP.

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	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

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:

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.
(4) Appropriately licensed and bonded in the state of Arkansas, as required, and possess all appropriate credentials, skills, and experience to perform the job (i.e., licensed plumbers, electricians, and HVAC techs)

DRAFT

Verification of Provider Qualifications

Entity Responsible for Verification:

PASSE

Frequency of Verification:

Annually. Proof of credentialing must be submitted to DMS.

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 agency or the operating agency (if applicable).

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 statute.

Service Title:

Supplemental Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Supplemental Support services meet the needs of the member to improve or enable the continuance of community living. Supplemental Support Services will be based upon demonstrated needs as identified in a member's PCSP as unforeseen problems arise that, unless remedied, could cause a disruption in the member's services or placement, or place the member at risk of institutionalization.

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

N/A

DRAFT

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	Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

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:

Home and Community Based Services Provider for Persons with Developmental Disabilities and Behavioral Health Diagnoses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be:
(1) Credentialed by the PASSE to provide HCBS services to persons with Developmental Disabilities and Behavioral Health Diagnoses.
(2) Permitted by the PASSE to perform these services.
(3) Not on the National or State Excluded Provider List.
Individuals who perform Supplemental support services for the PASSE must pass a drug screen, a criminal background check, a child maltreatment registry check, and an adult maltreatment registry check, and
--have a high school diploma, GED, or the equivalent, and
--at least one year of experience with developmental disability populations.

Verification of Provider Qualifications

Entity Responsible for Verification:

PASSE

Frequency of Verification:

Annually. Verification of credentialing must be submitted to DMS.

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Appendix C: Participant Services

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

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.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *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:

PASSE care coordinators provide care coordination (the case management service) to all CES waiver recipients. The State attests that care coordination service, defined in the Concurrent 1915(b) PASSE Waiver, Section A, Part I.F.8, meets the requirements of person centered planning. Please see Appendix D of this Waiver for more information.

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):

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Arkansas Code Ann. §20-38-101 et seq., Standards for Conducting Criminal Record Checks for Employees of Developmental Disabilities Service Providers, requires Home and Community Based Services Providers for Persons with Developmental Disabilities and Behavioral Health Diagnoses (HCBS Providers) to conduct criminal background checks for all employees, as defined in statute and standards. In certain circumstances a PASSE may waive disqualification of an applicant or employee in accordance with section the statute.

Employee is defined as a person who:
1) is employed by a service provider to provide care to individuals with disabilities served by the service provider; or
2) provides care to individuals with disabilities served by a service provider on behalf of, under supervision of, or by arrangement with the service provider; or
3) submits an application to a service provider for the purposes of employment; or
4) is a temporary employee placed by an employment agency with a service provider to provide care to individuals with disabilities served by the service provider; or
5) submits an application to the PASSE for the purpose of being credentialed service provider; or
6) resides in an alternative living home in which services are provided to individuals with developmental disabilities; and
7) has or may have unsupervised access to individuals with disabilities served by a service provider.

Criminal record checks are required for all employees and shall include both a state and national record check. A "state only" criminal record check is allowed if the provider can verify the applicant has lived continuously in the State of Arkansas for the past five years.

The provider may extend an offer of conditional employment pending the outcome of the DDS determination of employment eligibility, unless the applicant has self-reported a disqualifying offense. If the provider receives a criminal record report on an employee from the Arkansas State Police that shows no criminal record, the provider may continue to employ the person. If the provider receives a criminal record report on an employee from the Arkansas State Police that shows a criminal record, the provider must remove the person from unsupervised access to persons served.

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DDS checks the Arkansas State Police website for criminal records. If DDS finds a criminal record on a provider employee, DDS makes a determination for employment eligibility based on the record and sends notice to the provider. If a FBI record check is required, the FBI report is sent to DDS Quality Assurance. DDS makes a determination of employment eligibility based on the record and sends notice to the provider.

The DDS determination of employment eligibility is based on comparison of the conviction noted in the Arkansas State Police or FBI criminal record report with those offenses identified in Arkansas Code Ann. §20- 38-101 et seq. as disqualifying offenses. A person who is defined as an employee in this statute is not eligible to work for a DDS provider if they have a disqualifying offense. The provider is required to terminate employment of a person who has been disqualified. DDS Quality Assurance staff reviews evidence of criminal record checks by providers and employment determinations by DDS during the annual review of all certified providers.

DDS staff also have access to persons served and are also required to undergo criminal background checks. If a disqualifying criminal conviction is found, the individual's employment with DDS is terminated.
In certain narrowly prescribed circumstances, a provider may waive DDS disqualification of an applicant or employee in accordance with Section 504 of the DDS Criminal Record Check Standards.

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):

Arkansas maintains two statewide Central Registries of substantiated cases of abuse and neglect. The DHS Division of Children and Family Services (DCFS) maintains the registry for children and DHS Adult Protective Services (APS) maintains the adult abuse registry. All PASSE HCBS Providers must initiate a check of all employees on both registries. PASSEs or the Provider must also check any adult over the age of 18 residing in an alternative living home or group home, including employees' spouses. This check will provide documentation that the prospective employee's name and any adult family members' names do not appear on the statewide central registry.

Each PASSE is required to adopt policies that address what actions will be taken if an adult family member's name appears on the central registry when the individual being served is in an alternative living home or group home. If a record is found in either registry, the individual who received this information shall notify the Director of the program in writing so that corrective measures may be determined. When a PASEE or employer/provider is notified that an individual's name is on either Registry, the PASSE or employer/provider must take corrective measures that comply with their internal policies and A.C.A. 20-38-101 et seq. The Office of Innovation and Delivery System Reform (IDSR), in conjunction with DDS staff, review evidence of central registry checks for each credentialed PASSE provider during the annual review.

In addition, all DDS staff are required to undergo abuse registry checks. If any disqualifying record is found the individual's employment with DDS is terminated.

Process for ensuring that mandatory screenings have been conducted: on-site PASSE review includes review of credentialing files for compliance.

Appendix C: Participant Services

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

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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.

The State has undertaken activities as described in the transition plan to ensure that all residential settings comply with the characteristics described in the Final Rule. The group homes are community based and located in residential areas. The homes provide access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, and provide for privacy and easy access to resources and activities in the community. Each group home contains bedrooms and bathrooms that allow privacy. Members 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. Members are provided access to community resources and supports and are encouraged to build community relationships. Members are granted access to visitors at times convenient to the individual. Members are allowed a choice of roommates, if they are in a shared bedroom.

Group homes, owned and operated by HCBS 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. Arkansas imposed a moratorium and no additional group homes have been approved since July 1, 1995. Group homes built after July 1, 1995 are limited to a capacity of no more than 4 unrelated adults with developmental disabilities.

The capacity for supported living apartments owned and operated by waiver providers, regardless of date of DDS licensing, may serve a number of persons consistent with the number of bedrooms each apartment contains, but in no event more than four unrelated adults, age 18 and above, with developmental disabilities in each self-contained apartment unit.

Group Homes and Supported living arrangement apartments must be credentialed by the PASSE to provide services to PASSE members.

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Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Homes

Waiver Service(s) Provided in Facility:

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

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:

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

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
Supplemental Support	☐
Consultation	☒
Caregiver Respite	☐
Supported Employment	☒
Adaptive Equipment	☒
Environmental Modifications	☐
Specialized Medical Supplies	☒

Waiver Service	Provided in Facility
Community Transition Services	☐
Supportive Living	☒
Crisis Intervention	☒

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	☒

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

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

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.*

☐ **Self-directed**

☐ **Agency-operated**

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.*

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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:

Relatives/guardians may provide CES Waiver services; however, the state does not pay relatives or guardians directly. Instead, the State pays the PASSE a per member per month (PMPM) prospective payment for each attributed member. The PASSE may then utilize qualified relatives or guardians to provide the services. These individuals will need to be credentialed through the PASSE and meet the minimum qualifications established in this Waiver.

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:

Each PASSE is responsible for credentialing its own HCBS providers based on the minimum qualifications set forth in this Waiver. Under the 1915(b) waiver, the PASSE is required to ensure statewide access to services for each attributed member in accordance with the Managed Care rule. The PASSE is also subject to Arkansas's Any Willing Provider law found at Ark. Code Ann. 23-99-201 et seq. This law states that the insurer (PASSE) cannot prohibit or limit a provider who is qualified and willing to accept its terms from participating in its health plan.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

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Performance Measure:
QP A1: Number and percentage of HCBS providers who were properly credentialed according to the minimum qualifications set out in this Waiver and according to the PASSE's internal policies. Numerator: Number of HCBS providers who were properly credentialed; Denominator: Total number of credentialed providers reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:
On-site review of PASSE credentialing files.

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

		Sample Confidence Interval =
☒ **Other** Specify: PASSE administration	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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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: PASSE administration	☒ **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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

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

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

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

Performance Measure:
QP C1: Number and percentage of HCBS Provider entities that meet criteria for abuse and neglect reporting training for staff. Numerator: Number of provider agencies investigated who complied with required Abuse and neglect training set out in the Waiver and the PASSE provider agreement; Denominator: Total number of provider agencies reviewed or investigated.

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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:

PASSE		
	☒ **Continuously and Ongoing**	☒ **Other** Specify: In addition to annual credentialing review, when DHS receives a complaint on a PASSE or a provider it will be investigated regarding this training.
	☐ **Other** Specify:	

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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: PASSE	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP C2: Number and percentage of HCBS provider agencies that meet the requirements for training staff on the specific needs of the persons they serve. Numerator: Number of provider agencies who complied with training requirements set out in this Waiver or in the PASSE provider agreement; Denominator: Total number of provider agencies reviewed or investigated.

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: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Individual PASSEs and providers will be reviewed when a compliant is received.
	☐ **Other** Specify:	

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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: PASSE	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

IDSR and DDS verify annually, during an on-site PASSE provider review that each credentialed HCBS provider meets and adheres to promulgated and contractual standards regarding HCBS providers, and identifies and rectifies situations where providers do not meet the requirements.

