

# ARKANSAS REGISTER

## Transmittal Sheet

\* Use only for **FINAL** and **EMERGENCY RULES**



Secretary of State  
**Mark Martin**  
State Capitol, Suite 026  
Little Rock, Arkansas 72201-1094  
(501) 682-3527  
[www.sos.arkansas.gov](http://www.sos.arkansas.gov)



For Office  
Use Only:

Effective Date \_\_\_\_\_ Code Number \_\_\_\_\_

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Mark White E-mail Mark.White@dhs.arkansas.gov Phone 501-320-6009

Statutory Authority for Promulgating Rules Ark. Code Ann. §§ 20-10-1704, 20-77-107, 20-77-128, 20-77-1304, 25-

**Rule Title:** Task and Hour Standards, ARChoices 2-18 and Waiver, Living Choices Assisted Living 1-18 and Waiver, Independent Choices 1-18. Personal Care 1-18 and SPA #2018-014 and PACE 1-18

**Intended Effective Date**  
(Check One)

**Date**

Emergency (ACA 25-15-204)

Legal Notice Published

10-07-2018

30 Days After Filing (ACA 25-15-204)

Final Date for Public Comment

11-07-2018

Other January 1, 2019  
(Must be more than 30 days after filing date.)

Reviewed by Legislative Council

12-21-2018

Adopted by State Agency

01-01-2019

Electronic Copy of Rule submitted under ACA 25-15-218 by:

Becky Murphy

becky.murphy@dhs.arkansas.gov

Contact Person

E-mail Address

Date

### CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted  
In Compliance with Act 434 of 1967 the Arkansas Administrative Procedures Act. (ACA 25-15-201 et. seq.)

Signature

501-682-8330

tami.harlan@dhs.arkansas.gov

Phone Number

E-mail Address

Director, Division of Medical Services

Title

12/20/18

Date

**Arkansas Medicaid Task and Hour Standards (THS)**  
**For Use in Calculating Medically Necessary Hours of Services for Adult Beneficiaries**  
**ARChoices Attendant Care & Respite Care, Personal Care Services, and IndependentChoices Self-Directed Personal Assistance**

1	2	3	4	5	6	7	8	9	10	11	12
Task / Activity	Needs Intensity Score 1 Needs and Minute Ranges	Minutes Assigned within Range	Needs Intensity Score 2 Needs and Minute Ranges	Minutes Assigned within Range	Needs Intensity Score 3 Needs and Minute Ranges	Minutes Assigned within Range	Frequency	Total Minutes per week	Minutes of Assistance with Task Per Week from Another Source	Total Minutes/ Hours Per Week Net of Assistance from Another Source	Total Net Hours per Month
Bathing	<ul style="list-style-type: none"> <li>Laying out supplies</li> <li>Drawing water</li> <li>Standby assistance for safety</li> <li>Minimal assistance in/out of tub or shower</li> <li>Reminding, monitoring</li> </ul> Minute range: 5-10		<ul style="list-style-type: none"> <li>Tub/shower bathing</li> <li>Sponge bathing</li> <li>Bed bathing</li> <li>Drying</li> <li>Extensive assistance in/out of tub or shower</li> </ul> Minute range: 15-30		Total assistance with bathing  Minute range: 35-45						
Dressing	<ul style="list-style-type: none"> <li>Laying out clothing</li> <li>May require occasional help with zippers, buttons, putting on socks or shoes</li> <li>Reminding or monitoring</li> </ul> Minute range: 5-10		<ul style="list-style-type: none"> <li>Always requires assistance with zippers, buttons, socks, or shoes</li> <li>Requires assistance getting into and out of garments</li> </ul> Minute range: 15-20		Total assistance with dressing  Minute range: 25-30						
Feeding	<ul style="list-style-type: none"> <li>Verbal reminders &amp; encouragement</li> <li>Standby assistance</li> <li>Applying adaptive devices</li> </ul> Note: feeding is calculated by # of meals per week, not # of days  Minute range: 5-10		<ul style="list-style-type: none"> <li>Spoon feeding</li> <li>Bottle feeding</li> </ul> Minute range: 15-20		Total assistance with feeding  Minute range: 25-30						

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<p>Grooming/Routine hair and skin care</p>	<ul style="list-style-type: none"> <li>• Laying out supplies</li> <li>• Verbal reminders</li> <li>• Combing/brushing hair</li> <li>• Applying non-prescription lotion to skin</li> </ul> <p>Minute range: 10-20</p>		<ul style="list-style-type: none"> <li>• Shaving</li> <li>• Brushing teeth</li> <li>• Shaving legs, underarms</li> <li>• Caring for nails</li> <li>• Washing hair</li> <li>• Drying hair</li> <li>• Setting/rolling/braiding hair</li> <li>• Washing hands and face</li> <li>• Applying makeup</li> </ul> <p>Minute range: 30-50</p>		<p>Total assistance with grooming and routine hair and skin care</p> <p>Minute range: 60-75</p>						
<p>Toileting</p>	<ul style="list-style-type: none"> <li>• Preparing toileting supplies / equipment</li> <li>• Assisting with clothing during toileting</li> <li>• Occasional help with Cleaning self</li> <li>• Occasional help with catheter or colostomy care</li> <li>• Standby assistance</li> </ul> <p>Minute range: 5-10</p>		<ul style="list-style-type: none"> <li>• Assisting on/off bedpan</li> <li>• Assisting with the use of urinal</li> <li>• Assisting with toileting hygiene</li> <li>• Assisting with feminine hygiene needs</li> <li>• Changing diapers</li> <li>• Changing external catheter</li> <li>• Emptying catheter bag</li> <li>• Changing colostomy bag</li> </ul> <p>Minute range: 15-20</p>		<p>Total assistance with toileting</p> <p>Minute range: 25-30</p>						
<p>Transferring</p>	<ul style="list-style-type: none"> <li>• Helping with positioning (adjusting/changing position)</li> <li>• Minimal assistance in rising</li> <li>• Standby assistance</li> </ul> <p>Minute range: 5-10</p>		<ul style="list-style-type: none"> <li>• Non-ambulatory movement from one stationary position to another</li> <li>• Hands-on assistance with rising from a sitting to a standing position</li> <li>• Extensive assistance with positioning or turning</li> </ul> <p>Minute range: 15-20</p>		<p>Total assistance with positioning or transferring from bed to chair</p> <p>Minute range: 25-30</p>						

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Walking	<ul style="list-style-type: none"> <li>• Standby assistance with walking</li> <li>• Assistance with putting on and removing leg braces</li> </ul> <p>Minute range: 5-10</p>		<ul style="list-style-type: none"> <li>• Steadying in walking/using steps</li> <li>• Assistance with wheelchair ambulation</li> </ul> <p>Minute range: 15-20</p>		<p>Total assistance with wheelchair ambulation</p> <p>Minute range: 25-30</p>						
Cleaning	<ul style="list-style-type: none"> <li>• Minimal assistance with cleaning</li> <li>• Make bed</li> <li>• Straightening areas</li> </ul> <p>Minute range: 60-90</p>		<ul style="list-style-type: none"> <li>• Cleaning up after personal care tasks</li> <li>• Cleaning floors of living area used by individual</li> <li>• Dusting</li> <li>• Cleaning bathroom</li> <li>• Changing bed linens</li> <li>• Cleaning stove top, counters, washing dishes</li> <li>• Cleaning refrigerator and stove</li> <li>• Emptying and cleaning bedside commode</li> <li>• Carrying out trash, setting out garbage for pickup</li> </ul> <p>Minute range: 95-235</p>		<p>Total assistance with cleaning</p> <p>Minute range: 240-300</p>						
Laundry	<p>Individual requires at least minimal assistance but has no special laundry needs:</p> <p>Minute range: 30-120</p>		<p>Individual has special laundry needs:</p> <p>Minute range: 120-240</p>								

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Meal preparation	<ul style="list-style-type: none"> <li>• Warming, cutting, serving prepared food</li> <li>• Meal planning</li> <li>• Helping prepare meals</li> <li>Light Breakfast</li> <li>• Snacks</li> <li>• Cooking full meal.</li> <li>Indicate meals to be cooked. The maximum time per meal is 30 minutes. <ul style="list-style-type: none"> <li>○ Breakfast</li> <li>○ Lunch</li> <li>○ Supper</li> </ul> </li> <li>• Additional time for leftovers. Allow an extra 15 minutes per day for cooking enough for leftovers for the next meal, if needed.</li> <li>• Grinding and pureeing food</li> </ul> <p>Minute range: 10-90</p>										
Shopping	<ul style="list-style-type: none"> <li>• Preparing a shopping list</li> <li>• Picking up extra items</li> </ul> <p>Minute range: 10-30</p>		<ul style="list-style-type: none"> <li>• Going to the store; shopping for all items</li> <li>• Picking up medications</li> <li>• Putting items away</li> </ul> <p>Minute range: 35-90</p>		<p>Total assistance with shopping</p> <p>Minute range: 35-90</p>						
Employment-related personal care associated with travel											
<b>TOTAL Minutes/Hours for All Tasks Per Week</b>											
<b>TOTAL Minutes/Hours for All Tasks Per Month</b>											

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**Instructions for Completing the Above Task and Hour Standards Grid**

The Task and Hour Standards (THS) grid is used to provide the basis for calculating the number of approved and authorized minutes and hours of attendant care, respite care, personal care, and self-directed personal assistance that are medically necessary for an adult beneficiary aged 21 or older.

