

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



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Subchapter 1. General.

101. Authority.

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

102. Purpose.

The purpose of these standards is to:

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

103. Definitions.

(a) “Adverse agency action” means:

- (1) A denial of an application for CES Waiver Service certification;
- (2) Any enforcement action taken by DDS pursuant to sections 803 through 807; and
- (3) Any other adverse regulatory action or claim covered by the Medicaid Fairness Act, Ark. Code Ann §§ 20-77-1701 to -1718.

(b) “Alternative living home” means beneficiary residential setting that is not owned, leased, or controlled by the beneficiary, the beneficiary’s legal guardian, or a family member of the beneficiary.

(c) “Applicant” means an applicant for CES Waiver Service certification.

(d) “Beneficiary” means an individual receiving one (1) or more CES Waiver Services.

(e) “Business Day” means Monday through Friday, except for any day that is recognized as a holiday by the State of Arkansas.

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

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

(m)

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

(n)

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

(o)

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

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

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

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

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

Subchapter 2. Certification.

201. Certification Required.

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

202. Application for Certification.

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

203. Certification Process.

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

Subchapter 3. Administration.

301. Organization and Ownership.

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

302. Employee and Staffing Requirements.

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

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

303. Employee Training and Certifications.

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

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

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

304. Employee Records.

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

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

305. Beneficiary Service Records.

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

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

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

(2)

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

(B)

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

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

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

306. Marketing and Solicitation.

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

307. Third-party Service Agreements.

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

308. Financial Safeguards.

(a)

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

(b)

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

- (3) A Provider may only use, manage, or access a beneficiary's funds or other assets for the benefit of the beneficiary.
- (4) A Provider may only use, manage, or access a beneficiary's funds or other assets to the extent permitted by law.
- (5) A Provider must safeguard beneficiary funds or other assets whenever a Provider manages, uses, or has access to a beneficiary's funds or other assets.
- (6) A Provider must ensure that a beneficiary receives the benefit of the goods and services for which the beneficiary's funds or other assets are used.

(c)

- (1) A Provider must maintain financial records that document all uses of a beneficiary's funds or other assets.
- (2) Financial records for beneficiary funds must be maintained in accordance with generally accepted accounting practices.
- (3) A Provider must make beneficiary financial records available to a beneficiary or a beneficiary's legal guardian upon request.

(d)

- (1) A Provider must maintain separate accounts for each beneficiary whenever the Provider uses, manages, or accesses beneficiary funds or other assets.
- (2) Every beneficiary is not required to have separate commercial bank account. A single, collective commercial bank account may be used to hold the personal funds of multiple beneficiaries so long as Provider uses an accounting system that maintains a separate record for each beneficiary's deposit and withdrawal transactions from the single, collective commercial bank account.
- (3) All interest derived from a beneficiary's funds or other assets shall accrue to the beneficiary's account.

309. Infection Control.

(a)

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

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

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

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

311. Restraints and Other Restrictive Interventions.

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

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

312. Medications.

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

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

(d)

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

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

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

313. Behavioral Management Plans.

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

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

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

Subchapter 4. Entries and Exits.

401. Entries.

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

402. Exits.

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

- (ii) Medication management plan; and
 - (iii) Any other records requested by the beneficiary.
- (C) If copies of the exiting beneficiary's service record are not provided within thirty (30) days of a written request, it is presumed to be an unreasonable delay in violation of these standards.

403. Transitions from one CES Waiver Provider to another.

- (a)
 - (1) When a beneficiary transitions from one Provider to another Provider the requirements of this section 403 apply in addition to those in section 402.
 - (2) The requirements of this section 403 apply to any Provider-to-Provider transfer, including without limitation when:
 - (A) A beneficiary, or, if applicable, their legal guardian, elects to change Providers; and
 - (B) A Provider declares a refusal to serve in accordance with section 404.
- (b) A newly selected Provider must notify the current Provider of its selection within fourteen (14) business days of receiving notification of its selection from the PASSE.
- (c) The new Provider must hold a transition conference to develop a transition plan for the beneficiary within fourteen (14) business days of issuing the notification required in subsection (b) above. If the new Provider is unable to hold the transition conference within the required timeframe, reasonable justification for the delay must be documented.
- (d)
 - (1) The transition plan must at a minimum include:
 - (A) The effective date of the beneficiary's transition to the new Provider;
 - (B) Any upcoming or pending medical, counseling, or other appointments for the beneficiary;
 - (C) The date of the transition conference;
 - (D) How the transition conference was held (i.e. in person, by phone, zoom, etc.);

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

404. Refusal to Serve.

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

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

405. CES Waiver Eligibility Disqualification.

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

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

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

Subchapter 5. Settings Requirements.