In addition, IDSR and DDS review credentialing of providers when a compliant is received regarding that provider of HCBS services.

b. Methods for Remediation/Fixing Individual Problems

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

(PM QP A1)If deficiencies are cited as a result of the on-site review of a provider, DDS or DMS gives the provider an opportunity to develop a plan of correction. Within 30 days after receipt of an acceptable plan of correction, DDS or DMS staff returns for a follow-up onsite review. If the provider has not achieved substantial compliance, DDS informs the PASSE that the provider has not met the minimum qualifications and cannot be credentialed.

(PM QP C1,C2)When DDS or DMS determines, during a credentialing review or an investigation, that the PASSE or HCBS provider has not provided required abuse and neglect reporting training, or has not provided required training on the specific needs of the person the staff serves, the PASSE and provider is cited and must submit an acceptable plan of correction. The plan must include an attestation that the identified staff has been trained, as well as a description of the processes the PASSE and provider will put in place to assure the deficiencies do not occur again in the future.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **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 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.

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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*)

☐ **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.

☐ **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.

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Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please Refer to Main, Attachment # 2

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Services 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)**

☐ **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:

The PASSE care coordinator, which must meet the following qualifications:

A. Be a Registered Nurse (R.N.), a physician, or have a bachelor's degree in a social science or health-related field;
OR
Have at least one (1) year of experience working with developmentally or intellectually disabled clients;
B. Successfully complete a background check, that includes a criminal background and child and adult maltreatment registry check;
C. Successfully pass an initial drug screen prior to and working directly with beneficiaries;
D. Successfully pass an annual drug screen; and
E. Cannot be excluded or debarred under any state or federal law, regulation or rule or not eligible or prohibited to enroll as a Medicaid provider.

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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:*

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.

From the time an individual makes contact with DHS Beneficiary Support regarding receiving HCBS state plan services, DHS informs the individual and their care givers of their right to make choices about many aspects of the services available to them and their right to advocate for themselves or have a representative advocate on their behalf. It is the responsibility of everyone at DHS, the PASSE who receives assignment and provides care coordination, and the service providers to make sure that the PASSE member is aware of and is able to exercise their rights and to ensure that the member and their caregivers are able to make choices regarding their services.

The PASSE care coordinator is responsible for arranging the PCSP development meeting and ensuring that the enrolled member is able to participate to the fullest extent possible. During the PCSP development meeting, everyone in attendance is responsible for supporting and encouraging the member to express their wants and desires and to incorporate them into the PCSP when possible. The care coordinator is responsible for managing and resolving any disagreements which arise during the PCSP development meeting.

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):

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A. Before the Person Centered Service Plan (PCSP):
1. Independent Assessments
Every applicant must undergo an Independent Assessment that will determine whether the individual is a Tier 2 (requires paid care or services less than 24 hours per day, seven days a week) or Tier 3 (requires paid care or services 24 hours a day, seven days a week). This Independent Assessment will also assess each applicants overall strengths, needs, and risks; and will be used to develop the PCSP. The Independent Assessment must be completed every three (3) years.

2. Interim Service Plan (ISP):

Immediately following enrollment in a PASSE, the PASSE care coordinator must develop an Interim Service Plan (ISP) for the member. If the member was already enrolled in the Waiver prior to being enrolled in a PASSE, that member's current Person Centered Service Plan (PCSP) will remain effective as the ISP for that member. The ISP may be effective for up to 60 days from enrollment, pending completion of the full PCSP. For newly enrolled members, the ISP must, at a minimum, address the needs identified on the member's Independent Assessment.

B.PCSP:
1. Development, Participation and Timing

The PASSE's care coordinator is responsible for scheduling and coordinating the PCSP development meeting. As part of this responsibility the care coordinator must ensure that anyone the member wishes to be present is invited. Typically, the development team will consist of the member and their caregivers, the care coordinator, service providers, professional who have conducted assessments or evaluations, and friends and persons who support the member. The care coordinator must ensure that the member does not object to the presence of any participants to the PCSP development meeting. If the member or the caregiver would like a party to be present, the care coordinator is responsible for inviting that individual to attend.

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2. Assessment Types, Needs, Preferences, Goals and Health Status

After enrollment, and prior to the PCSP development meeting, the care coordinator must conduct an in-person health questionnaire with the member. The care coordinator must also secure any other information that may be needed to develop the PCSP, including, but not limited to:

a) Results of any evaluations that are specific to the needs of the member;
b) The results of any psychological testing;
c) The results of any adaptive behavior assessments;
d) Any social, medical, physical, and mental health histories; and
e) A risk assessment.

The PCSP development team must utilize the results of the independent assessment, the health questionnaire, and any other assessment information gathered. The PCSP must include the member's goals, needs (behavioral, developmental, and health needs), and preferences. All needed services must be noted in the PCSP and the care coordinator is responsible for coordinating and monitoring the implementation of the PCSP.

Licensed professionals conduct applicable assessments. Other assessments which do not require a licensed person, are conducted by persons who are most familiar with the beneficiary.

The PCSP must be developed within 60 days of enrollment into the PASSE. At a minimum, the PCSP must be updated annually.

3. Information regarding availability of services

The PASSE the member was assigned to will provide the member with information regarding the available services under the Waiver. Additionally, the Care Coordinator assigned to that member will be responsible for answering any questions the member or the care giver may have regarding available services and discussing appropriate services for the member in light of the results of the independent assessment and other evaluations.

4. Addressing goals, needs and preferences and assignment of responsibilities

All individual's present at the PCSP's development meeting are responsible for assuring that the service plan developed addresses the member's goals, needs, and preferences (including health care goals, needs and preferences). The Care Coordinator is responsible for implementation of and monitoring the PCSP. During the annual onsite review of each PASSE, DMS and DDS staff review PCSPs to make sure all elements are included.

Each PASSE must include a PCSP update on its Quarterly Report. This update must include the number of new PCSPs developed and the number updated; as well as the number of PCSP development meetings scheduled.

C. After the PCSP
5. Coordination of services

The PASSE care coordinator has the responsibility for coordinating and monitoring the implementation of all services identified in the PCSP, including waiver, state plan and generic services. The care coordinator must coordinate with the direct service providers to ensure quality service delivery.

6. Updating PCSP

The PASSE Care Coordinator is responsible for making sure that the PCSP is updated at least annually. The PCSP Development Team uses the data gathered by the Care Coordinator as they work with the beneficiary to determine if goals should change. The beneficiary may request an update of their PCSP at any time. If their is a change in circumstances such that the beneficiary's tier level may have changed, he or she (or their provider) may request a new independent assessment be done.

7. Participant Engagement

The PASSE Care Coordinator must consider input from the member and anyone there to represent the member regarding PCSP goals and objectives. During the course of the plan year, the member has a say in whether they want to work on new or revised goals. Each PCSP must contain a description of member engagement in the development process.

If a member is denied a service or the PASSE provider of their choice, the individual may appeal the denial to the PASSE. If the PASSE upholds the denial, the member may appeal to the State.

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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.

The PCSP Development Team must address risks to the member during the PCSP development process, including the risk of institutionalization, risk to personal safety, risk of homelessness, suicide risk, health risks, and overall functional capacity. In conjunction with the member and their care giver, the team must address health and behavioral risks and risks to personal safety, either real or perceived, and known or potential. The team must document each identified risk and write the PCSP with individualized mitigation strategies. The strategies must be designed to respect the needs and preferences of the member. The team must identify how and who will be responsible for the ongoing monitoring of risk levels and risk management strategies as well as addressing how key staff will be trained regarding those risks.

Providers must document practices and decisions regarding risk assessment and the ongoing management of risks. Providers must specify the tool they use. Members enrolled in the CES Waiver, as they exercise their rights about their services, make choices about the amount of risk they wish to take. In negotiating trade-offs between choice and safety, care coordinators and providers are required to document the concerns of the team members, the negotiation process and the analysis and rationale for the decisions made and the actions taken.

Care Coordinators, in conjunction with direct service providers, must develop and implement behavior management plans to address behavioral risks. The specific details of behavior management plans are addressed in Appendix G2.Ai. Care Coordinators and providers must minimize certain personal safety risks by imposing certain "physical environment" requirements without compromising the natural, home-like atmosphere in any setting in which the member resides. All PASSE care coordinators must be trained in the development of PCSPs.

Providers must develop backup plans to address contingencies such as emergencies, including the failure of a support worker to appear when scheduled. Complete descriptions of backup arrangements must be included in the PCSP. Each provider must specify the type of back-up arrangements that are employed, and make sure that each PCSP addresses the unique needs and circumstances of the member.

Appendix D: Participant-Centered Planning and Service Delivery

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

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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.

Before a PASSE member can access CES Waiver services, they must be enrolled in a PASSE under the 1915(b) Provider Led Shared Savings Entities Waiver. Beginning on the first day of enrollment, the PASSE is responsible for providing all needed services to all enrolled members and may limit a member's choice of providers based on its provider network. The provider network must meet minimum adequacy standards set forth in the 1915(b) Waiver, the PASSE Provider Manual, and the PASSE provider agreement.

The member has 90 days after initial enrollment to change their assigned PASSE. Once a year, there is a 30-day open enrollment period, in which the member may change their PASSE for any reason. At any time during the year, a member may change their PASSE for cause, as defined in 42 CFR 438.56.

The State has a Beneficiary Support Office to assist the member in changing PASSE's, including informing the member of their rights regarding choosing another PASSE and how to access information on each PASSE's provider network. The Beneficiary Support Office will begin reaching out to a beneficiary once it is determined he or she meets the qualifications to be enrolled in a PASSE.

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):

DMS and DDS performs annual PCSP reviews, using the sampling guide, “A Practical Guide for Quality Management in Home and Community-Based Waiver Programs,” developed by Human Services Research Institute and the Medstat Group for CMS in 2006. A systematic random sampling of the active case population is drawn whereby every “nth” name in the population is selected for inclusion in the sample. The sample size is based on a 95% confidence interval with a margin of error of +/- 8%. An online calculator is used to determine the appropriate sample size for the Waiver population. To determine the “nth” integer, the sample is divided by the population. Names are drawn until the sample size is reached.

