AR DHS HCBS Rate Review – Online Survey PDF Copy 20250605
Arkansas Department of Human Services

Thank you for your participation in this provider survey to inform the Arkansas Department of Human Services (DHS)'s rate review of intellectual and developmental disability (I/DD) and behavioral health (BH) services included in the home- and community-based (HCBS) manual.

Please be advised of the following:

- The online survey is intended to be completed in one sitting and does not save progress on partially completed responses. If you exit the survey before submitting it, your progress will not be saved. Please refer to the PDF of the survey questions **[pdf link from DHS website to be inserted]** if you would like to preview the information being requested.

- This survey is intended for providers that served less than 20 individuals in the last 12 months and do not provide Therapeutic Community, Residential Community Reintegration Program, or Supportive Living - Shared Staffing services. If you served 20 or more individuals or provide any of the previously listed services, please complete the Excel-based survey that is available here:

[Excel link from DHS website to be inserted]

- If you submitted the online survey in error or you would like to change any of your responses, please contact DHS' contractor Milliman at DHS-HCBS-Rate-Review@milliman.com.
- For the purposes of this survey, the term direct care staff refers to personnel who are directly engaged in providing care to individuals.

Submission Deadline: Responses must be submitted no later than **June 27, 2025.**

Thank you for your participation in the survey. If you have any questions regarding the completion of this survey, please contact us at DHS-HCBS-Rate-Review@milliman.com.

Start

* Do you provide one or more of the below services?

- Adult Rehabilitation Day Services
- Behavioral Assistance
- Child and Youth Support Services
- Consultation Services
- Crisis Stabilization Intervention
- Peer Support
- Pharmacologic Counseling by RN
- Residential Community Reintegration Program
- Respite
- Supported/Supportive Employment - Group
- Supported/Supportive Employment - 1:1
- Supportive Housing
- Adult Life Skills / Supportive Life Skills - Youth and Adult
- Supportive Living - Group Home
- Supportive Living - Non-Group Home
- Therapeutic Communities

◯ Yes

◯ No

< Next

If “No” is selected to “Do you provide one or more of the below services?” then the following message appears:

This survey is intended only for those providers delivering at least one of the listed services. You may exit the survey now, as you indicated you do not deliver any of these services. Thank you for your interest in participating.

< Next

If “Yes” is selected to “Do you provide one or more of the below services?” then the following question appears:

* Do you provide any of the three services below?

- Residential Community Reintegration Program
- Supportive Living - Group Home
- Therapeutic Communities

○ Yes

○ No

< Next

If "Yes” is selected to “Do you provide any of the three services below?” then the following message appears:

Providers delivering any of the three specified services should complete the Excel-based survey instead of this online survey. Please exit this survey and go to DHS' survey webpage to download and complete the Excel-based survey: **[Excel link from DHS website to be inserted]**

< Next

If “No” is selected to “Do you provide any of the three services below?” then the following question appears:

* Have you served less than 20 individuals in the last 12 months of operation?

○ Yes

○ No

< Next

If “No” is selected to “Have you served less than 20 individuals in the last 12 months of operation?” then the following message appears:

Providers serving 20 or more individuals should complete the Excel-based survey instead of this online survey. Please exit this survey and go to DHS' survey webpage to download and complete the Excel-based survey: **[Excel link from DHS website to be inserted]**

< Next

If “Yes” is selected to “Have you served less than 20 individuals in the last 12 months of operation?” then the following question appears:

What type of Medicaid services does your agency provide? Select all from the list below.

- [ ] Adult Rehabilitation Day Services
- [ ] Behavioral Assistance
- [ ] Child and Youth Support Services
- [ ] Consultation Services
- [ ] Crisis Stabilization Intervention
- [ ] Peer Support
- [ ] Pharmacologic Counseling by RN
- [ ] Respite
- [ ] Supported/Supportive Employment - Group
- [ ] Supported/Supportive Employment - 1:1
- [ ] Supportive Housing
- [ ] Adult Life Skills / Supportive Life Skills - Youth and Adult
- [ ] Supportive Living - Non-Group Home

< Next

If nothing is selected to “What type of Medicaid services does your agency provide?” then the following message appears:

This survey is intended only for those providers delivering at least one of the listed services. You may exit the survey now, as you indicated you do not deliver any of these services. Thank you for your interest in participating.

< Next

Next, general provider and contact information is requested (please note, all fields must be completed):

Enter provider and contact information.

* Provider Name

* Contact Name

* Contact Phone Number

* Contact Email Address

* Contact Mailing Address

< Next

Next, staffing information is requested for each individual direct care or clinical staff member:

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In the below table, complete a row for each staff person at your organization that provides direct/clinical care. For example, if you and two staff provide direct/clinical care, you would complete three rows. Please complete the requested information in the columns below as appropriate. Use the scroll bar at the bottom of the table to access any columns beyond the visible area.