Whenever there is a change in condition for the beneficiary or a change in assistance from other sources, the DHS RN or contractor will update the THS grid for the beneficiary. The updated THS grid may result in a change the minutes/hours of attendant care, respite care, personal care, or self-directed personal assistance approved for the beneficiary.

The DHS nurse/contractor will assign a Needs Intensity Score to the beneficiary for each task based on the beneficiary's and/or representative's responses to questions during the ARIA assessment conducted by an RN from the Independent Assessment Contractor. A Needs Intensity Score is required for completion of the THS grid.

***Steps for completing the THS grid to calculate the number of medically necessary and reasonable minutes/hours of attendant care, respite care, personal care, or personal assistance for the beneficiary per week/month:***

1. Identify the beneficiary's Needs Intensity Score (0, 1, 2, or 3) for each task from the ARIA assessment results and from information collected by the DHS RN during the PCSP meeting with the participant. If the Needs Intensity Score for the task is 0, the beneficiary will not be approved for any minutes for that task and THS grid would not be completed for the task. If the beneficiary's Needs Intensity Score is 1, 2, or 3, the grid will be completed for the task and the Needs Intensity Score will determine which minute range (Columns 2, 4, and 6) is applicable for the task.
2. Columns 3, 5, and 7: (Complete only one of these three.) The DHS nurse/contractor will calculate the number of minutes within the minute range for that Needs Intensity Score that are appropriate for the beneficiary based on conditions specific to the beneficiary. For example, if a beneficiary has cognitive or behavioral issues, the nurse may find that the maximum number of minutes in the range for bathing is warranted. On the other hand, assigning the maximum number of minutes for grooming for a beneficiary who is bald would probably not be appropriate.
  - In exceptional circumstances and based on documented need, the DHS nurse/contractor may approve minutes in excess of the minute range for the task, so long as the justification of need is documented in writing, the justification is based on the beneficiary's assessed or

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observed medical needs, the justification is not for the convenience of the provider or attendant, and the DHS nurse/contractor obtains written supervisory approval.

3. Column 8: Insert the frequency with which the task is performed based on the reasonable needs and preferences of the beneficiary. The frequency with which a given task is performed for a beneficiary will be calculated by the DHS nurse or contractor, drawing upon information from the ARIA assessment results and, as applicable, the information collected by DHS nurses during the PCSP meeting with the beneficiary and/or information submitted by the beneficiary's provider.
4. Column 9: Multiply the total minutes assigned for the task in Columns 3, 5, or 7 by the frequency with which the task is performed (Column 8) to arrive at the total minutes per week. Insert that product in Column 9.
5. Column 10: If the beneficiary is receiving assistance with the task from another source such as (a) informal caregivers (e.g., relatives, neighbors, and friends), (b) community-based agencies such as Meals on Wheels, and/or (c) Medicare or a Medicare Advantage health plan), calculate approximately how many of the assigned minutes for the task are being performed by the other source (e.g., 45 minutes for bathing because the beneficiary's mother needs total assistance and the daughter performs the entire bathing task once a week) and insert in Column 10. The amount of support with ADLs and IADLs provided by other sources is primarily calculated by the DHS nurse or contractor based on ARIA assessment results, during PCSP meetings with the participant, and from information supplied by providers.
6. Column 11: Subtract the number of Minutes of Assistance Per Week from Another Source in Column 10 from the number of Total Minutes Per Week in Column 9. Divide that number by 60 to arrive at the number of hours per week. Enter both minutes and hours per week in this column.
7. Column 12: Multiply the number of hours per week in Column 11 by 4.334 to arrive at the number of hours per month.

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Request Information

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

**B. Program Title:**

**ARChoices in Homecare**

**C. Waiver Number: AR.0195**

**Original Base Waiver Number: AR.0195.**

**D. Amendment Number: AR.0195.R05.01**

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

01/01/19

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

### 2. Purpose(s) of Amendment

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



The ARChoices in Homecare waiver is being amended regarding the following:

1. Section 1.F is amended to clarify that the State does not enroll individuals who need a skilled level of nursing care. Conforms to current State administrative rules, and the State's definition of skilled level of nursing care is set forth in this Amendment in B-6-d.
2. For assessments and re-assessments, replacement of (a) independent assessments performed by DHS registered nurses (RNs) using the ArPath assessment instrument with (b) independent assessments performed by RNs of the DHS Independent Assessment Contractor using the new Arkansas Independent Assessment (ARIA) instrument.
3. For Attendant Care Services and Respite Care Services, policy reforms and clarifications to limit the amount, frequency, and duration based on Task and Hour Standards; reduce overuse, misuse, and potential abuse of services; and revise scope of services descriptions.
4. For Attendant Care Services, three Instrumental Activity of Daily Living (IADL) tasks are eliminated (managing basic personal finances; communication with others; and traveling) to align with State Plan personal care services and self-directed personal assistance services (Independent Choices), reduce risk of duplication, and improve program integrity; and (for waiver participants) synchronize the prior authorization/prior approval of State Plan personal care services and waiver Attendant Care Services.
5. The deletion of Adult Family Home Services, an obsolete service not used by enrollees;
6. The addition of a new service, Prevocational Services, for persons with physical disabilities.
7. To ensure cost effectiveness and fiscal sustainability of waiver services, the maximum dollar amount of waiver services authorized for each specific participant is limited by a prospectively determined Individual Services Budget (ISB).
8. Various technical revisions are made to reflect responsibilities of new DHS Division of Provider Services and Quality Assurance (DPSQA) (a new operating agency), new name of the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (formerly Division of Aging and Adult Services, an operating agency), and location of Office of Long-Term Care (OLTC) in DPSQA.
9. To accommodate past and projected growth in participation in ARChoices, the limitations on the maximum number of participants served at any point in time are increased to 9,071 for Waiver Year 4; and 9,434 for Waiver Year 5.

### 3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	1.F.; 2; 7; 8; A; B
Appendix A Waiver Administration and Operation	A-1; A-2-b; A-3; ;A-5; A-6; A-7; Quality Improvement
Appendix B	B-3-b; B-5-b; B-5-d; B-6-c,d,e,f,i,j; Quality Improvement; B-7-a; B-8

Component of the Approved Waiver	Subsection(s)
Participant Access and Eligibility	
Appendix C Participant Services	C-1/C-3; C-1-c; C-2-a, b (1 of 3); C-2-e, f (3 of 3); C-4-a; Quality Improvement
Appendix D Participant Centered Service Planning and Delivery	D-1-c (3 of 8), d(4 of 8), e(5 of 8), f(6 of 8), g(7 of 8), i(8 of 8); D-2-a, b Quality
Appendix E Participant Direction of Services	
Appendix F Participant Rights	F-1; F-3-b,c
Appendix G Participant Safeguards	G-1-b,c,d,e; G-2; Quality Improvement; G-3-b (1 of 2)
Appendix H	H-1-a,b
Appendix I Financial Accountability	I-1; Quality Improvement; I-2-a,d; I-5-b
Appendix J Cost-Neutrality Demonstration	J-1; J-2: 1 of 9 (a.), 3 of 9 (c.i.), 4 of 9, 5 of 9 (d.ii.), 6 of 9 (d.ii.), 7 of 9 (d.ii.), 8 of

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

**Modify target group(s)**

**Modify Medicaid eligibility**

**Add/delete services**

**Revise service specifications**

**Revise provider qualifications**

**Increase/decrease number of participants**

**Revise cost neutrality demonstration**

**Add participant-direction of services**

**Other**

Specify:

1. Transition independent assessment process from (a) DHS RNs using the ArPath instrument to (b) RNs of independent assessment contractor using the Arkansas Independent Assessment (ARIA) instrument. DHS RNs will gather additional information from individuals in connection with developing the person-centered service plan (PCSP).
2. Add limit on the maximum dollar amount of waiver services authorized for each specific participant by the prospectively determined Individual Services Budget (ISB).
3. To accommodate past and projected growth in participation in ARChoices, the limitations on the maximum number of participants served at any point in time are increased to 9,071 for Waiver Year 4; and 9,434 for Waiver Year 5.
4. Technical edits to reflect changes in operating divisions (names, responsibilities).

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

### 1. Request Information (1 of 3)

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

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

ARChoices in Homecare

**C. Type of Request:** amendment

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

3 years     5 years

**Original Base Waiver Number:** AR.0195

**Waiver Number:** AR.0195.R05.01

**Draft ID:** AR.005.05.05

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

Regular Waiver

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

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

### 1. Request Information (2 of 3)

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

**Hospital**

Select applicable level of care

**Hospital as defined in 42 CFR §440.10**

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

**Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

**Nursing Facility**

Select applicable level of care

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

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

Individuals requiring a skilled level of care are not eligible for the ARChoices program. The State's definition of "skilled level of care" is set forth below at b-6-d.

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

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

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

## 1. Request Information (3 of 3)

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I  
Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates (check each that applies):**

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

**§1915(b)(2) (central broker)**

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

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

**A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

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

Specify the program:

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

## **2. Brief Waiver Description**

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

The purpose of the ARChoices in Homecare (ARChoices) waiver is to offer cost-effective, person-centered home and community-based services as an alternative to nursing home placement to persons aged 21 to 64 years of age with a physical disability or 65 and older who require an intermediate level of care in a nursing facility and who do not require a skilled level of care, as defined by State administrative rule which is set forth in B-6-d. Through person-centered service plans managed by State-employed registered nurses (RN), the waiver maintains Medicaid-eligible participants at home, promotes dignity, autonomy, privacy, and safety, fosters community inclusion, and precludes or postpones institutionalization of the participant.