DMS or DDS then requires the PASSE to submit the PCSP for all individuals in the sample. DMS or DDS conducts a retrospective review of provided PCSPs based on identified program, financial, and administrative elements critical to quality assurance. DMS or DDS reviews the plans to ensure they have been developed in accordance with applicable policies and procedures, that plans ensure the health and welfare of the member, and for financial and utilization components. DMS or DDS communicates findings from the review to the PASSE for remediation. Systemic findings may necessitate a change in policy or procedures. A pattern of non-compliance from one PASSE may result in sanctions to that PASSE under the PASSE Provider Manual and Provider Agreement.

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:

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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:

The member's PASSE.

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 PASSE and its assigned Care Coordinator are responsible for the implementation and monitoring of the PCSP. They must maintain regular contact with the member, making at least one contact with the member or their legal representative each month. During the contact, the care coordinator must discuss issues related to both CES Waiver and non-waiver services and whether or not the member feels that their needs are being met, if they remain satisfied with their provider and express an understanding that they may change providers, and any issues related to the health and safety of the member. If they identify problems, the care coordinator must take action to remediate the issue. The care coordinator is required to maintain documentation of their conversation with the member as evidence that they are fulfilling their obligation to monitor the PCSP.

The PCSP must be reviewed by the care coordinator and the PCSP development team at least annually. The Team must review the member's objectives and determine if they are accomplished, to be continued, or should be modified or discontinued. The team must use the member's input, data collection and provider case notes to make decisions as they review the PCSP.

It is sometimes necessary to place CES Waiver cases in abeyance to allow the member to receive behavior, physical or health treatment or stabilization in a licensed or certified treatment program. Abeyance allows the member's CES Waiver services case to remain open while the member receives this treatment.

DMS and DDS staff conduct a random retrospective review of PCSPs. DMS and DDS compare planned services to those actually provided as documented on encounter data from the Medicaid Management Information System (MMIS)and provided by the PASSE's on their quarterly reports.

Annually, DDS and DMS will select a sample of at least 10% of members assigned to each PASSE and conduct interviews, make observations and file reviews to monitor implementation of the PCSP and the health and welfare of the member. If any of the processes reveal a problem with implementation of the PCSP, DMS and DDS cite a deficiency in the report of their review to the PASSE. The PASSE must submit an acceptable plan of correction and implement corrective actions. If a pattern of deficiencies is noted, other sanctions may be implemented according to the PASSE Provider Manual and the PASSE Provider Agreement.

Additionally, the PASSE will be required to submit a PCSP update on their Quarterly Reports to DMS.

DDS participates in the National Core Indicator (NCI) project. During the interview, staff ask members if they exercised their right to choose providers within the PASSE's network, if their services are meeting their needs and wants and if they have an effective backup plan when emergencies occur. DDS and DMS review the annual NCI report to identify any areas of need and takes appropriate action as necessary.

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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:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
SP A1: Percentage of PCSPs developed by PASSE Care Coordinators that were adequate and appropriate to the needs of members as indicated by their assessment(s). Numerator: Number of PCSPs that adequately and appropriately address the member's needs. Denominator: Total number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE PCSP records

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Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with =/- 8% margin of error
☒ **Other** Specify: PASSE	☒ **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:

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Performance Measure:
SP A2: Percentage of PCSP's that adequately address the member's risk factors. Numerator: Number of PCSP's that adequately address the member's risk factors; Denominator: Total number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE PCSP files

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

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with =/- 8% margin of error
☒ **Other** Specify: PASSE	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
SP C1: Percentage of PCSPs that were updated at least annually. Numerator: Number of PCSPs that were updated before the previous PCSP expired; Denominator: Total number of PCSPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE PCSP files

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%, with =/- 8% margin of error
☒ **Other** Specify: PASSE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
SP D1: Number and percentage of providers who delivered services in the type, scope, amount, frequency & duration specified in the PCSP. Numerator: Number of provider agencies reviewed or investigated who delivered services as specified in the PCSP. Denominator: Total number of provider agencies reviewed or investigated.

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Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Service Plan Frequency and Duration Deficiencies

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

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

Performance Measures

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

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

Performance Measure:
SP E2: Number and percentage of participants who were offered choice of PASSE providers. Numerator: Number of participants who were offered choice of a PASSE provider, as indicated by an appropriately completed and signed freedom of choice form that specified choice of providers; Denominator: Number of files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual File Review

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

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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:

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

The state operates a system of review that assures completeness, appropriateness, and accuracy of the PCSP development and service delivery, and assures freedom of choice by the member. The system focuses on person-centered service planning and delivery, beneficiary rights and responsibilities, and member outcomes.

DMS and DDS review a random sample of PCSP's developed by PASSE care coordinators for verification of service delivery in the type, scope, amount, frequency and duration specified. They also review to determine if the PCSP address assessed needs, personal goals, risk factors, and were developed according to established procedures. They also review to determine if PCSP are updated annually or when needs change.

b. Methods for Remediation/Fixing Individual Problems

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

If deficiencies are cited based on any of the deficiencies relative to the performance measures stated above as a result of a review of the PASSE or its providers, DMS or DDS gives the PASSE or provider an opportunity to develop a plan of correction. The plan of correction must address how individual problems have been resolved as well as what processes the provider will put in place to assure the deficiencies do not occur again in the future. After receipt of an acceptable plan of correction, depending on the severity of the cited deficiencies, DDS staff either successfully resolves the compliant or returns for a follow-up onsite review. If the follow-up review reveals that the PASSE or provider has not successfully corrected the deficiencies, DMS or DDS may impose an array of enforcement remedies.

DMS and DDS maintains investigative staff so that, on an ongoing basis, they may investigate any complaints regarding the provider. When it is determined that a PASSE or provider has not met the requirements of the Waiver, the PASSE provider manual, or the PASSE Provider agreement, the PASSE or provider is cited and must submit an acceptable plan of correction. The plan must include an attestation that the deficiency has been corrected for the specific individuals on which the deficiency was written, as well as a description of the processes the provider will put in place to assure the deficiencies do not occur again in the future.

Annually, the PASSE must provide the member with choice 1)between institutional care and CES Waiver services and 2) among qualified PASSE Network providers who serve the county in which the member resides and offers the services that the member needs. The PASSE care coordinator should assist the member or his or her caregiver with making these choices.

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:

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c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

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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.

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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.

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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 CES 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 DDS to inform the person or the legally responsible representative of appeal rights specific to the applicant or of program denial of ICF/IDD Level of Care or Medicaid Income Eligibility. It is the responsibility of DDS staff to inform the person or legally responsible representative of appeal rights specific to closure of an application case for failure of the person or legal representative to comply with requests for required application assessment information. DDS staff sends copies of official letters to the DDS Psychology Team. When the determination is favorable to the applicant the team issues a notice of approval.

When the applicant is determined to meet eligibility criteria DDS staff inform the person or the legally responsible person of appeal rights specific to:
1) Continued choice for institutional or community based services;
2) Provider choice, including the right to change providers;
3) Service denials;
4) When their chosen providers refuse to serve them, and
5) Case closure.

The right to change providers more frequently than annually is specified in the Waiver handbook that is published on the DDS website, the promulgated Medicaid PASSE Provider manual, and on the Rights and Choice form that is given to the participants annually. The form states: "I have the right to change providers within the PASSE network at any time I may choose without fear of retaliation." This topic is covered on NCI surveys conducted by the DMS and DDS.

Thereafter, the PASSE care coordinator provides continued education at each annual review regarding the PASSE's appeal process.

The member or the legal representative may file an appeal with the PASSE of any adverse decision, including reduction or suspension of benefits. The member or legal representative may appeal the PASSE's decision to DHS following those processes, which the care coordinator must also inform the member of.

All PASSE appeal processes must meet the requirements of CMS's managed care regulations, as set forth in the PASSE 1915(b) waiver in Section A-IV-E. Additionally, DDS and DMS will use an appeal process in accordance with the Medicaid Provider Manual, Section 191.000 and the Arkansas Administrative Procedures Act, A.C.A. 25-15-201 et seq. Each PASSE must make its members aware of the appeal process and the members' appeal rights.

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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.

Members must utilize their PASSE's internal grievance process as described in the PASSE 1915(b) waiver, Section A-IV-E.

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:

Each PASSE must have a grievance process in place. If the member is not satisfied with the results of that grievance process, he or she may appeal to DMS or DDS.

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).

Each PASSE must have a process by which a member can file a complaint or grievance regarding, at a minimum, the type of services available to PASSE members, the denial of a specific service or provider, the quality of service provide, or regarding a provider in the PASSE's network, including a care coordinator.

The PASSE must provide enrolled members with their grievance rights and how to access them in the Member Handbook. All grievances must be filed within 45 days of the event. If the member is unsatisfied with the outcome of the grievance, he or she may appeal to DMS within 30 days of the PASSE's final decision on the grievance.

The PASSE's grievance system must comply with the requirements of CMS's managed care regulations, the PASSE provider Manual, and the PASSE Provider Agreement.

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

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).

The Arkansas Child Maltreatment Act, Ark. Code Ann. §12-18-101 et seq., and the Arkansas Adult Maltreatment Act, Ark. Code Ann. §12-12-1701 et seq. defines the acts that are considered abuse or neglect. The acts define who is a mandated reporter and includes employees of DDS and HCBS providers. PASSE care coordinators are also mandated reporters. Failure on the part of a mandated reporter to report suspected abuse or neglect is a criminal offense. The AR Department of Human Services (DHS), Division of Children and Family Services (DCFS) and the Arkansas State Police, Crimes Against Children Division (CACD) are responsible for investigating allegations of child abuse or neglect. The DHS Division of Aging and Adult
Services is responsible investigating allegations of adult abuse or neglect.

DHS Incident Reporting Policy 1090 and the Medicaid PASSE Provider Manual and PASSE Provider Agreement describe the incidents that PASSE Care Coordinators and HCBS providers must report. They must report incidents, using automated form DHS 1910 via secure e-mail, to DMS or DDS within two working days following the incident. In instances that might be of interest to the media, the providers must immediately report the incident to DMS or DDS who in turn notifies the DHS Communication Director. Care Coordinators and HCBS Providers must report suicide, death from adult abuse or child maltreatment, or a serious injury within one hour of occurrence, regardless of the hour.