	Direct or Clinical Care Staff Type	Current Hourly Wage (A)	Average weekly hours within the last month (B)	Does this individual receive a W-2 from your organization? (C)	Does this individual supervise other direct care / clinic staff members? (D)	Did this individual regularly work overtime in the last 12 months? (E)	Has this indiv regularly receiv call pay in the months? (F)
1	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
2	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
3	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
4	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
5	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
6	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
7	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
8	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
9	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
10	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
11	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
12	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
13	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
14	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
15	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
16	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
17	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
18	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
19	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
20	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
21	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
22	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
23	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
24	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --
25	-- Select --			-- Select --	-- Select --	-- Select --	-- Select --

If you selected "Other" in Direct or Clinical Care Staff Type, please describe the positions below.

If you selected "Other" for W-2 or contracted employees, please describe the arrangement below.

What is your organization's current number of unfilled positions for direct care or clinical staff?

Next

Next, employee benefit information is requested for each W-2 direct care or clinical staff member:

* Do non-contracted employees receive holiday pay?
  - Yes
  - No

* Do W-2 employees receive sick leave, vacation, or other forms of paid time off?
  - Yes
  - No

Next

* Do you offer health insurance to your W-2 employees (excluding dental and vision)?
  - Yes
  - No

Next

If “Yes” is selected to “Do you offer health insurance […]?”:

* Indicate the approximate percentage of W-2 employees (including yourself) that participate in health insurance benefits.

0% 100%

Next

* Do you offer dental insurance to your W-2 employees?

- Yes
- No

Next

If “Yes” is selected to “Do you offer dental insurance […]?”:

* Indicate the approximate percentage of W-2 employees (including yourself) that participate in dental insurance benefits.

0% 100%

Next

* Do you offer vision insurance to your W-2 employees?

- Yes
- No

Next

If “Yes” is selected to “Do you offer vision insurance […]?”:

* Indicate the approximate percentage of W-2 employees (including yourself) that participate in vision insurance benefits.

0% 100%

Next

* Do you offer retirement benefits to your W-2 employees?

- Yes
- No

Next

If “Yes” is selected to “Do you offer retirement benefits […]?”:

* Indicate the approximate percentage of W-2 employees (including yourself) that participate in retirement benefits.

0% 100%

Next

The following questions will be repeated for each service they indicated they provide:

Adult Rehabilitation Day Services

Most common direct care staff delivering **Adult Rehabilitation Day Services** (face-to-face)

-- Select --

Most common staff position supervising the direct care staff delivering **Adult Rehabilitation Day Services**

-- Select --

What is the average time spent to deliver **Adult Rehabilitation Day Services?**

a. Direct time in minutes (time spent face-to-face with client or otherwise billable)?

b. Indirect time in minutes (time specific to the service such as note taking but is not "person-facing" or billable)?

Where do you most commonly provide **Adult Rehabilitation Day Services**?

-- Select --

If staff must travel between locations to deliver **Adult Rehabilitation Day Services**, **do you pay staff for travel time?**

- ◯ Yes
- ◯ No
- ◯ N/A - no travel required for this service

If staff must travel between locations to deliver **Adult Rehabilitation Day Services**, **do you pay staff for vehicle costs (e.g., mileage reimbursement)?**

- ◯ Yes
- ◯ No
- ◯ N/A - no travel required for this service

What is the average number of **locations a direct care or clinical care staff member must travel to in a typical day when delivering Adult Rehabilitation Day Services?** If you indicated that there is no travel required for **Adult Rehabilitation Day Services**, please ignore this question.

What is the average amount of time, in minutes, a direct care or clinical care staff member **spends traveling to each location (one-way)**? If you indicated that there is no travel required for **Adult Rehabilitation Day Services**, please ignore this question.

What is the average number of miles traveled **per one-way trip**? If you indicated that there is no travel required for **Adult Rehabilitation Day Services**, please ignore this question.

Are **Adult Rehabilitation Day Services** delivered in a group setting?

- ◯ Yes
- ◯ No

If **Adult Rehabilitation Day Services** are delivered in a group setting, what is the average number of members in a group? Please ignore this question if **Adult Rehabilitation Day Services** are not delivered in a group setting.

< Next

A section is provided towards the end of the survey for any provider feedback to be reported:

Please provide any comments you have regarding the information you submitted, or comments or feedback regarding DHS' rate review in general.

Lastly, a certification statement is requested to be completed before submission (please note, all fields must be completed):

CERTIFICATION STATEMENT OF

(Provider Name)
to
Arkansas Department of Human Services
For the Provider Cost and Wage Survey - 2025 Online Survey

* Name of Preparer

* Title

* Phone Number

* E-mail Address

I hereby attest that the information submitted in the report herein is current, complete, accurate, and in compliance with 2 CFR Part 200 to the best of my knowledge. Failure to attest (as indicated by the completed section below) will result in non-acceptance by State of Arkansas, Department of Human Services.

* Name

* Date

* Title

Once submitted, the following message appears:

Thank you for your participation in the survey. If you have any questions regarding the completion of this survey, please contact us at DHS-HCBS-Rate-Review@milliman.com. For more info on this rate review initiative, please visit DHS' website at https://humanservices.arkansas.gov/newsroom/hcbs/hcbs-rate-review/