ARChoices is administered by two state operating agencies, the Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of Provider Services and Quality Assurance (DPSQA). DAABHS and DPSQA operate under the authority of the Division of Medical Services (DMS), the Medicaid Agency. DAABHS, DPSQA, and DMS are all under the umbrella of the Arkansas Department of Human Services (DHS). DMS is responsible for all policy decisions concerning the waiver, promulgation of provider manuals and regulations governing the waiver, reimbursement of certified waiver providers, and oversight of all waiver-related functions delegated to DAABHS and DPSQA. DAABHS is responsible for the day-to-day administration of the waiver, establishing waiver program policies and procedures, and overseeing the development and management of person-centered service plans, among other functions. DPSQA, through its Office of Long Term Care (OLTC), is responsible for the final determination of level of care. DPSQA is also responsible for provider certification, licensure for ARChoices services such as adult day care and adult day healthcare, compliance, and provider quality assurance. DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the Arkansas Independent Assessment (ARIA) system.

Functional eligibility for the waiver is determined using assessments and reassessments performed by the State's Independent Assessment Contractor using a new electronic instrument, the Arkansas Independent Assessment (ARIA) system and the contractor's team of registered nurses. The assessment is sent to the Office of Long-Term Care (OLTC) in the Division of Provider Services and Quality Assurance (DPSQA) to determine if the applicant's functional need is at the nursing home level of care. If an applicant is determined both financially and functionally eligible, the DHS county office approves the application.

Services are provided according to individualized person-centered service plans that are developed and authorized by DHS RNs. Service needs are assessed by the Independent Assessment Contractor using the ARIA instrument. Participants' preferences, goals, desired outcomes, and risk factors are assessed by the DHS RN. ARChoices services include Attendant Care, Adult Day Services, Adult Day Health Services, Home-Delivered Meals, Personal Emergency Response System (PERS), Environmental Accessibility Adaptations/Adaptive Equipment, Prevocational Services, and Respite Care (in-home & facility-based).

Each ARChoices person-centered service plan includes the Individual Services Budget (ISB) amount applicable to the participant and determined prospectively by population groupings using the methodology and population-specific factors specified in Appendix C-4(a). The total cost of all authorized services (other than environmental modifications/adaptive equipment) in any ARChoices person-centered service plan (including provisional plans) may not exceed the participant's ISB amount applicable to the time period covered by the service plan.

Both the person-centered service plan and the ISB are informed by the tier level assigned by the ARIA instrument to the participant. The tier level is based on the individual's functional needs as determined during the ARIA-based assessment process.

### 3. Components of the Waiver Request

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

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

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

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

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

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

**Yes. This waiver provides participant direction opportunities.** Appendix E is required.

**No. This waiver does not provide participant direction opportunities.** Appendix E is not required.

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

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

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

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

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

#### 4. Waiver(s) Requested

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

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

**Not Applicable**

**No**

**Yes**

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

**No**

**Yes**

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

**Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

**Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in Appendix E available only to individuals who reside in the

following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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



- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

**I. Public Input.** Describe how the State secures public input into the development of the waiver:

Policy and form revisions, procedural changes and clarifications are based on input from participants, family and providers. Comments are reviewed and appropriate action taken to incorporate changes or modifications to benefit the participant, service delivery and quality of care. Comments and public input are gathered through routine monitoring of program requirements, provider workshops/trainings, program integrity audits, and monitoring of participants and contact with stakeholders. These experiences and lessons learned are applied to the operations of ARChoices.

Updates and revisions to the waiver are posted on the DMS website to allow for a general public comment period of at least 30 days. Notices of updates or revisions are also published in a statewide newspaper to allow for public review and comment. Regulations, policies, rules and procedures are promulgated in accordance with the Arkansas Administrative Procedure Act. Promulgation includes review by two Arkansas legislative committees, which are open to the public and may include public testimony. After legislative review, the regulations, policies, rules and procedures are adopted and incorporated into the appropriate document. All provider manuals containing program rules are available to providers and the general public via the DMS website.

The agency first conducted five public meetings in the summer to outline the reforms being considered for the waiver amendments: Jonesboro (6/4/18); Fort Smith (6/6/18); Monticello (6/8/18); Hope (6/11/18); and Little Rock (6/14/18). The public notice was published in the statewide newspaper Arkansas Democrat Gazette on October 14-16, 2018. The comment period ended November 12, 2018. The entire waiver application was published for comment. Physical copies of the proposed waiver amendments were mailed to constituents upon request. A copy was also published on the state's Medicaid website at this link: <https://www.medicaid.state.ar.us/general/comment/comment.aspx>

The agency conducted five public hearings during the public comment period in different parts of the state: Fort Smith (10/15/18); Monticello (10/18/18); Hope (10/22/18); Little Rock (10/29/18); and Jonesboro (11/7/18). At each public comment hearing, members of the public were invited to provide oral and/or written comments regarding the proposed waiver amendments. A court reporter was provided at each location to transcribe the entire hearing and all comments received. The agency provided sign-in sheets for attendees who chose to register their attendance.

#### Summary of Public Comments and Responses

During the public comment period for the ARChoices in Homecare waiver, Arkansas DHS received comments from consumer groups, providers, advocacy groups, and other stakeholders. Comments were provided through physical letters mailed/delivered to the agency; e-mails; telephone voicemails; and oral statements at public hearings. Comments included:

Comment: The most common comment was a form e-mail publicized by an advocacy group expressing opposition to Medicaid "cuts" generally, and concern for a lack of transparency in the development of the proposed amendment, and for "inadequate data" and "incorrect assumptions" in the actuarial studies supporting proposed rate changes.

Response: DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. DHS has conducted a total of 10 regional public meetings concerning these changes and two publicly-available webinars, in addition to meeting with both provider and consumer stakeholder groups to explain the changes and gather input. The comments fail to specify what data or assumptions are supposedly inaccurate, and rate studies were prepared by nationally-recognized actuaries.

Comment: The second most common comment was an objection to a proposal to restrict the ability of a beneficiary's family members and roommates to serve as a paid agency caregiver for that beneficiary. Several of the comments provided specific data illustrating that a significant number of paid caregivers are related to the beneficiaries they serve, and provider express particular concern that this restriction would create significant barriers to access to care for beneficiaries in rural areas.

Response: In light of the data provided in comments, DHS agrees that this proposal could unnecessarily restrict access to care. DHS has removed this proposal from the waiver amendment.

Comment: The third most common comment was an objection to Medicaid "cuts" generally.

Response: DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require.

Two additional comments and responses are contained in Main Section B, "Additional Needed Information (Optional)."

**J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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

Last Name:

Mills

First Name:

Dave

Title:

Business Operations Manager, Office of Policy Coordination & Promulgation

Agency:

Arkansas Department of Human Services

Address:

P. O. Box 1437, Slot S-295

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 320-6306 Ext:  TTY

**Fax:**

(501) 404-4619

**E-mail:**

dave.mills@dhs.arkansas.gov

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

**Last Name:**

White

**First Name:**

Mark

**Title:**

Deputy Director

**Agency:**

Arkansas Dept. of Human Services, Division of Aging, Adult, and Behavioral Health Services

**Address:**

P. O. Box 1437, Slot S-530

**Address 2:**

**City:**

Little Rock

**State:**

Arkansas

**Zip:**

72203-1437

**Phone:**

(501) 320-6009 Ext:  TTY

**Fax:**

(501) 682-8155

**E-mail:**

mark.white@dhs.arkansas.gov

## 8. Authorizing Signature

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

**Signature:**

Mark White

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State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Arkansas**

Zip:

Phone:  Ext:  TTY

Fax:

E-mail:

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**Attachments**

**Attachment #1: Transition Plan**

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

**Replacing an approved waiver with this waiver.**

**Combining waivers.**

**Splitting one waiver into two waivers.**

**Eliminating a service.**

**Adding or decreasing an individual cost limit pertaining to eligibility.**

**Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

**Reducing the unduplicated count of participants (Factor C).**

**Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

**Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

**Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

(Please refer to Section Main (B), "Additional Needed Information (Optional)", for the full Transition Plan, as it is too long for this text box in the waiver portal.)

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

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

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

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

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

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

**Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

Additional Information from Main Section 6(I) regarding public input:

Comment: A smaller number of commenters objected to the proposed Arkansas Medicaid Task and Hour Standards, stating that the standards are too rigid. Others expressed similar objections but also compared the Task and Hour Standards with the Resource Utilization Group (RUG) methodology used in the current waiver for allocation of attendant care hours. These commenters expressed concern that "computer algorithms" are insufficient to accurately measure the needs of an individual beneficiary.

Response: DHS believes many of these comments are based in misunderstandings and misinterpretations of the structure and intent of the proposed Task and Hour Standards. DHS has revised the language in the proposed billing manuals to clarify that the time limits contained in the Task and Hour Standards are aggregate weekly/monthly limits, and not limitations on the time for performance of each instance of a specific task. The proposed Task and Hour Standards provide flexibility so that the Person-Centered Service Plan and its allocation of care hours can be uniquely tailored to the specific needs of each beneficiary. The proposed rules include opportunities for exceptions, with justification and supervisory approval, to address exceptional situations. Unlike the RUGs currently in use, the Task and Hour Standards are not a computer algorithm that assigns hours based on broad population categories; rather, the Standards focus on the specific functional needs of the individual beneficiary.