The following is a list of the incidents which must be reported and are tracked by DDS. However, the State does not require follow-up or investigation of each listed incident. A description of how DDS makes the determination that follow-up action is required and by whom is described in Item G-1-d. Specifically, DDS has designated the following incidents as critical and sufficiently serious as to require follow-up:
1) attempted suicide,
2) suspected abuse or neglect by a staff person,
3) elopement,
4) use of restrictive interventions,
5) death, and
6) arrest.
When DMS or DDS staff receive reports of any of the critical incidents, they evaluate the information contained in the report to determine if the incident requires an investigation or possible follow up at the next annual review of the provider.

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Incidents which must be reported (but are not necessarily considered critical, unless also on the above list):
1. Death
2. The use of any restrictive intervention, including seclusion, or physical, chemical or mechanical restraint,
3. Suspected maltreatment or abuse as defined in Ark. Code Ann. §§ 12-18-103 & 12-12-1703;
4. Any injury that:
a. Requires the attention of an Emergency Medical Technician, a paramedic, or physician,
b. May cause death,
c. May result in a substantial permanent impairment, or
d. Requires hospitalization.
5. Suicide, threatened or attempted,
6. Arrest or conviction of any crime,
7. Any situation in which the location of a person has been unknown for two hours,
8. Any event in which a staff threatens a person served by the program,
9. Sentinel events, such as unexpected occurrences involving actual or risk of death or serious physical or psychological injury,
10. Medication errors made by staff that cause or have the potential to cause serious injury or illness,
11. Any rights violation that jeopardizes the health and safety or quality of life of a person served by the program,
12. Communicable disease,
13. Violence or aggression,
14. Vehicular accidents,
15. Bio-hazardous accidents,
16. Use or possession of illicit substances or licit substances in an unlawful or inappropriate manner,
17. Property destruction, and
18. Any condition or event that prevents the delivery of services for more than 2 hours.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or

families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DDS provides training and information to participants and legally responsible persons in the form of the Arkansas Guide to Services for Children and the Arkansas Guide to Services for Adults, The DDS Waiver Handbook, and the DDS website. DDS staff will provide training to PASSEs, Care Coordinators, and HCBS Providers regarding the reporting requirements contained. Additionally, PASSEs are required to ensure all credentialed HCBS providers and their staff are trained regarding the prevention of adult and child maltreatment, reporting adult and child maltreatment and DHS and DDS requirements for reporting incidents. This training must be conducted annually. All PASSE members must be informed of their rights. PASSE Care Coordinators must provide support and training to members so that they may recognize attempts to exploit them.

The DHS Division of Children and Family Services (DCFS) provides statewide training on child abuse and neglect prevention, as well as how to report suspected abuse or neglect. The DHS Division of Aging and Adult Services provides statewide training regarding adult maltreatment.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

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The DHS Division of Aging and Adult (DAAS), Adult Protective Services, (APS) receives reports of critical events designated as adult abuse or neglect and investigates those allegations. The methods to evaluate the reports and the time-frames for responding are defined at Ark. Code Ann. § 12-12-1711(b)(1). The law requires that, if the APS staff who receives the report believes that the act described by the reporter constitutes criminal behavior, they must contact the appropriate law enforcement agency. If the APS staff believes the individual to have an immediate need, the staff must treat it as an emergency and report it to 911 services. The APS investigator must see the individual within 24 hours of the report. In non-emergency situations, investigation staff must see the individual who is the subject of concern within three working days and must complete the investigation within 60 days. Based on information provided in the Case Summary Report and the recommendation of the APS staff, the APS Field Manager determines if the allegations are unfounded, founded or incomplete. If founded, the case summary report must contain details of how the APS staff met their responsibility to protect the person and to remedy the circumstances found to exist.

The DHS Division of Children and Family Services (DCFS) receives reports of critical events designated as child abuse or neglect and investigates those allegations. The method to evaluate the report and the time-frames for responding are defined at Ark. Code Ann. § 12-18-102. The Arkansas Child Maltreatment Hotline accepts reports of alleged maltreatment and determines if the report constitutes an event defined as abuse or neglect and if the report constitutes a Priority I or Priority II offense. A Priority I offense is sexual abuse, death, broken bones, head injuries, exposure to poison and noxious chemicals and substances and other critical injuries or events. A Priority II offense is one that involves serious issues, but those that are not life threatening.

Generally, DHS DCFS investigates allegations designated as Priority II and the Arkansas State Policy, Crimes Against Children Division (CACD) investigates Priority I allegations. If the nature of a child maltreatment report suggests that a child is in immediate risk, DCFS or CACD initiates an investigation immediately or as soon as possible. DCFS maintains primary responsibility for ensuring the health and safety of children regardless of whether the investigation is conducted by CACD or DCFS. DCFS and CACD complete investigations and make an investigative determination within thirty days. If the circumstances of the child present an immediate danger, the DCFS may take the child into protective custody for up to 72 hours.

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When a HCBS Provider or PASSE Care Coordinator reports an incident to the Adult or Child Hotline, they must also submit an incident report (DHS 1910) to DMS or DDS. The State Staff reviews and evaluates the incident reports to determine if correct procedures and time frames were followed. If the HCBS Provider or Care Coordinator did not report the incident according to proscribed timeframes, the State staff will issue a deficiency and request an Assurance of Adherence of Standards which describes how the PASSE or HCBS Provider will ensure future compliance with the required reporting time frames.

If the State Staff reviewing the incident report determines that the incident should have been reported to a hotline and was not, the staff will immediately report the incident to the appropriate hotline. Additionally, the staff will issue a deficiency and request an Assurance of Adherence of Standards which describes how the PASSE or HCBS Provider will ensure future compliance with the required hotline reporting requirements.

If an incident warrants investigation, the State Staff will initiate an investigation according to the PASSE Provider Manual and Provider Agreement. Staff must complete an investigation within 30 days.

DDS has designated the death of an individual as a critical incident. DDS Policy 1018, Mortality Review of Deaths guides the process to conduct a review of each death in order to identify issues and trends related to deaths in order to improve division and provider practices by identifying issues, recommending changes, influencing development of excellent policies and to gather data in order to identify and analyze trends. The purpose is to facilitate Continuous Quality Improvement by gathering information to identify systemic issues that may benefit from scrutiny and analysis in order to make system improvements and to provide opportunities for organizational learning DDS maintains an unit which investigates complaints and concerns, which may or may not constitute a critical concern and proscribes the methods and timeframes for conducting an investigation of a concern or complaint. In brief, the staff member has three working days from the time the complaint is received to make initial contact with the person making the complaint. The staff must begin the fact finding process within one day of initiation of the investigation and must complete the investigation within 30 days. The staff provides a written report to the PASSE and HCBS Provider in question and to the individual making the complaint. If the staff substantiates the complaint, they issue a deficiency to the PASSE or HCBS provider and requests an Assurance of Adherence to Standards which must explain how they will remedy the situation with the individual involved as well as how they will prevent similar situations from occurring in the future.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DDS, in conjunction with DMS, is responsible for overseeing the reporting of and response to critical incidents regarding CES Waiver participants. There are three primary facets to the oversight process. One part of the process occurs during the annual onsite readiness review of the PASSE to ensure that the PASSE and its HCBS providers are following applicable policies and procedures and that necessary follow up is conducted on a timely basis. The second occurs as DDS staff reviews and responds as appropriate to reports of incidents that HCBS providers submit to DDS. Third, DDS maintains a database of incidents in order to facilitate the identification of trends and patterns and identify opportunities for improvements and support the development of strategies to reduce the occurrence of incidents in the future.

PASSEs are required to develop and implement policy that requires HCBS providers report adult abuse, maltreatment or exploitation, or child maltreatment to the Child Abuse or Adult Maltreatment Hotline. The policy must:
1. Include all incidents described as by DDS,
2. Include any other incidents determined reportable by the program, and
3. Require notification to the parent or guardian of all children age birth to 18 or adults who have a guardian, each time the provider submits an incident report to DDS or according to the Internal Incident Reporting policy.
4. Develop and implement policy regarding follow-up of all incidents.

During the annual onsite review, DDS and DMS staff review the documentation maintained by the PASSE which supports compliance with these requirements. Staff review documentation of incidents to determine if the incident constitutes a reportable incident and confirm that a report was submitted. Staff also review and/or interview PASSE leadership and care coordination staff, as well as HCBS providers in that PASSE's network, to determine if they are familiar with the requirements of incident reporting.

DDS staff receive and review incident reports that PASSE care coordinators and HCBS providers submit according to guidelines described in d. above. They review the report to determine if the PASSE and/or provider responded appropriately to the incident, if they reported timely, if they reported to the appropriate hotline if necessary and it the incident requires investigation by DDS.

DDS maintains a database of incidents that includes the type of incident, the name of the PASSE and HCBS provider involved, the name of the HCBS Waiver participant, and the date of occurrence. Staff review the information on a quarterly basis to determine if there are trends that are relative to specific providers at a system-wide level or within the waiver population. If trends are identified, the information is provided to the Office of Innovation and Delivery System Reform (IDSR) within DMS to determine if any actions are needed.

DDS conducts oversight of CES Waiver investigative activities. Staff maintains a database that includes timeframes regarding initiation and resolution, including notification to the parties involved. Staff generate monthly reports and administrative staff analyzes data on a quarterly basis. Systemic issues, when identified, are presented to the IDSR.

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Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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DDS permits the use of physical restraints when the challenging behavior exhibited by the Waiver beneficiary threatens the health or safety of the individual or others. Physical restraint means the application of physical force without the use of any device, for the purposes of restraining the free movement of an individual's body. Manually holding all or part of a person's body in a way that restricts the person's free movement; including any approved controlling maneuvers. This does not include briefly holding, without undue force, a person in order to calm the person, or holding a person's hand to escort the person safely from one area to another.

DDS does not permit medications to be used to modify behavior or for the purpose of chemical restraint. Chemical Restraint means the use of medication for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition.