501. Emergency Plans and Drills.

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

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

502. Provider Owned Residential Setting Requirements.

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

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

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

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

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

503. Provider Owned Residential Setting Exceptions and Variations.

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

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

Subchapter 6. Programs and Services.

601. Supportive Living.

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

602. Complex Care Home.

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

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

(b)

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

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

(A) Behavioral health needs; or

(B) Physical health needs.

(3)

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

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

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

(d)

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

(2) The medical director is responsible for:

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

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

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

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

(e)

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

(f)

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

(g)

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

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

- (D) Each multidisciplinary team leader is responsible for:
 - (i) Overseeing the development of the treatment plan for those services to be performed by the Provider;
 - (ii) Monitoring the Provider's delivery of all services included in the beneficiary's treatment plan;
 - (iii) Directly supervising Provider employees performing the services included in the beneficiary's treatment plan; and
 - (iv) Providing case consultation and in-service training to members of the multidisciplinary team, as needed.

(i)

- (1) A Provider operating a complex care home must establish, implement, and maintain a site-specific crisis response plan at each complex care home location.
- (2) Each site-specific crisis response plan must include a twenty-four (24) hour emergency telephone number that provides for a:
 - (A) Direct access call with a mental health professional (MHP) within fifteen (15) minutes of an emergency/crisis;
 - (B) Face-to-face crisis assessment of a beneficiary within two (2) hours of an emergency/crisis (which may be conducted through telemedicine) unless a different time frame is within clinical standards guidelines and mutually agreed upon by the requesting party and the responding MHP; and
 - (C) Clinical review by the clinical director within twenty-four (24) hours of the emergency/crisis.

(j) A Provider operating a complex care home must:

- (1) Provide the twenty-four (24)-hour emergency telephone number to all beneficiaries, and, if applicable, the legal guardians of all beneficiaries, residing in the complex care home;
- (2) Post the twenty-four (24)-hour emergency telephone number on all public entrances to each complex care home location; and
- (3) Include the twenty-four (24)-hour emergency telephone phone number on all answering machine greetings.

603. Respite.

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

604. Supported Employment.

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

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

605. Specialized Medical Supplies.

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

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

606. Adaptive Equipment.

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

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

607. Community Transition Services.

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

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

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

608. Consultation.

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

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

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

609. Environmental Modifications.

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

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

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

610. Supplemental Support.

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

Subchapter 7. Incident and Accident Reporting.

701. Incidents to be Reported.

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

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

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

702. Reporting Requirements.

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

703. Notification to Legal Guardians.

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

Subchapter 8. Enforcement.

801. Monitoring.

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

802. Written Notice of Enforcement Action.

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

803. Enforcement Actions.

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

- (3) Impact of noncompliance on a beneficiary's health, safety, or well-being;
- (4) Responsiveness in correcting noncompliance;
- (5) Repeated noncompliance in the same or similar areas;
- (6) Noncompliance with previously or currently imposed enforcement actions;
- (7) Noncompliance involving intentional fraud or dishonesty; and
- (8) Noncompliance involving violation of any law, rule, or other legal requirement.

(d)

- (1) DDS shall report any noncompliance, action, or inaction by a Provider to appropriate agencies for investigation and further action.
- (2) DDS shall report noncompliance involving Medicaid billing requirements to DMS, the Arkansas Attorney General's Medicaid Fraud Control Unit, and the Office of Medicaid Inspector General.

(e) These enforcement actions are not mutually exclusive and DDS may apply multiple enforcement actions simultaneously to a failure to comply with these standards.

(f) The failure to comply with an enforcement action imposed by DDS constitutes a separate violation of these standards.

804. Moratorium.

(a) DDS may prohibit a Provider from accepting new beneficiaries.

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

805. Transfer of Beneficiaries.

(a) DDS may require a Provider to transfer a beneficiary to another provider if DDS finds that the Provider cannot adequately provide services to the beneficiary.

(b) If directed by DDS, a Provider must continue providing services until the beneficiary is transferred to their new service provider of choice.

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

806. Monetary Penalties.

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

807. Suspension and Revocation of Certification.

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

Subchapter 9. Closure.

901. Closure.

(a)

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

(b)

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

(4)

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

Subdivision 10. Appeals.

1001. Reconsideration of Adverse Regulatory Actions.

(a)

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

(b)

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

(c)

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

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

1002. Appeal of Regulatory Actions.

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