Comment: Some providers objected to the use of an outside contractor for the administration of the initial Independent Assessment. These commenters noted delays and problems encountered with this contractor in other programs outside of the waiver.

Response: The contractor selected by DHS has now performed more than 50,000 independent assessments (IAs) in Arkansas in other Medicaid populations. The results have supported the accuracy and validity of the IA system. Independent assessments are a federal requirement for Medicaid waivers for home and community-based services. DHS is working to improve its internal processes in handling IA referrals and will continue to implement changes to improve the reliability of those processes.

Additional Information from Main Section A regarding Transition Plan for the Waiver:

Transition Plan for the Waiver

Similarities and differences between the services covered in the approved waiver and those covered in the amended waiver:

All types of services covered in the approved waiver continue to be covered in the amended waiver, except as follows:

1. The amended waiver adds a new Prevocational Services benefit for persons with physical disabilities who wish to join the general workforce. Prevocational Services are a range of learning and experiential type activities to help prepare a participant for paid employment or self-employment in the community.
2. The amended waiver eliminates Adult Family Home Services, which is not used by any waiver participants and obsolete.

When services in the approved waiver will not be offered in the new or renewed/amended waiver or will be offered in lesser amount, how the health and welfare of persons who receive services through the approved waiver will be assured:

No type of service covered by the approved waiver and received by any current participant is discontinued under the amended waiver.

The amended waiver modifies the scope of attendant care services to align with Instrumental Activity of Daily Living (IADL) tasks covered for adults under the State Plan personal care services benefit and the self-directed personal assistance program (Independent Choices). The modifications will also support the new assessment system and waiver administration, effectively use the capabilities of the new assessment tool, reduce duplication and inappropriate service substitutions, reduce a risk of abuse of beneficiary personal finances, and reduce other program integrity risks. Specially, three IADL tasks not covered under the under the State Plan personal care services benefit are eliminated from the ARChoices attendant care scope of services (i.e.,



managing basic personal finances, communication with others, and traveling).

By definition, all IADLs, whether or not assistance is covered, are not necessary for fundamental functioning. Human assistance with medically necessary ADLs (such as toileting and mobility and ambulating) remain covered both in the home setting and outside the home when a waiver participant wishes to participate in community activities or attend religious services and needs such assistance at those venues. Non-emergency medical transportation is already a covered service. Management of a participant's personal finances should be performed by either the participant themselves if able or by a properly delegated and qualified family member or professional. Management of finances by attendants presents risks for abuse and oversight is extremely difficult. With modern communications technology, communication with others is far more readily available and, where assistance is needed, it is incidental to time covered for other covered services or tasks. Finally, under the current ArPath assessment system replaced in this waiver amendment and ArPath use of RUGs-based hours calculations, time for these three IADL tasks was rarely explicitly covered, identified, or quantified or otherwise supported by the RUGs-determined hours per the assessment results, and/or in approved in service plans. Therefore, these reforms to the IADL-related portion of the attendant care service description are not expected to adversely affect participant health and welfare.

The amended waiver includes policy reforms to improve program integrity, better ensure cost-effectiveness, support fiscal sustainability, and provide transparency of the actual costs of waiver services. Specifically, these reforms are:

1. **Program Integrity Reforms:** The service definitions and service limitations to the amount, duration, and frequency of Attendant Care Services and Respite Care Services are clarified and improved to reduce overuse, misuse, and duplication of services; ensure only medically necessary services are covered; and better ensure waiver services do not inappropriately supplant other services available to the participant (such as family supports, Medicare covered services, and targeted or supplemental services offered by a participant's Medicare Advantage plan).
2. **Prospective Individual Services Budget:** The Individual Services Budget (ISB), a prospectively determined dollar limit on the amount of all waiver services that may be authorized in a service plan over and above any limits on amount, duration, and frequency that apply to individual waiver services. (Please note that the Individual Services Budget applies post-eligibility and is not an "individual cost limit pertaining to eligibility" as defined in CMS guidance.)

In individual cases and as part of the person-centered service planning process, these reforms may result in a lesser amount of authorized waiver services than may have been authorized previously in the participant's most recent service plan under the approved (original) waiver. Through a range of policies and safeguards, the state will assure the health and welfare of persons who now receive services through the approved waiver but for whom services may be offered in a lesser amount under the amended waiver. These include:

1. The registered nurses who develop the person-centered service plans have a reasonable degree of professional discretion to adjust the amount, duration, and frequency of Attendant Care Services and Respite Care Services to meet individual needs and circumstances. The amended waiver itself covers other services that may be adjusted, as appropriate.
2. Waiver eligibility also provides participants with access to a broad mix of services covered under the Arkansas Medicaid State Plan, including personal care, durable medical equipment, and targeted case management.
3. After considering the participant's assessed needs, priorities, preferences, goals, and risk factors, if services authorized in the individual's person-centered service plan are not sufficient to meet their needs, the registered nurse will make referrals to appropriate services available through the Medicaid State Plan or another waiver program, Medicare, the participant's Medicare Advantage plan or Medicare prescription drug plan, and other federal, state, or community programs.
4. In the event the waiver services authorized for the participant within the limit of the applicable Individual Services Budget amount, Medicaid State Plan services, other waiver services, Medicare-covered services, and other available family and community supports, when taken together, are insufficient to meet the participant's needs, the DAABHS registered nurse will counsel the participant on Medicaid-covered services in other settings that are available to meet their needs (e.g., nursing facility services and assisted living facility services) and make appropriate referrals. The nurse may also order a re-assessment of the participant.

5. In the event that a participant's Individual Services Budget (ISB) amount requires limitations to waiver services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, the participant will be given the opportunity during the person-centered service plan process to choose a different mix, type, or amount of waiver covered services. (For example, the participant could decide to forego a day of adult day health services to have additional attendant care hours.)
6. As detailed in the amended waiver (appendix C-4), the prospective Individual Services Budget amounts are determined using population-based factors.
7. Participants may request an exception to their Individual Services Budget amount. A panel of registered nurses will review exception requests to determine if an adjustment is necessary due to unusual, exceptional circumstances. Approved exceptions will be in the form of a temporary increase in the participant's Individual Services Budget amount for a period not to exceed one year.
8. Further, the revised service definitions and service limitations for Attendant Care Services and Respite Care Services are written to ensure that services authorized and received are reasonable and medically necessary, consistent with the participant's needs and risks as determined through the independent assessment, not duplicative, and exclude coverage of services unrelated or contrary to the participant's health and welfare. This includes nurse review and approval of the number of service hours for tasks according to published medical necessity guidelines (Task and Hour Standards). The overuse, misuse, abuse, or duplication of a covered service do not support a person's health and welfare. The receipt of medically unnecessary services does not serve the health and welfare of participants and in fact may adversely affect a beneficiary's health and welfare. Therefore, by design, the application of these new policies will serve to further protect participant health and welfare by ensuring that service scopes and amounts, durations, and frequencies of services under the amended waiver are sufficient, reasonably flexible to meet differences in participants' assessed needs, and exclude medically unnecessary activities and quantities.

A large proportion of waiver participants are also Medicare enrollees. Whenever possible, dual eligible beneficiaries should access and receive Medicare-covered, medically necessary services and supports rather than relying upon substitute or alternative Medicaid State Plan or waiver-based services. This objective is consistent with Medicare beneficiary rights and Medicaid's status as secondary payor and is essential for Medicaid program integrity and fiscal sustainability. Therefore, it is important to note recent significant policy changes easing or expanding the availability of home-based services and supports through the federal Medicare home health benefit and new Medicare Advantage plan supplemental benefits for persons with chronic conditions.

Broader Medicare home health nursing, home health aide, and therapy services coverage as a result of the Jimmo v. Sebelius settlement and associated CMS policy clarifications in 2013-2017 is expected to eliminate longstanding impediments to beneficiaries receiving these Medicare-reimbursed services. Under the Bipartisan Budget Act of 2018 (BBA 2018), Medicare's documentation requirements for home health eligibility were simplified, reducing a significant obstacle for home health agencies to receive coverage approvals for their patients (BBA 2018 section 51002). In both instances, prior policies tended to restrict access to Medicare-covered services, forcing many providers and their patients nationwide to seek coverage through Medicaid and Medicaid HCBS waiver programs instead. For waiver participants who are dual eligibles, these positive policy changes should improve their ability to access, when medically necessary, Medicare-covered nursing visits and Medicare home health aide assistance with ADL tasks like bathing, dressing, and toileting.

Further, starting in CY 2019, Medicare Advantage (MA) health plans (including MA Special Needs Plans for dual eligibles) may offer supplemental services not otherwise covered under regular Medicare Part A or Part B benefits and at no additional cost to plan enrollees. These targeted or supplemental benefits may include a wide range of non-medical, in-home services or supports. They must be designed to improve or maintain the health or overall functioning of beneficiaries with chronic conditions. This new supplemental benefit option in Medicare Advantage (Medicare Part C) is through the Medicare Advantage Value-Based Insurance Design demonstration (expanding nationwide as required under BBA 2018 section 50321), the new expanded benefit option for chronically ill enrollees created by BBA 2018 section 50322 (42 U.S.C. 1395w-22(a)(3)(D)), and CMS final rules promulgated on April 2, 2018 (CMS-4182-F). Medicare Advantage plans will vary in how they choose to use this increased flexibility and Medicare Part C enrollment is voluntary. However, many waiver participants may have access to "Medicaid-like"

supportive services offered through their MA plan or one or more of the competing MA plans available to them in Arkansas.