DDS does not permit the use of mechanical restraints. Mechanical Restraint means any physical apparatus or equipment used to limit or control challenging behavior. This apparatus or equipment cannot be easily removed by the person and may restrict the free movement, or normal functioning, or normal access to a portion or portions of a person's body, or may totally immobilize a person.

Definitions:

"Challenging behaviors" are behaviors defined as problematic or maladaptive by others who observe the behaviors or by the person displaying the behaviors. They are actions that:
1. Come into conflict with what is generally accepted in the individual's community,
2. Often isolate the person from their community, or
3. Can be barriers to the person living or remaining in the community, and
4. Vary in seriousness and intensity.

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DDS requires that, before a provider may use physical restraints, they must have developed alternative strategies to avoid the use of restraints by developing a behavior management plan which incorporates the use of positive behavior support strategies as an integral part of the plan. The plan must:
1. Be designed so that the rights of the beneficiary are protected,
2. Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or puts the individual at medical risk,
3. Identify the behavior to be decreased,
4. Identify the behavior to be increased,
5. Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior,
6. Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person,
7. Identify the event that likely occurs right before a behavior of concern,
8. Identify what staff should do if the event occurs,
9. Identify what staff should do if the behavior to be increased or decreased occurs,
10. Involve the fewest interventions or strategies possible, and
11. Specify the length of time restraints must be used, who will authorize the use of restraints, and methods for monitoring restraints.

A behavior management plan must be written and supervised by a qualified professional who is, at a minimum, a Qualified Developmental Disabilities Professional. The PASSE care coordinator must be involved in the development of the behavior management plan. The provider must provide training to all persons who implement the behavior management plan. Training requirements include Introduction to Behavior Management, Abuse and Neglect and any other training as necessary.

The provider must collect data and review the plan. Since the success of a behavior management plan is measured by reductions in challenging behaviors, performance of alternative behaviors and improvements in quality of life, the provider is required to:
1. Develop a simple, efficient and manageable method of collecting data,
2. Collect data regarding the frequency, length of time of each use, the duration of use over time and the

impact of the use of restraint, restrictive intervention or seclusion,
3. Review the data regularly, and
4. Revise the plan as needed if the interventions do not achieve the desired results.

DDS Standards require that the PASSE or HCBS provider report to DDS the use restraints. DDS staff review each report to determine if the use of the technique was authorized or misapplied. Additionally, in an effort to detect the unauthorized use of or misapplication of restraints, DDS staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider.

PASSEs must prohibit maltreatment or corporal punishment of individuals by HCBS providers or their staff. PASSEs must also guarantee an array of rights which includes the right to be free from the use of a physical or chemical restraint, medications, or isolation as punishment for the convenience of the provider except when such measure is necessary for the health and safety of the beneficiary or others.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DDS responsible for monitoring the use of restraints by HCBS Providers credentialed by the PASSEs. Therefore, PASSEs and HCBS providers must report the use of restraints to DDS. The DDS staff review each report to determine if the use of the technique was authorized or misapplied. Additionally, in an effort to detect the unauthorized use of or misapplication of restraints, DDS staff review records of incident reports and behavior management plans, this review may include interviews of the PASSE care coordinator and/or Provider staff.

DDS collects data on restraints from incident reports. The data includes the frequency, length of time of each use, the duration of use over time and the impact of the use of restraint. The staff produces a report on a monthly basis and reviews the data to detect any trends specific to individuals, providers, or PASSEs that may emerge. On a quarterly basis, the DDS presents a quarterly report of the data to IDSR. If a trend is identified, DDS or IDSR may initiate an investigation to identify root causes and require corrective action to reduce or eliminate the inappropriate use of restraints and restrictive interventions.

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Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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.

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Restrictive interventions are defined as procedures that restrict an individual's freedom of movement, restrict access to their property, prevent them from doing something they want to do, require an individual to do something they do not want to do, or remove something they own or have earned. Restrictive interventions include the use of time-out or separation (exclusionary and non- exclusionary).

Restrictive interventions that include aversive techniques, restrict an individual's right, involve a mechanical or chemical restraint are prohibited.

Time-out or separation is permitted. Time-out or separation is a restrictive intervention in which a person is temporarily, for a specified period of time, removed from positive reinforcement or denied the opportunity to obtain positive reinforcement for the purpose of providing the person an opportunity to regain self-control. During which time, the person is under constant visual and auditory contact and supervision. Time-out interventions include placing a person in a specific time-out room, commonly referred to as exclusionary time-out and removing the positively reinforcing environment from the individual, commonly referred to as non-exclusionary time-out. The person is not physically prevented from leaving. Time-out may only be used when it has been incorporated into a positive behavior plan which has specified the use of positive behavior support strategies to be used before utilizing time-out.

DDS requires that, before a provider may use any restrictive intervention, they must have developed alternative strategies to avoid the use of those interventions by developing a behavior management plan which incorporates the use of positive behavior support strategies as an integral part of the plan. The plan must:
1.Be designed so that the rights of the individual are protected,
2.Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or puts the individual at medical risk,
3.Identify the behavior to be decreased,
4.Identify the behavior to be increased,
5.Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior,
6.Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person,
7.Identify the event that likely occurs right before a behavior of concern,
8.Identify what staff should do if the event occurs,
9.Identify what staff should do if the behavior to be increased or decreased occurs, and
10.Involve the fewest interventions or strategies possible.

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A behavior management plan must be written, implemented and supervised with the involvement of the PASSE Care Coordinator. The Care Coordinator and/or HCBS Provider must provide training to all persons who implement the behavior management plan. Training requirements include Introduction to Behavior Management, Abuse and Neglect and any other training as necessary.

The care coordinator and/or HCBS provider must collect data and review the plan. Since the success of a behavior management plan is measured by reductions in challenging behaviors, performance of alternative behaviors and improvements in quality of life, the care coordinator and/or provider is required to:
1.Develop a simple, efficient and manageable method of collecting data,
2.Collect data regarding the frequency, length of time of each use, the duration of use over time and the impact of restraint and seclusion,
3.Review the data regularly, and
4.Revise the plan as needed if the interventions do not achieve the desired results.

The PASSE care coordinator or the HCBS provider must report to DDS the use of any restrictive intervention. The DDS staff review each report to determine if the use of the technique was authorized or misapplied. Additionally, in an effort to detect the unauthorized use of or misapplication of restraints, DDS staff review records of incident reports and behavior management plans and may interview the PASSE care coordinator or HCBS provider staff and individuals.

PASSE's must have policies that prohibit maltreatment or corporal punishment of members and guarantee an

array of rights which includes the right to be free from the use of a physical or chemical restraint, medications, or isolation as punishment for the convenience of the provider except when a physical restraint is necessary for the health and safety of the individual.

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 is responsible for monitoring use of restrictive interventions. PASSE care coordinators or HCBS providers must report to DDS the use of any restrictive intervention. The DDS staff review each report to determine why the use of the technique occurred and what corrective action the provider took to prevent the reoccurrence of the use of the restrictive intervention. Additionally, in an effort to detect the unauthorized use of restrictive intervention, DDS staff review records of incident reports and behavior management plans and interview provider staff and individuals during the annual onsite review of each certified provider. DDS also investigates any complaints or concerns regarding the possible use of restrictive interventions.

DDS staff collect data from provider incident reports. The data includes the frequency, length of time of each use, the duration of use over time and the impact of the restrictive intervention. The staff produces a report on a monthly basis and reviews the data to detect any trends specific to individuals or providers that may emerge. If a trend is identified, DDS or IDSR may initiate an investigation to identify root causes and require corrective action to reduce or eliminate the use of restrictive interventions.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

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c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Seclusion is defined as the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving. DDS is responsible for monitoring use of seclusion. PASSE care coordinators or HCBS Providers must report to DDS the use of seclusion. The DDS staff review each report to determine why the use of the technique occurred and what corrective action the provider took to prevent the reoccurrence of the use of seclusion. Depending on the circumstances described in the incident report, DDS staff conduct an onsite investigation and cite the PASSE or HCBS provider with deficient practices as necessary.

Additionally, DDS staff review records of incident reports and behavior management plans and interview provider staff and individuals.

Each PASSE must have policies in place that prohibit the use of seclusion.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

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.

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The PASSE Care Coordinator and HCBS service provider has on-going responsibility for first-line monitoring the member's medication regimens. The PASSE Care Coordinator is responsible at all times to assure that the service plan identified and addressed all needs with other supports as necessary to assure the health and welfare of the member.

The Care Coordinator must develop and implement a Medication Management Plan for all members receiving prescription medications. The plan must describe:
1. How direct service staff will, at all times, remain aware of the medications being used by the member,
2. How direct service staff will be made aware of the potential side effect effects of the medications being used by the member,
3. How the care coordinator and service providers will ensure that the member or their guardian will be made aware of the nature and the effect of the medication,
4. How the care coordinator and service providers will ensure that the member or their guardian gives their consent prior to the use of the medication, and
5. How the service providers will ensure that administration of the medication will be performed in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

The HCBS provider providing direct services must maintain medication logs that document at least the following:
1. Name and dosage of the medication given,
2. Route medication was given,
3. Date and time the medication was given,
4. Initials of the person administering or assisting with administration of the medication,
5. Any side effects or adverse reactions, and
6. Any errors in administering the medication.

The HCBS service provider must ensure that a supervisory level staff monitors the administration of medications at least monthly by reviewing medication logs to ensure that:
1. The member consumed the medications accurately as prescribed,
2. The medication is effectively addressing the reason for which they were prescribed,
3. Any side effects are being managed appropriately,

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When medication is used to treat specifically diagnosed mental illness, the medication must be prescribed and managed by a psychiatrist who is periodically provided information regarding the effectiveness of and any side effects experienced from the medication. The prescription and management may be by a physician, if a psychiatrist is not available, or when requested and agreed to by the member or the member's guardian and when based upon the documented need of the member. Medications may not be used to modify behavior in the absence of a specifically diagnosed mental illness, or for the purpose of chemical restraint.

Prescription PRN and over-the-counter medications may be appropriate in the use of treating specific symptoms of illnesses. If used, the HCBS Provider must keep data regarding:
1. How often the medication is used,
2. The circumstances in which the medication is used,
3. The symptom for which the medication was used, and
4. The effectiveness of the medication.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The PASSE is responsible for second-line medication management process to ensure that beneficiaries medications are managed appropriately and in accordance with the medication management plan. DDS and DMS staff review medication management plans and medication logs to ensure compliance with this Waiver, the PASSE Provider Manual, and the PASSE Provider Agreement. If errors are found, State Staff cite the PASSE and the HCBS Provider with a deficient practice and require a plan of correction.

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).

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PASSE HCBS Providers must adhere to the Arkansas Nurse Practice Act, which addresses how medications may be administered and by whom. The Care Coordinator must develop and implement a separate Medication Management plan for all members receiving prescription medications. The plan must describe:
1. How direct service staff will, at all times, remain aware of the medications being used by the member,
2. How direct service staff will be made aware of the potential side effects of the medications being used by the member,
3. How the beneficiary will be made aware of the nature and the effect of the medication,
4. How the beneficiary gives their consent prior to the administration of the medication, and
5. How the administration of the medication will be performed in accordance with the Nurse Practice Act and the Consumer Directed Care Act.

The PASSE must require all HCBS Providers maintain Medication Logs that document at least the following:
1. Name and dosage of the medication given,
2. Route of medication,
3. Date and time the medication was given,
4. Initials of the person administering or assisting with administration of the medication,
5. Any side effects or adverse reactions, and any actions taken as a result, and
6. Any errors in administering the medication.

The Organization providing direct services must ensure that a supervisory level staff documents oversight of the administration of medications at least monthly by reviewing medication logs to determine if:
1. The member consumed the medications accurately as prescribed,
2. The medication is effectively addressing the reason for which it was prescribed, and
3. Any side effects are noted, reported and are being managed appropriately.

The direct service provider must ensure that designated staff report to a supervisor and record the following medication errors missed dose,wrong dose,wrong time of dose,wrong route, and wrong medication.

The direct service provider must ensure that designated staff record any charting omission, loss of medication, unavailability of medications, falsification of records, and any theft of medications.

Additionally, the direct service provider must keep data regarding how often the medication is used, the circumstances in which the medication is used, the symptom for which the medication was used, and the effectiveness of the medication.

PASSE's must develop and implement policies which describe how HCBS Providers will administer or assist with the administration of medications. The policy must, at least, describe the qualifications of who may administer medications, describe the qualification of who may assist with the administration of medications, specify which class of drugs may be administered by which staff, and require that PRN medications are used only with the consent of the member and according to approval from the prescribing health care professional.

PASSE's are required to provide training to HCBS Providers and staff who provide direct services which details the specifics of the member's service plan including training that provides information related to any medications taken by the person they serve, including possible side effects.

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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:

Providers are required to report medication errors to the PASSE. These reports must be made available to DMS upon request and must be reported annually to DMS.

(b) Specify the types of medication errors that providers are required to *record:*

The direct services provider must ensure that designated staff report to a supervisor and record medication errors as follows: missed dose, wrong dose,wrong time of dose, wrong route, and wrong medication.

The direct services provider must ensure that designated staff record the following: any charting omission, loss of medication, unavailability of medications, falsification of records, and theft of medications.

(c) Specify the types of medication errors that providers must *report* to the state:

Providers are required to report medication errors to DDS that cause or have the potential to cause serious injury or illness.

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 is responsible for monitoring the performance of providers in the administration of medications to persons. As part of quality review of PASSE's, DDS Staff review medication management plans, logs and error reports. They also review internal incident reports as well as those incident reports that the provider submitted to DDS to detect any potentially harmful practices. If they find errors, DDS staff cite the PASSE or HCBS Provider with a deficient practice and require a plan of correction.

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Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW1 : Number of members that were given information was given about how to report abuse, neglect, and exploitation from their PASSE Care Coordinator. Numerator: Number of files that document members were given about how to report abuse, neglect, and exploitation; Denominator: Number of files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual File Review

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

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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: PASSE	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW2: Number and percentage of PASSE Care Coordinators and HCBS Providers who reported critical incidents to DDS within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Total number of critical incidents that occurred and were reviewed.

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Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Critical Incidents

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: PASSE	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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Performance Measure:
HW3: Number and percentage of critical incidents reported to APS or CPS. Numerator: Number of critical incidents reported to APS, CPS ; Denominator: Total number of critical incidents required to be reported to APS or CPS.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Report of Critical Incidents Reported to APS or CPS

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:	

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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**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW4: Percentage of PASSE Care Coordinators and HCBS Providers who took corrective actions regarding critical incidents to protect the health and welfare of the member. Numerator: Number of PASSE Care Coordinators and HCBS Providers who took corrective actions; Denominator: Number of PASSE Care Coordinators and HCBS Providers required to take protective actions regarding critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Corrective Actions

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

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Performance Measure:
HW5: Number and percentage of complaint investigations that were completed on a timely basis. Numerator: Number of complaint investigations that were completed on a timely basis; Denominator: Number of complaint investigations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report of Timely Completed Complaint Investigations

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

(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:	

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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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW6: Number and percentage of reported deaths which were reviewed by the Mortality Review Committee Numerator: Number of reported deaths which were reviewed timely by the Mortality Review Committee; Denominator: Number of deaths reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data Source Report of Timely Mortality Reviews

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

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	☐ **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:

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Performance Measure:
HW7: Percentage of HCBS Providers who adhered to PASSE policies for the use of restrictive interventions. Numerator: Number of HCBS providers who adhered to PASSE policies for the use of restrictive interventions as documented on an incident report; Denominator: Number of individuals for whom the provider utilized restrictive intervention as documented on an incident report.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident Report of Restrictive Interventions

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

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

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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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HW4: Percentage of PASSE Care Coordinators and HCBS Providers who took corrective actions regarding critical incidents to protect the health and welfare of the member. Numerator: Number of PASSE Care Coordinators and HCBS Providers who took corrective actions; Denominator: Number of PASSE Care Coordinators and HCBS Providers required to take protective actions regarding critical incidents.

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Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of incident reports.

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

Specify: PASSE		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:

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c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HW7: Percentage of HCBS Providers who adhered to PASSE policies for the use of restrictive interventions. Numerator: Number of HCBS providers who adhered to PASSE policies for the use of restrictive interventions as documented on an incident report; Denominator: Number of individuals for whom the provider utilized restrictive intervention as documented on an incident report.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of incident reports.

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

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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:

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d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW9-Number and percentage of PASSE Care Coordinators who demonstrate responsibility for maintaining overall health care standards. Numerator: Number of provider agencies who met standards and metrics set forth in the PASSE Provider Manual and Provider Agreement. Denominator: Total number of PASSE Care Coordinators reviewed or investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PASSE Care Coordinator Encounter Data and PASSE Quarterly Reports

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

(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: PASSE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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.

(HW 1) The PASSE must inform all enrolled members of their right to report abuse and the contact information for Child and Adult Hotlines. This form must be included in the Member handbook which is approved by DMS.

(HW4) DDS staff identify critical incident reports that describe incidents which require protective actions, such as behavior management plans, changes in staffing levels, or changes in goals. Staff will determine, through the use of interviews, observations and file reviews, if the provider has taken necessary action to protect the individual in question.

(HW 5) DDS staff must complete the investigations of critical incidents within 30 calendar days of receipt of the concern.

(HW 7) DDS requires that PASSE HCBS Providers submit incident reports each time they utilize a restrictive intervention. DDS staff reviews each report and determines if the methods described in the incident report adhere to the requirements for the use of the type intervention used. DDS staff may contact the PASSE Care Coordinator or the HCBS Provider to obtain additional information, if necessary.

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b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 and DDS may take remedial action against the PASSE for any deficiencies noted or for any pattern of non-compliance. These actions are set forth in the PASSE Provider Manual and the PASSE Provider Agreement.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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.

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Appendix H: Quality Improvement Strategy (1 of 3)

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 QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and

- 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 OIS* 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 QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

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.

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1. Methods for Analyzing Data and Prioritizing Need for System Improvement

By using encounter data, the State will have the ability to measure the amount of services provided compared to what is described within the Person Centered Service Plan (PCSP) that is required for individuals receiving CES Waiver services. The state will utilize the encounter data to monitor services provided to determine a baseline, median and any statistical outliers for those service costs.

Additionally, the state will monitor grievance and appeals filed with the PASSE regarding CES Waiver services under the broader Quality Improvement Strategy for the 1915(b) PASSE Waiver.

2. Roles and Responsibilities

The State will work with an External Quality Review Organizations (EQRO) to assist with analyzing the encounter data and data provided by the PASSEs on their quarterly reports.

The State's Beneficiary Support Team will proactively monitor service provision for individuals who are receiving CES Waiver services. Additionally, the team will review PASSE provider credentialing and network adequacy.

3. Frequency

Encounter data will be analyzed quarterly by the State and annually by the EQRO.

Network adequacy will be monitored on an ongoing basis.

4. Method for Evaluating Effectiveness of System Changes

The State will utilize multiple methods to evaluate the effectiveness of system changes. These may include site reviews, contract reviews, encounter data, grievance reports, and any other information that may provide a method for evaluating the effectiveness of system changes.

Any issues with the provision of CES Waiver services that are continually uncovered may lead to sanctions against providers or the PASSE that is responsible for access to those services.

The State will randomly audit PCSPs that are maintained by each PASSE to ensure compliance.

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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: PASSE	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a

description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Arkansas DDS has developed and implemented an HCBS quality improvement strategy that includes a continuous improvement process, measures of program performance, and measures of experience of care.
Components:
Continuous improvement process: DDS convened in November of 2011 a Quality Assurance Committee, made up of state agency staff, providers, and other stakeholders. This Committee meets at least quarterly. Measures of program performance: DDS has developed robust measures of program performance though Performance Measures related to the subassurances.
Experience of care: DDS has conducted the National Core Indicator Adult Consumer Survey since July of 2006. During these seven survey cycles, DDS has improved its process and the transparency of its results. NCI survey data is on the DDS webpage.
Beginning in 2019, an External Quality Review Organization will be conducting quality reviews on all PASSE activities and service delivery.