How persons served in the existing waiver are eligible to participate in the amended waiver:

Individuals served in the existing waiver may continue to participate in this HCBS program under the amended waiver, provided they (1) continue to meet financial eligibility and (2) meet the functional level of care criteria for the program as defined in the state rule and determined following their reassessment under the new Arkansas Independent Assessment (ARIA) process.

The level of care criteria for waiver and nursing facility services are established by state rule and are unchanged. The amended waiver includes a clarification that under the existing functional level of care criteria that persons requiring skilled care (as defined in the state rule) are not eligible for the waiver. This re-states existing policy and is incorporated in the assessment and eligibility determination processes.

The approved waiver provides for assessments using the ArPath system, which is based primarily on the interRAI instrument. The ArPath system includes two algorithms that gather necessary information to ascertain whether an applicant or participant needs the state's level of care criteria related to Alzheimer's or related dementia (Cognitive Performance Scale) and daily skilled monitoring of a life-threatening medical condition (Changes in Health, End-Stage Disease and Symptoms and Signs [CHESS]). Under the new Arkansas Independent Assessment (ARIA) system, the necessary information for these criteria are built into the ARIA instrument. Assessment instruments involve a complex array of questions asked by registered nurses during the face-to-face evaluation meetings with applicants and participants. As with the implementation of any new assessment instrument and routinely in the course of each assessment or re-assessment, new or additional information directly relevant to level of care criteria, and therefore a person's functional / non-financial eligibility, may be received.

How new limitations on the amount of waiver services in amended waivers will be implemented:

Before implementation of the amended waiver, the state will promulgate the new/revised provider manual. In Arkansas, manual promulgation includes a public comment period and legislative committee review. Also, the state will provide for a series of regional training sessions and webinars for providers and other stakeholders.

All new policies about person-centered service planning, including authorization of services and the prospective Individual Services Budgets, will be phased in and applied to existing participants as their existing person-centered service plans are renewed, updated, or otherwise revised for a new period (up to one year). Similarly, re-assessments of existing participants will be performed through the new independent assessment process on a revolving basis as previously approved person-centered service plans near expiration or earlier if appropriate (such as in the event of care transitions).

All new policies about provider service delivery practices and program integrity, including service definitions and limits to eliminate or reduce overuse, misuse, abuse, and duplication of waiver services, are reasonable and necessary to protect program integrity and better ensure provision of covered, medically necessary services appropriate to meet assessed needs. Therefore, these policies will go into effect with the amended waiver.

Specifically, any services authorized under a person-centered service plan in effect on the effective date of the amended waiver and promulgated provider manual must comply with the service definitions and limitations in the amended waiver. For example, providers must adhere to new service definitions and limitations concerning the types of activities that are covered under attendant care and respite care. The quantity of services authorized for a participant may not exceed that specified in the participant's prevailing, approved person-centered service plan. Where the amended waiver establishes new policies affecting quantities, these will apply as new person-centered service plans are created and following an assessment/re-assessment. However, providers must comply with all non-quantity limitations, such as the amended waiver's more precise definitions of covered tasks and the policy excluding coverage of attendant care visits for entertainment activities.

The prevocational services benefit, by being new, will not negatively affect any participant and therefore requires no transition for existing participants.

No participants use the adult family home service proposed for elimination. We expect no requests for it before the effective

date of the amended waiver. Therefore, no transition is needed for this service elimination.

If persons served in approved waiver will not be eligible to participate in the new or renewed/amended waiver, the plan describes the steps that the state will take to facilitate the transition of affected individuals to alternate services and supports that will enable the individual to remain in the community:

The amended waiver makes no changes to waiver eligibility policy other than a technical change to Section 1.F, Levels of Care, to clarify that individuals requiring a skilled level of care are not eligible for the ARChoices program. This clarification aligns Section 1.F with the current Brief Waiver Description, which states that the waiver eligibility is limited to “persons aged 21 to 64 years of age with a physical disability, or 65 and older who require an intermediate level of care in a nursing facility.” The new assessment process and instrument and eligibility determination process are based on the existing level of care criteria established in state regulations.

In the event that a person in the approved waiver is, for whatever reason, not eligible for the amended waiver, they will be referred to other, alternative services, including, as appropriate, other waivers, Medicaid State Plan services, Medicare services, and community services.

Includes the timetable for transitioning individuals to the new waiver (i.e., will participants in the existing waiver transition to the new waiver all at the same time or will the transition be phased in?).

As described above, existing participants will be transitioned to the amended waiver on revolving basis according to the expiration date of their current person-centered service plan and timing of their next re-assessment. Existing participants requiring earlier-than-planned re-assessments as a result of care transitions or other life changes will be phased into the amended waiver during that re-assessment and new service plan.

How participants are notified of the changes and informed of the opportunity to request a Fair Hearing:

Participants may request a Fair Hearing concerning eligibility determinations, person-centered service plans, and Individual Services Budgets.

Current notification processes, including letters with information on how to request a Fair Hearing, will continue, with information updated as necessary.

DAABHS will inform participants of their prospective Individual Services Budget amounts as described in Appendix C-4.

Relevant beneficiary materials will be updated to describe policy changes.

Additional public and stakeholder notification are achieved through the state’s formal public comment and promulgation process for the waiver program manual.

## Appendix A: Waiver Administration and Operation

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

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

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

**The Medical Assistance Unit.**

Specify the unit name:

*(Do not complete item A-2)*

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

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

*(Complete item A-2-a).*

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

Specify the division/unit name:

Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS) and Division of Provider Services and Quality Assurance (DPSQA)

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

## **Appendix A: Waiver Administration and Operation**

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### **2. Oversight of Performance.**

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

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

The Arkansas Department of Human Services (DHS) uses an Interagency Agreement to define the responsibilities of the three DHS divisions – Division of Medical Services (DMS, the Medicaid agency) DAABHS, and DPSQA – charged with responsibility for administering both the ARChoices in Homecare (ARChoices) and Living Choices in Assisted Living (Living Choices) HCBS waiver programs. This agreement is reviewed annually and updated as needed. DMS, as the Medicaid agency, monitors this agreement on a continuous basis to assure that the provisions specified are executed.

DMS is responsible for all policy decisions concerning the waiver, promulgation of provider manuals and regulations governing the waiver, reimbursement of certified waiver providers, and oversight of all waiver-related functions delegated to DAABHS and DPSQA, including monitoring compliance with the Interagency Agreement.

DAABHS is responsible for the day-to-day administration of the waiver, establishing waiver program policies and procedures, overseeing the development and management of person-centered service plans, developing Individual Services Budgets, and overseeing the Independent Assessment Contractor.

DPSQA is responsible for provider certification, compliance, and provider quality assurance. Through its Office of Long Term Care (OLTC), DPSQA is responsible for level of care determinations. DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the Arkansas Independent Assessment (ARIA) system.

To oversee and monitor the functions performed by DAABHS and DPSQA in the administration and operation of the waiver, DMS will conduct team meetings as needed with DAABHS and DPSQA staff to discuss compliance with the performance measures in the programs, results of chart reviews performed by DMS and DAABHS, corrective action plans, remediation, and systems improvements to maintain effective administration of the programs.

## Appendix A: Waiver Administration and Operation

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

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

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

A contractor (“Independent Assessment Contractor”) will perform independent assessments that gather functional need information about each ARChoices waiver applicant and participant using the Arkansas Independent Assessment (ARIA) instrument. The information gathered is used to determine the individual’s level of care, the number of medically necessary hours of attendant care, and the tier level (which is intended to help inform waiver program oversight and administration and person-centered service planning).

**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

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**4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.



Check each that applies:

**Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

## Appendix A: Waiver Administration and Operation

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

As described in the Interagency Agreement between the Division of Medical Services (DMS, the Medicaid agency), the Division of Aging, Adult, and Behavioral Health Services (DAABHS), and the Division of Provider Services and Quality Assurance (DPSQA), DAABHS and DMS will jointly share responsibility for oversight of the performance of the Independent Assessment Contractor, with DMS being ultimately accountable. The contract provides for performance measures the Independent Assessment Contractor is required to meet.

## Appendix A: Waiver Administration and Operation

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

The state assesses the performance of the Independent Assessment Contractor on a monthly and annual basis through review and assessment of the monthly and annual Program Performance Reports submitted by the Independent Assessment Contractor to the Contract Monitor. The state's contract with the Independent Assessment Contractor includes performance standards and requirements for a quality monitoring and assurance program.

The Independent Assessment Contractor's quality monitoring and assurance process must include (1) the staff necessary to perform quality monitoring and assurance reviews for accuracy, data consistency, integrity, and completeness of assessments and (2) procedures for assessing the performance of the staff conducting the assessments, include a desk review of assessments, tier determinations, and recommended attendant care services hours according to the Task and Hour Standards for a statistically significant number of cases. The Independent Assessment Contractor is required to include the results of the quality monitoring and assurance process in the monthly reports submitted to the Contract Monitor in the format required by DHS.

The monthly reports include the following:

1. Demographics about the beneficiaries who were assessed;
2. An activities summary, including the volume, timeliness and outcomes of all Assessments and Reassessments; and
3. A running total of the activities completed.