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 systemic 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 amendment of the HCBS Waiver to CMS. The collaborative process includes participation by the section or unit who has specific strategy responsibility with open discussion opportunity prior to a strategy change of direction.

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Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

No

Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other *(Please provide a description of the survey tool used):*

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).

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PASSE encounter claims data will be audited quarterly for program policy alignment. Discovery and monitoring also includes an ongoing review of CMS-372 reports and CMS-64 reports.

The entity responsible for the periodic independent audit of the waiver program is Arkansas Legislative Audit. Audits are conducted in compliance with state law. All providers who receive a total of $100,000 up to $500,000 in state funding are required to submit a GAS audit annually. Providers who receive $500,000 or more are required to submit an A133 audit annually. The audit must be an independent audit of the provider's financial statements. All audits are reviewed by the Department of Human Services, Office of Chief Counsel (OCC) audit staff for compliance with audit requirements. If there are any concerns or problems noted, the OCC Audit staff will notify the funding division.

The PASSEs will be responsible for maintaining a claims payment system that can interface with the Medicaid Management Information System (MMIS) used by DHS. All HCBS Providers who bill for the PASSE's enrolled members must utilize the PASSE's claims system. DMS will pay a per member, per month (PMPM) prospective payment for each enrolled member to cover all services for that month. DMS, in conjunction with DDS, will conduct utilization reviews of the encounter data to ensure adequate services are delivered to the enrolled member based on his or her PCSP, in accordance with the 1915(b) PASSE Waiver Section B, Part II.s. If the PASSE is found to be out of compliance with the provision of services in accordance with the PCSP, the State may take any of the actions allowed under the PASSE Waiver and listed in the PASSE Provider Agreement, including instituting corrective action plans and recoupment.

The Office of Medicaid Inspector General (OMIG) conducts annual random reviews of all Medicaid programs, including the PASSE and CES Waiver programs. If a review finds errors in billing, and fraud is not suspected, Medicaid recoups the money from the provider. If fraud is suspected, a referral of the Waiver provider is made to the Arkansas Attorney General's Office for appropriate action.

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

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DMS uses the sampling guide "A Practical Guide for Quality Management in Home & Community-Based Waiver Programs" developed by the Human Services Research Institute and the Medstat Group for CMS in 2006. A systematic random sampling of the active case population is drawn whereby every "nth" name in the population is selected for inclusion in the sample for Individual File Review. The sample size is based on a 95% confidence level with a margin of error of +/-5%. An online calculator is used to determine the appropriate sample size for the Waiver population. To determine the "nth" integer, the sample is divided by the population. Names are drawn until the sample size is reached. The sample is divided by twelve for monthly review. DMS oversight results are reconciled quarterly with DDS. Corrective action plans are required if indicated by file review. Payment Integrity looks at the circumstances to determine if fraud is suspected If so, Payment Integrity forwards the case to the Office of Medicaid Inspector General. If policy manual or rules change are indicated, a recommendation is made to the Medicaid Program, Planning and Development.

OMIG performs regular reviews of Waiver services delivered. During the last two state fiscal years, 21% of our audits were devoted to Waiver providers.
OMIG utilizes a few different sampling techniques, including simple random, stratified, and cluster samples. The application of sampling technique is largely dependent upon data hypothesis and sampling frame. If a provider contains subpopulations that are necessary for review, then a stratified or cluster sample would be most appropriate. If not, the default sampling methodology is a simple random sample.

The recommended sample size based on a defined sampling frame has a 95% confidence interval with a 5% margin of error. However, sample sizes are no less than a 90% confidence interval with 10% margin of error, and this is only in the case of a very large provider with a prohibitively large patient population. This sample size would only be intended to be a probe of that patient population, with the option to drill down and expand the sample size if necessary based on findings.

The sample size is calculated using a sample size calculator by Raosoft. This calculator can be accessed at http://www.raosoft.com/samplesize.html. The calculator provides the desired sample size by prompting for margin of error, confidence interval, population size, and response distribution. Once the desired sample size has been identified, a random number generator is applied to the recipient list for a provider selected for review for a defined time period. The random members identified in the sampling frame then constitute the sample for review, and all other recipients' claims are

removed from the claims universe; this only leaves the selected sample of recipients' claims for review.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

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Performance Measure:
FA1: Number and percent of reviewed encounter claims that align with services specified in the member's PCSP. Numerator: Number of encounter claims that align with services in the member's PCSP; Denominator: Number of encounter claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Recipient PCSPs and PASSE encounter claims

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

		95% with a +/- 5% margin of error.
☒ ***Other*** *Specify:* *PASSE*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
PASSE Quarterly Report

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

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b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Developmental Disabilities Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in periodic team meetings to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DDS and DMS have an Interagency Agreement that includes measures related to financial accountability for the CES Waiver.

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:*

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c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

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).*

All CES Waiver services are provided under a capitated PMPM rate methodology. The global payment is described in the PASSE 1915(b) Waiver, AR.0007.R00.01, and accompanying Cost Effectiveness Worksheets.

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:*

HCBS Providers will bill directly to the PASSE's for CES Waiver services provided to enrolled members. The PASSE's must establish rates with the HCBS Waiver providers that ensure services are provided to all enrolled members across the state.

The PASSE's will receive a prospective PMPM for each enrolled member and DMS, in conjunction with DDS, will review all encounter claims quarterly.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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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:*

The assessed needs of each person are identified through a functional Independent Assessment. The PASSE's care coordinator must use that Independent Assessment, the health questionnaire, and other evaluations and assessments to create a PCSP for each member. The services provided to that member must be based upon the objectives and goals set forth in the PCSP.

Providers maintain case notes of each service day with the person served. Providers maintain administrative records such as timesheets and payroll records for provider staff. DMS staff, in conjunction with DDS, reviews the provider records against the encounter claims to ensure services were provided in accordance with the PCSP.

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):*

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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:

Payments are made to the PASSEs through the MMIS system. These payments are a PMPM to cover all the member's services.

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.***

☐ ***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.

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HCBS providers of CES Waiver services are only provided and paid by the PASSE's.

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:

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.

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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.

No, the capitated payment is not 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.

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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:

DDS has established an Organized Health Care Delivery System (OHCDS) option as per 42 CFR 447.10 (b) for HCBS Waiver providers credentialed by a PASSE. The PASSE Provider Agreement requires that the services of a subcontractor will comply with Medicaid regulations. The OHCDS provider assumes all liability for contract non-compliance. The OHCDS provider must provide at least one HCBS Waiver service directly utilizing its own employees. The OHCDS provider must also have a written contract that specifies the services and assures that work will be completed in a timely manner and be satisfactory to the person served. OHCDS is optional.

iii. Contracts with MCOs, PIHPs or PAHPs.

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.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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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:*

☒ ***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 state funding that is used for Medicaid HCBS 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:

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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:*

The PASSE must implement policies that require Supplemental Security Income (SSI)/personal accounts are used to cover room and board costs and are maintained separately from HCBS Waiver reimbursements. Providers are prohibited from including room and board as any part of HCBS Waiver direct/indirect expense formulations.

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.

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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)

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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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

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	48237.50	15678.00	63915.50	115475.00	15811.00	131286.00	67370.50
2	43663.49	16148.00	59811.49	118939.00	5986.00	124925.00	65113.51
3	43723.84	16632.00	60355.84	122507.00	6165.00	128672.00	68316.16
4	44216.09	17131.00	61347.09	126182.00	6350.00	132532.00	71184.91
5	45105.47	17645.00	62750.47	129968.00	6541.00	136509.00	73758.53

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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 Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	4303	4303
Year 2	4803	4803
Year 3	4863	4863
Year 4	4883	4883
Year 5	5503	5503

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 average is based on the actual prior experience from FY 2014 372 report. The average length of stay is 354.6 days.

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 and methodology for these estimates is as follows:*

The basis for estimates of all services was based on FY 2015 Expenditures derived from AR MMIS system pending acceptance of 372 Report for time period.

In Waiver Year 3, all CES Waiver clients will be enrolled in a PASSE and will transition from receiving care coordination under the 1915(c) Waiver to receiving it through the PASSE under the 1915(b) Waiver.

Additionally, the CES Waiver rates have been updated, as reflected in this Appendix. Those rates will now be paid as part of a global payment/PMPM described in the 1915(b) Waiver, AR.0007.R00.01.

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:*

Utilization of Medicaid services provided outside of the scope of the waiver have been carried forward to represent anticipated costs.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

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Historic cost trends have been carried forward to represent anticipated institutional costs.

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:*

Historic cost trends have been carried forward to represent anticipated costs residents may incur outside of the institution.