The annual report includes the following:

1. A summary of the activities over the prior year;
2. A summary of the Independent Assessment Contractor's timeliness in scheduling and performing assessments and reassessments;
3. A summary of findings from Beneficiary feedback research conducted by the Independent Assessment Contractor;
4. A summary of any challenges and risks perceived by the Independent Assessment Contractor in the year ahead and how the Independent Assessment Contractor proposes to manage or mitigate those; and
5. Recommendations for improving the efficiency and quality of the services performed.

The Contract Monitor and senior staff from DAABHS and DMS review the monthly and annual reports submitted by the Independent Assessment Contractor within 15 days after they have been submitted, and determine whether the Independent Assessment Contractor has submitted the required information, following its quality monitoring and assurance process, and meeting the performance standards in the contract. If not, the state will initiate appropriate corrective and preventive actions, which may include, for example, further analysis and problem solving with the contractor, root cause analysis to identify the cause of a discrepancy or deviation, enhanced reporting and monitoring, improved performance measures, requiring development and execution of corrective action plans, reallocation of staff resources, data and systems improvements, consultation with stakeholders, and/or sanctions under the contract.

## Appendix A: Waiver Administration and Operation

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**7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*



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

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

#### a. Methods for Discovery: Administrative Authority

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

#### i. Performance Measures

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

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

*Where possible, include numerator/denominator.*

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

**Performance Measure:**

**Number and percent of participants with delivery of at least one waiver service per month as specified in the service plan in accordance with the agreement with the Medicaid Agency. Numerator: Number of participants with at least one service per month; Denominator: Number of participants served**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**No Waiver Service Report**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number of active participants and number of unduplicated participants served within approved limits specified in the approved waiver. Numerator: Number of active and unduplicated participants served within approved limits; Denominator: Number of active/unduplicated participants**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MMIS**

<b>Responsible Party for data collection/generation(check each that applies):</b>	<b>Frequency of data collection/generation(check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>

<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**ACES Report of Active Cases (Point in Time)**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text" value="Division of County Operations"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and</b>	<b>Other</b>

	<b>Ongoing</b>	Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**Performance Measure:**

**Number and percent of policies and/or procedures developed by DAABHS, in consultation with DPSQA, that are reviewed and approved by the Medicaid Agency (DMS) prior to implementation. Numerator: Number of policies and procedures by DAABHS reviewed by DMS before implementation; Denominator: Number of policies and procedures developed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**PDQA Request Forms**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other Specify:</b> <input type="text"/>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of waiver claims paid correctly on the same date of service as institutional services as specified in the waiver application. Numerator: Number of claims paid correctly; Denominator: Number of claims**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Overlapping Services Report or similar data preferred by Operating Agency and approved by Medicaid Agency**

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

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

DMS completes a validation review of participant records reviewed by DAABHS. For the validation review, DMS reviews 20% of the records reviewed by DAABHS. For the provider file sample, the Raosoft online calculator is used to determine a statistically valid sample size with a 95% confidence level and a margin of error of +/- 5%. Every nth name is selected for review until the sample size is reached. The sample is then divided into twelve groups for monthly review by DMS.

**b. Methods for Remediation/Fixing Individual Problems**

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



The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency), and the Division of Medical Services (DMS) (Medicaid agency) participate in team meetings as needed to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement for measures related to administrative authority of the waiver.

In cases where the numbers of unduplicated participants served in the waiver are not within approved limits, remediation includes waiver amendments and implementing waiting lists. DMS reviews and approves all policies and procedures (including waiver amendments) developed by DAABHS prior to implementation, as part of the Interagency Agreement. In cases where policies or procedures were not reviewed and approved by DMS, remediation includes DMS reviewing the policy upon discovery, and approving or removing the policy.

In cases where there are problems with level of care determinations completed within specified time frames and by a qualified evaluator, additional staff training, staff counseling or disciplinary action may be part of remediation. In addition, if these problems arise, the LOC determination is completed upon discovery, the LOC determination may be redone and payments for services may be recouped. Similarly, remediation for service plans not completed in specified time frames includes, completing the service plan upon discovery, additional training for staff, staff counseling or disciplinary action. DAABHS conducts all remediation efforts in these areas.

Remediation to address participants not receiving at least one waiver service a month in accordance with the service plan and the agreement with DMS includes closing a case, conducting monitoring visits, revising a service plan to add a service, checking on provider billing and providing training.

Remediation associated with provider certifications that are not current according to the DAABHS/DPSQA/DMS agreement may include recertifying providers upon discovery if appropriate, requesting termination of the provider's Arkansas Medicaid enrollment, referral to the Office of Medicaid Inspector General for possible recoupment for services provided after certification expired, or allowing the participant to choose another provider. DAABHS conducts remediation efforts in these areas.

The tool used for record review documents and tracks remediation.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):

**c. Timelines**

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

**No**

**Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix B: Participant Access and Eligibility**

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<b>Aged or Disabled, or Both - General</b>					
		Aged	65		
		Disabled (Physical)	21	64	
		Disabled (Other)			
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
<b>Intellectual Disability or Developmental Disability, or Both</b>					
		Autism			
		Developmental Disability			
		Intellectual Disability			
<b>Mental Illness</b>					
		Mental Illness			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

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

Not Applicable. The State does not further specify its target group.

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

**Not applicable. There is no maximum age limit**

**The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

The participant who ages out in the Disabled (Physical) target subgroup at age 65 automatically remains in the waiver under the Aged target subgroup.

## Appendix B: Participant Access and Eligibility

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

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

**No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

**Other**

*Specify:*

**Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services

furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

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

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

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

**The following dollar amount:**

Specify dollar amount:

**The dollar amount (select one)**

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

Specify the formula:

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

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

Specify percent:

**Other:**

*Specify:*

---

## Appendix B: Participant Access and Eligibility

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

---

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

---

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

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

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

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

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

**Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

**Table: B-3-a**

Waiver Year	Unduplicated Number of Participants
Year 1	11350
Year 2	11350
Year 3	11350
Year 4	11350
Year 5	11350

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

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

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

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

**Table: B-3-b**

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	8032
Year 2	8176
Year 3	8320
Year 4	9071
Year 5	9434

## Appendix B: Participant Access and Eligibility

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

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

**Not applicable. The state does not reserve capacity.**

**The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes
Arkansas Money Follows the Person (MFP) Program

## Appendix B: Participant Access and Eligibility

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

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

Arkansas Money Follows the Person (MFP) Program

**Purpose** (*describe*):

Reserved for individuals transitioning from the nursing facilities to the community via the Arkansas Money Follows the Person (MFP) program. At CMS's recommendation, Arkansas MFP will be intensifying efforts through the end of the program, which is currently scheduled to end September 30, 2016, but there is a possibility for an extension so we are reserving capacity for all 5 years. The reserved slots will ensure that transitioned individuals will have access to more cost-effective services.

**Describe how the amount of reserved capacity was determined:**

The number of MFP participants who have historically transitioned into the waivers which ARChoices in Homecare represents has ranged from 25-36 per year. The 100 slots will allow a substantial buffer to account for the intensified activity level.

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

Waiver Year	Capacity Reserved
Year 1	100
Year 2	100
Year 3	100
Year 4	100
Year 5	100

## Appendix B: Participant Access and Eligibility

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

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

**The waiver is not subject to a phase-in or a phase-out schedule.**

**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

**Waiver capacity is allocated/managed on a statewide basis.**

**Waiver capacity is allocated to local/regional non-state entities.**

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

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

The ARChoices waiver provides for the entrance of all eligible persons on a first-come, first-served basis, once individuals meet all functional and financial eligibility requirements.

However, once all waiver slots are filled, a waiting list will be implemented for this program and the following process will apply. Each ARChoices application will be accepted and eligibility will be determined. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services; that all waiver slots are filled; and that the applicant is number \_ in line for an available slot. It is not permissible to deny any eligible person based on the unavailability of a slot in the ARChoices program.

Entry to the waiver will then be prioritized based on the following criteria:

- a) Waiver application determination date for persons inadvertently omitted from the waiver waiting list (administrative error);
- b) Waiver application determination date for persons residing in a nursing facility and being discharged after a 90 day stay; waiver application determination date for persons residing in an approved Level II Assisted Living facility for the past six months or longer;
- c) Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);
- d) Waiver application determination date for all other persons.

## Appendix B: Participant Access and Eligibility

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

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

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## Appendix B: Participant Access and Eligibility

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### B-4: Eligibility Groups Served in the Waiver

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

**§1634 State**

**SSI Criteria State**

**209(b) State**

- 2. Miller Trust State.**

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

**No**

**Yes**

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

---

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

---

**Low income families with children as provided in §1931 of the Act**

**SSI recipients**

**Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

**Optional State supplement recipients**

**Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one:*



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

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

Specify percentage:

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

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

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

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

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

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

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

*Specify:*

---

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

---

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

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

*Select one and complete Appendix B-5.*

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

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

*Check each that applies:*

**A special income level equal to:**

*Select one:*

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

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

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

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

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

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

**Use spousal post-eligibility rules under §1924 of the Act.**

*(Complete Item B-5-b (SSI State) and Item B-5-d)*

**Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

**Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-**

**eligibility rules for individuals with a community spouse.**  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (2 of 7)

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

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

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

---

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

---

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

*Select one:*

**SSI standard**

**Optional State supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

*(select one):*

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

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

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

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the State Plan**

*Specify:*

**The following dollar amount**

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

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

*Specify:*

**Other**

*Specify:*

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

---

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

---

**Not Applicable**

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

*Specify:*

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

**SSI standard**

**Optional State supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

---

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

---

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

**Other**

*Specify:*

---

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

---

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

Select one:

**Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

**The State does not establish reasonable limits.**

**The State establishes the following reasonable limits**

*Specify:*

---

## Appendix B: Participant Access and Eligibility

---

### B-5: Post-Eligibility Treatment of Income (3 of 7)

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

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

---

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

---

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (4 of 7)

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

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

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

below).

**i. Allowance for the personal needs of the waiver participant**

*(select one):*

**SSI standard**

**Optional State supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

**A percentage of the Federal poverty level**

Specify percentage:

**The following dollar amount:**

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

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

*Specify formula:*

**Other**

*Specify:*

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

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

Select one:

**Allowance is the same**

**Allowance is different.**

*Explanation of difference:*

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

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

**The State does not establish reasonable limits.**

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

---

## Appendix B: Participant Access and Eligibility

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

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

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

---

**Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.**

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (6 of 7)

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

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

---

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

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## Appendix B: Participant Access and Eligibility

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

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

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

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

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**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

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## Appendix B: Participant Access and Eligibility

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### B-6: Evaluation/Reevaluation of Level of Care

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

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

**i. Minimum number of services.**

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

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

**The provision of waiver services at least monthly**

**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

**Directly by the Medicaid agency**

**By the operating agency specified in Appendix A**

**By an entity under contract with the Medicaid agency.**

*Specify the entity:*

**Other**

*Specify:*

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

These activities are performed by registered nurses (RNs) licensed by the State of Arkansas under the rules and standards of the State Board of Nursing. Arkansas is a participant in the multi-state Nurse Licensure Compact.

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



Level of Care Criteria: The functional level of care criteria for ARChoices in Homecare waiver eligibility are established in administrative rules and the ARChoices manual, as promulgated by the Arkansas Department of Human Services (DHS). Please see DHS rule 016.06 CARR 057 (2017) (Procedures for Determination of Medical Need for Nursing Home Services).

As specified in the rule, to meet functional (non-financial) eligibility for the waiver program an individual must:

1. Fully meet at least one of the following three level of care criteria:

a. The individual is unable to perform either of the following:

A. At least one (1) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or,

B. At least two (2) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without limited assistance from another person; or,

b. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,

c. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening; and

2. Not require a skilled level of care, as defined in the State rule. The State rule defines "Skilled Level of Care" to mean the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount:

a. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure;

b. Intravenous injections and hypodermoclysis or intravenous feedings;

c. Levin tubes and nasogastric tubes;

d. Nasopharyngeal and tracheostomy aspiration;

e. Application of dressings involving prescription medication and aseptic techniques;

f. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV;

g. Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress;

h. Initial phases of a regimen involving administration of medical gases;

i. Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies that are part of

active treatment, to obtain a specific goal and not as maintenance of existing function;

- j. Ventilator care and maintenance; and
- k. The insertion, removal and maintenance of gastrostomy feeding tubes;

No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition that is temporary and expected to last no more than 21 days.

For administration of this waiver, the term “life-threatening” means the probability of death from the diagnosed medical condition is likely unless the course of the condition is interrupted by medical treatment.

Instrument/Tool Used: Currently, ArPath is the instrument approved for use by registered nurses (RNs) from DHS to collect information used to determine (or re-determine) each applicant’s or participant’s level of care. The ArPath instrument, which is based primarily on the interRAI toolset, was federally approved for use in the current waiver.

Beginning on the effective date of this amended waiver, Arkansas will instead use a new instrument – the Arkansas Independent Assessment (ARIA) – to collect information to evaluate level of care. Registered nurses from the Independent Assessment Contractor will use the ARIA instrument to conduct face-to-face, in-home assessments and reassessments. Using the information collected during the assessment, the Office of Long Term Care in DPSQA will evaluate whether an individual meets the State’s level of care criteria.

All State laws, regulations, and policies concerning level of care criteria and the assessment instrument/tool (including the current ArPath instrument, the new ARIA instrument, the ARChoices waiver program manual, and the ARIA manual) are available to CMS upon request through DAABHS.

Note that the Arkansas Independent Assessment (ARIA) system is also being used to help determine medical necessity and help adjudicate prior authorization requests for State Plan personal care services and IndependentChoices self-directed personal assistance.

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

**The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

**A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

Level of Care Instrument for Institutional Care:

The instrument used to evaluate institutional level of care is form DHS-703 (Evaluation of Medical Need Criteria). The DHS-703 is completed by a registered nurse (RN) and includes information obtained from the participant, family members, caregivers, and others. The DHS-703 was designed based on the minimum data set (MDS) and the State's nursing home admission criteria. It includes the nurse's professional assessment of the participant and observations and evaluation of the participant's ability to perform activities of daily living, along with other relevant information regarding the individual's medical history.

Level of Care Instrument for Waiver Program:

Currently, the instrument used to determine the level of care for the ARChoices program is ArPath, based on the interRAI tool. Following the transition period, the Arkansas Independent Assessment (ARIA) system will be used to support the level of care determination process.

Data needed for determining whether the State's level of care criteria are met are gathered by both instruments. The State's level of care criteria are the same for the waiver and institutional care, with the exception that individuals needing skilled nursing care are excluded from the waiver.

Both the ARIA instrument (as with the current ArPath instrument) and the DHS-703 assess needs, are used by registered nurses, and are person-centered, focusing on the participant's functioning and quality of life. Both are used through independent, conflict-free assessment processes staffed by registered nurses.

The state ensures that ARIA is valid and reliable through multiple stages of testing. The Independent Assessment Contractor conducts its own system testing via automated test scripts as well as business testing to validate outcomes. In addition, the state provides mock assessments for a blinded validation analysis. The mock assessments are designed to test the validity of ARIA-assigned tiers (0, 1, 2, 3) compared to the nursing home level of care criteria for waiver functional eligibility. The mock assessments are uploaded to ARIA and tracked, and the ARIA results are compared to the expected tier levels identified by the state. This testing is single-side blinded so that the Independent Assessment Contractor is not aware of the expected tiers before the tests are run.

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

The new process for evaluating waiver applicants and re-evaluation of waiver program participants for their respective needs for the level of care under the waiver is described below.

Under the new process, each waiver applicant needing an evaluation and each waiver participant needing a re-evaluation will receive an individual assessment performed by the Independent Assessment Contractor. Each assessment or re-assessment is performed by a licensed registered nurse (RN) using the Arkansas Independent Assessment (ARIA) instrument. The ARIA tool will generate a proposed level of care evaluation. The Office of Long Term Care (OLTC) in DPSQA will review the ARIA results and the ARIA-recommended tier level, and make the final level of care determination. Functional need eligibility is valid for one year, unless a shorter period is specified by OLTC.

As described in B-6-e, the Independent Assessment Contractor's RNs will complete the ARIA instrument for each initial evaluation and subsequent re-evaluation, drawing upon information from a face-to-face meeting with the applicant/participant and, if necessary, information from other parties familiar with the individual's conditions, functional limitations, and circumstances.

Re-evaluations will continue to be performed on at least an annual basis, with the level of care re-affirmed or revised and a written determination issued by the Office of Long Term Care. A re-evaluation may also be ordered anytime (or scheduled on a more frequent than annual basis) by the DHS registered nurse responsible for the participant's person-centered service plan, said nurse's supervisor, the DPSQA Office of Long Term Care director (or his/her designee), or the DAABHS deputy director (or his/her designee). In cases where a participant has experienced a significant change in circumstances (e.g., an inpatient hospital admission, skilled nursing facility admission, or the loss of a primary family caregiver), a re-assessment will be performed as appropriate. In the manner specified in the DHS Independent Assessment Manual, a participant (or their legal representative) or the participant's physician may request that the DAABHS deputy director (or his/her designee) order a re-assessment.

The ARIA instrument is a comprehensive tool to collect detailed information to determine an individual's functional eligibility; identify needs, current supports, some of the individual's preferences, and some of the risks associated with home and community-based care for the individual; and inform the development of the person-centered service plan. The ARIA instrument is used to gather information on the applicant's (or participant's in the case of a re-evaluation) demographics; health care providers; current services and supports received (including skilled nursing, therapies, medications, durable medical equipment, and human assistance services), housing and living environment; decision-making and designated representatives; emergency contacts; Activities of Daily Living (ADLs) needs; Instrumental Activities of Daily Living (IADLs) needs; health status (including symptoms, conditions, and diagnoses); psychosocial status (including assessment of behavioral health impairments and risk factors); memory and cognition; mental status; sensory and functional communication skills; self-preservation capabilities and supports; family and other caregiver supports; participation in work, volunteering, or educational activities; and quality of life (including routines, preferences, strengths and accomplishments, and goals for future).

Once ARIA is operational, using assessment results and a DAABHS-approved tiering methodology, the ARIA system will assign tiers designed to help further differentiate individuals by need. Each waiver applicant or participant will be assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment. The tiers are intended to help inform waiver program oversight and administration and person-centered service planning. Once available through ARIA, tier levels will also be a population-based factor in determining participants' prospective individual services budgets. The tiers do not replace the Level of Care criteria described in B-6-d, waiver eligibility determinations, or the person-centered service plan process.

In summary:

1. Tier 0 (zero) and Tier 1 (one) indicate the individual's assessed needs, if any, do not support the need for either ARChoices waiver services or nursing facility services.