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	
Caregiver 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.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Caregiver Respite Total:							305942.79
Caregiver Respite	☐	day	151	18.16	111.57	305942.79	
Caregiver Respite	☐	0	0	0.00	0.01	0.00	
Supported Employment Total:							666444.05
Supported Employment	☐	15 minutes	101	1838.01	3.59	666444.05	
Supportive Living Total:							204064441.56
Supportive Living	☐	day	4162	294.00	166.77	204064441.56	
Specialized Medical Supplies Total:							593950.50
Specialized Medical Supplies	☐	monthly	923	11.00	58.50	593950.50	
Adaptive Equipment Total:							681224.67
Personal Emergency System Service Fee	☐	monthly	24	12.00	29.25	8424.00	
Adaptive Equipment	☐	package	286	1.39	1692.41	672800.67	
Community Transition Services Total:							369009.27
Community Transition Services	☐	package	108	1.05	3254.05	369009.27	
Consultation Total:							113899.50

GRAND TOTAL:	207565957.36
Total: Services included in capitation:	
Total: Services not included in capitation:	207565957.36
Total Estimated Unduplicated Participants:	4303
Factor D (Divide total by number of participants):	48237.50
Services included in capitation:	
Services not included in capitation:	48237.50
Average Length of Stay on the Waiver:	355

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultation	☐	hour	177	6.25	102.96	113899.50	
Crisis Intervention Total:							5084.00
Crisis Intervention	☐	hour	25	1.60	127.10	5084.00	
Environmental Modifications Total:							685201.32
Environmental Modifications	☐	package	147	1.05	4439.27	685201.32	
Supplemental Support Total:							80759.69
Supplemental Support	☐	monthly	64	3.33	378.94	80759.69	

GRAND TOTAL:	207565957.36
Total: Services included in capitation:	
Total: Services not included in capitation:	207565957.36
Total Estimated Unduplicated Participants:	4303
Factor D (Divide total by number of participants):	48237.50
Services included in capitation:	
Services not included in capitation:	48237.50
Average Length of Stay on the Waiver:	355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

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d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Caregiver Respite Total:							326203.90
Caregiver Respite	☐	day	161	18.16	111.57	326203.90	
Caregiver Respite	☐	0	0	0.00	0.01	0.00	
Supported Employment Total:							699436.33

GRAND TOTAL:	209715762.61
Total: Services included in capitation:	
Total: Services not included in capitation:	209715762.61
Total Estimated Unduplicated Participants:	4803
Factor D (Divide total by number of participants):	43663.49
Services included in capitation:	
Services not included in capitation:	43663.49
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment	☐	15 minutes	106	1838.01	3.59	699436.33	
Supportive Living Total:							206025656.76
Supportive Living	☐	day	4202	294.00	166.77	206025656.76	
Specialized Medical Supplies Total:							600385.50
Specialized Medical Supplies	☐	monthly	933	11.00	58.50	600385.50	
Adaptive Equipment Total:							708259.17
Personal Emergency System Service Fee	☐	monthly	34	12.00	29.25	11934.00	
Adaptive Equipment	☐	package	296	1.39	1692.41	696325.17	
Community Transition Services Total:							403176.79
Community Transition Services	☐	package	118	1.05	3254.05	403176.80	
Consultation Total:							120334.50
Consultation	☐	hour	187	6.25	102.96	120334.50	
Crisis Intervention Total:							7117.60
Crisis Intervention	☐	hour	35	1.60	127.10	7117.60	
Environmental Modifications Total:							731813.66
Environmental Modifications	☐	package	157	1.05	4439.27	731813.66	
Supplemental Support Total:							93378.39
Supplemental Support	☐	monthly	74	3.33	378.94	93378.39	

GRAND TOTAL:	209715762.61
Total: Services included in capitation:	
Total: Services not included in capitation:	209715762.61
Total Estimated Unduplicated Participants:	4803
Factor D (Divide total by number of participants):	43663.49
Services included in capitation:	
Services not included in capitation:	43663.49
Average Length of Stay on the Waiver:	355

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Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Caregiver Respite Total:							383210.87
Caregiver Respite	☒	hourly	166	127.12	18.16	383210.87	
Caregiver Respite	☐	0	0	0.00	0.01	0.00	
Supported Employment Total:							732428.60
Supported Employment	☒	15 minutes	111	1838.01	3.59	732428.60	
Supportive Living Total:							208781277.60
Supportive Living	☒	hourly	4222	2940.00	16.82	208781277.60	
Specialized Medical Supplies Total:							603603.00
Specialized Medical Supplies	☒	monthly	938	11.00	58.50	603603.00	
Adaptive Equipment Total:							721776.42
Personal Emergency System Service Fee	☒	monthly	39	12.00	29.25	13689.00	
Adaptive Equipment	☒	package	301	1.39	1692.41	708087.42	
Community Transition Services Total:							420260.56
Community Transition Services	☒	package	123	1.05	3254.05	420260.56	
Consultation Total:							123552.00
Consultation	☒	hour	192	6.25	102.96	123552.00	
Crisis Intervention Total:							8134.40

GRAND TOTAL:	212629051.02
Total: Services included in capitation:	212629051.02
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	4863
Factor D (Divide total by number of participants):	43723.84
Services included in capitation:	43723.84
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	355

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Crisis Intervention	☒	hour	40	1.60	127.10	8134.40	
Environmental Modifications Total:							755119.83
Environmental Modifications	☒	package	162	1.05	4439.27	755119.83	
Supplemental Support Total:							99687.75
Supplemental Support	☒	monthly	79	3.33	378.94	99687.75	

GRAND TOTAL:	212629051.02
Total: Services included in capitation:	212629051.02
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	4863
Factor D (Divide total by number of participants):	43723.84
Services included in capitation:	43723.84
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

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ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Caregiver Respite Total:							361549.62
Caregiver Respite	☒	hour	176	127.12	16.16	361549.62	
Caregiver Respite	☐	0	0	0.00	0.01	0.00	
Supported Employment Total:							861365.01
Supported Employment	☒	15 minutes	116	1838.01	4.04	861365.01	
Supportive Living Total:							211884447.60

GRAND TOTAL:	215907164.51
Total: Services included in capitation:	215907164.51
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	4883
Factor D (Divide total by number of participants):	44216.09
Services included in capitation:	44216.09
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Living	☒	hour	4222	2940.00	17.07	211884447.60	
Specialized Medical Supplies Total:							606820.50
Specialized Medical Supplies	☒	monthly	943	11.00	58.50	606820.50	
Adaptive Equipment Total:							735293.67
Personal Emergency System Service Fee	☒	monthly	44	12.00	29.25	15444.00	
Adaptive Equipment	☒	package	306	1.39	1692.41	719849.67	
Community Transition Services Total:							437344.32
Community Transition Services	☒	package	128	1.05	3254.05	437344.32	
Consultation Total:							126769.50
Consultation	☒	hour	197	6.25	102.96	126769.50	
Crisis Intervention Total:							9151.20
Crisis Intervention	☒	hour	45	1.60	127.10	9151.20	
Environmental Modifications Total:							778425.99
Environmental Modifications	☒	package	167	1.05	4439.27	778425.99	
Supplemental Support Total:							105997.10
Supplemental Support	☒	monthly	84	3.33	378.94	105997.10	

GRAND TOTAL:	215907164.51
Total: Services included in capitation:	215907164.51
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	4883
Factor D (Divide total by number of participants):	44216.09
Services included in capitation:	44216.09
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	355

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Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Caregiver Respite Total:							**394417.77**
Caregiver Respite	☒	hour	192	127.12	16.16	**394417.77**	
Caregiver Respite	☐	0	0	0.00	0.01	**0.00**	
Supported Employment Total:							**1023845.09**
Supported Employment	☒	15 minutes	132	1838.01	4.22	**1023845.09**	
Supportive Living Total:							**243575942.40**
Supportive Living	☒	hour	4644	2940.00	17.84	**243575942.40**	
Specialized Medical Supplies Total:							**715176.00**
Specialized Medical Supplies	☒	monthly	1032	11.00	63.00	**715176.00**	
Adaptive Equipment Total:							**852576.58**
Personal Emergency System Service Fee	☒	monthly	53	12.00	33.75	**21465.00**	
Adaptive Equipment	☒	package	338	1.39	1769.00	**831111.58**	
Community Transition Services Total:							**492692.76**
Community Transition Services	☒	package	144	1.05	3258.55	**492692.76**	
Consultation Total:							**147936.25**
Consultation	☒	hour	220	6.25	107.59	**147936.25**	
Crisis Intervention Total:							**11474.78**
Crisis Intervention	☒	hour	54	1.60	132.81	**11474.78**	
Environmental Modifications Total:							**877488.15**

GRAND TOTAL:	**248215404.74**
Total: Services included in capitation:	248215404.74
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	**5503**
Factor D (Divide total by number of participants):	**45105.47**
Services included in capitation:	45105.47
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	355

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications	☒	package	187	1.05	4469.00	877488.15	
Supplemental Support Total:							123854.95
Supplemental Support	☒	monthly	97	3.33	383.44	123854.95	

GRAND TOTAL:	248215404.74
Total: Services included in capitation:	248215404.74
Total: Services not included in capitation:	0.00
Total Estimated Unduplicated Participants:	5503
Factor D (Divide total by number of participants):	45105.47
Services included in capitation:	45105.47
Services not included in capitation:	0.00
Average Length of Stay on the Waiver:	355

DRAFT

State of Arkansas *As Engrossed: S4/4/19*
92nd General Assembly **A Bill**
Regular Session, 2019 HOUSE BILL 1491

By: Representatives Miller, Beck, Della Rosa, Eubanks, Payton, Rushing, Rye, Sullivan
By: Senators K. Hammer, B. Sample

For An Act To Be Entitled

AN ACT TO ELIMINATE THE WAITING LIST FOR THE ALTERNATIVE COMMUNITY SERVICES WAIVER PROGRAM, ALSO KNOWN AS THE "DEVELOPMENTAL DISABILITIES WAIVER"; AND FOR OTHER PURPOSES.

Subtitle

TO ELIMINATE THE WAITING LIST FOR THE ALTERNATIVE COMMUNITY SERVICES WAIVER PROGRAM, ALSO KNOWN AS THE "DEVELOPMENTAL DISABILITIES WAIVER".

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77, Subchapter 1, is amended to add an additional section to read as follows:

20-77-135. Elimination of waiting list.

(a) The Department of Human Services shall eliminate the waiting list as existing on *March 1, 2019*, for the Alternative Community Services Waiver Program, also known as the "Developmental Disabilities *Waiver", or successor program.*

(b) The department shall meet the requirements of subsection (a) of this section as soon as possible but no later than three (3) years after the effective date of this section by using available funding streams, unless the department determines that an adequate number of providers for *individuals with developmental disabilities does not exist within the state.*

(c) An individual who applies for coverage or enrolls in the program

after March 1, 2019, may be placed on a waiting list if the department determines that adequate funding streams or resources are not available at the time of application or enrollment.

/s/Miller

APPROVED: 4/16/19

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

MEMORANDUM

TO: Interested Persons and Providers

FROM: Melissa Stone, Director, Division of Developmental Disabilities Services

DATE: August 27, 2020

SUBJ: Community and Employment Supports (CES) Home and Community Based Waiver

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you have any comments, please submit those comments in writing, no later than September 26, 2020.