2. Tier 2 (two) indicates the individual's assessed needs are consistent with services available through either the ARChoices waiver program or a licensed nursing facility.

3. Tier 3 (three) indicates the individual needs skilled care available through a licensed nursing facility and not through the waiver program.

These indications notwithstanding, the final determination of Level of Care and functional eligibility is made by the Office of Long-Term Care (OLTC).

(Note that ARIA-based assessments are also used to help determine whether Medicaid enrollees meet the minimum ADL needs-based criteria for State Plan coverage of Medicaid personal care services and self-directed personal assistance services. Tier 1 (one) and Tier 2 (two) each indicate that the Medicaid enrollee meets the minimum criteria for personal care or self-directed personal assistance service coverage. Coverage of these State Plan services for Medicaid enrollees is further subject to a medical necessity determination and prior authorization.)

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

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule**

*Specify the other schedule:*

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

**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

**The qualifications are different.**

*Specify the qualifications:*

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

DAABHS has established and maintains procedures for tracking review dates and initiating timely re-evaluations prior to each participant's respective level of care review date and prior to the expiration of the participant's current person-centered service plan (Arkansas' term for a person-centered care plan). This process ensures timely reevaluations prior to the level of care review date and the expiration of the person-centered service plan so that no lapse in service occurs.

Specifically, DAABHS uses a "tickler" file system approach that DAABHS registered nurses (DHS RNs) and RN supervisors use to monitor upcoming review data and service plan expirations. The process of reassessment begins two months prior to the expiration date of the current person-centered service plan or two months prior to the annual anniversary date of the last independent assessment, whichever is earlier.

On at least a monthly basis, the DHS RN will identify participants who are due for re-assessment. The DHS RN will add the cases to the assessment schedule of the Independent Assessment Contractor by submitting the participants' information through an online web portal maintained by the Independent Assessment Contractor. The DHS RN will use the "tickler" file system, referenced above, to monitor for both the need for reassessment, and for timely completion of the reassessment by the Independent Assessment Contractor. Once the re-assessment is completed and the level of care is revised as appropriate, the DHS RN begins development of the new person-centered service plan.

Reassessments are ordinarily submitted to the Independent Assessment Contractor with a contractually-required 30-day time limit for completion of the reassessment. However, the contract also allows DHS, at its discretion, to submit reassessments with a 10-day time limit or a 7-day time limit when DHS deems it necessary.

The DHS RN supervisory staff, through the record review process and through routine monitoring and auditing procedures, notifies the appropriate DHS RN, RN supervisor and the Independent Assessment Contractor if a re-assessment has not been completed within the specified DAABHS policy timeframes.

The ACES report produced by the Division of County Operations is used as a tool by the DHS RN and RN supervisor to determine if the assessment is current or has expired. Patterns of noncompliance are documented and disciplinary action is taken if necessary.

Each Targeted Case Manager is also required to maintain a "Tickler" system to track the Medicaid eligibility reevaluation date and the service plan expiration date. If the reassessment process has not been completed timely, the Targeted Case Manager notifies the DHS RN prior to the expiration date of the current service plan.

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

Records of evaluations and reevaluations of level of care are maintained by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS), the primary authority for the daily operation of the waiver program, and the Office of Long Term Care (OLTC) in the Division of Provider Services and Quality Assurance (DPSQA), which is responsible for the level of care evaluations and reevaluations. DAABHS maintains records for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations, or court cases are resolved for a participant, whichever is longer.

## **Appendix B: Evaluation/Reevaluation of Level of Care**

### **Quality Improvement: Level of Care**

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of applicants who had a LOC indicating need for nursing facility LOC prior to receipt of services. Numerator: Number of applicants who received level of care prior to service; Denominator: Total number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

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

		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>



<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of waiver participants who received an annual redetermination of LOC eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC re-evaluation. Numerator: Number of participants receiving annual redetermination in 12 months; Denominator: Number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

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

		<p>Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px;"> <p>DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.</p> </div>
<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p><b>Annually</b></p>	<p><b>Stratified</b> Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of participants LOC determinations made where the LOC criteria were accurately applied. Numerator: Number of participants LOCs with correct criteria; Denominator: Number of participants**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Monthly Level of Care Report**

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

		<b>Sample Confidence Interval =</b> <input type="text"/>
<b>Other Specify:</b> <input type="text"/>	<b>Annually</b>	<b>Stratified Describe Group:</b> <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other Specify:</b> <input type="text"/>
	<b>Other Specify:</b> <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other Specify:</b> <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other Specify:</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):

**Performance Measure:**

**Number and percent of participants annual re-evaluation LOC determination forms that were completed as required by the state. Numerator: Number of participants with LOC with forms completed correctly; Denominator: Number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;">             DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.           </div>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of participants LOC determinations made by a qualified evaluator. Numerator: Number of participants with LOC made by a qualified evaluator; Denominator: Number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">             DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.           </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

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



The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency, with primary responsibility for waiver program operations and oversight of the independent assessment process), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency with responsibility for level of care determinations), and the Division of Medical Services (Medicaid agency) – all three of which are part of the Arkansas Department of Human Services (DHS) – participate in team meetings as needed to discuss and address individual problems associated with level of care determinations, assessments, and system improvements, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures related to level of care determinations for the waiver.

The system currently in place for new applicants to enter the waiver program does not allow for services to be delivered prior to an initial level of care determination. Also, DAABHS requires that all initial assessments and reassessments are completed by a registered nurse.

Level of Care assessments are required annually using the approved assessment instrument (currently, the ArPath instrument, and under the amended waiver the Arkansas Independent Assessment (ARIA) instrument) and applying the level of care criteria. For the ArPath instrument, the DHS RN supervisors currently complete a regional monthly activity report, which lists the number of level of care evaluations and re-evaluations conducted. Remediation efforts are included on the DHS RN supervisors’ monthly report. For ARIA, the DHS Independent Assessment Contractor will submit data reports to DMS at least monthly listing the number of level of care evaluations and re-evaluations conducted. DMS will require the DHS Independent Assessment Contractor to develop a corrective action plan when remediation in this area is needed, and document completion of the corrective action plan.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

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

**No**

**Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

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### B-7: Freedom of Choice

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

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

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

At the time of assessment and re-assessment of the waiver participant, the DHS RN explains the services available through the ARChoices waiver, discusses the qualified ARChoices providers in the state, and develops an appropriate person-centered service plan. As part of the service plan development process, the participant (or representative) documents their choice to have services provided in the community setting through the HCBS waiver as opposed to receiving services in an institutional setting. In addition, freedom of choice is explained through a Freedom of Choice form and the applicable qualified provider listing; both are signed by the waiver participant or their representative. This is documented on the service plan, which includes the signature of the waiver participant (or representative) and the DHS RN, and included in the participant's electronic record.

NOTE: For reassessments, the Freedom of Choice form is utilized showing if changes are requested by the participant. If no changes are requested, no signatures are required on the provider listing; however, the Freedom of Choice form is signed and dated by the participant or representative. The participant's signature on the service plan, as entered by the participant or representative, documents that the participant (or representative) has made an informed decision to receive HCBS rather than services in an institutional setting and that HCBS are based on the participant's assessment of needs. Freedom of Choice documentation is tracked through the record review process, all staff performance evaluations and monthly reporting.

If necessary, the DHS RN will read all relevant information to the participant. If this is done, it will be documented in the participant's record. All forms and information will be provided in alternate formats upon request. If an alternate format is requested and/or provided, the DHS RN will document the format requested and/or provided in the participant's record.

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

Copies of the waiver participant's service plan are maintained with the DAABHS (operating agency) and with the providers chosen by the participant and included on the service plan. Freedom of Choice forms and person-centered service plans are maintained for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations or court cases are resolved for a participant, whichever is longer.

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## Appendix B: Participant Access and Eligibility

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

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

All Department of Human Services (DHS) forms are available in English and Spanish. The forms can be translated into other languages when the need arises. DHS maintains an ongoing contract with a Spanish interpreter and translator agency for translation services.

All accommodations are provided on an individualized basis according to the participant's needs. DHS has a contract with an interpreter to accommodate applicants/participants who are hearing impaired. DHS RNs provide written materials to participants and will read any information to participants if needed. DHS RNs may utilize assistance from other divisions within the Arkansas Department of Human Services (DHS), such as the Division of Services for the Blind, in these instances. When this occurs, it is documented in the participant record.

## Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Respite		
Other Service	Adult Day Services		
Other Service	Adult Family Home		
Other Service	Attendant Care Services		
Other Service	Environmental Accessibility Adaptations/Adaptive Equipment		
Other Service	Home-Delivered Meals		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Prevocational Services		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04050 adult day health

**Category 2:**

11 Other Health and Therapeutic Services

**Sub-Category 2:**

11010 health monitoring

**Category 3:**

11 Other Health and Therapeutic Services

**Sub-Category 3:**

11120 cognitive rehabilitative therapy

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Adult day health are services furnished two or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Adult day health care provides a continuing, organized program of rehabilitative, therapeutic and supportive health and social services and activities to participants who are functionally impaired and who, due to the severity of their functional impairments, are not capable of fully independent living.

Adult day health facilities operate on a service day of no more than twelve (12) hours. The adult day health center shall serve one meal of nutritional content equal to one-third of the Recommended Daily Allowance, to participants who are present in the adult day health center for more than five (5) hours in that day.

The goals of adult day health go beyond the custodial and personal care goals of adult day services. The emphasis is on rehabilitative and health services. The goals of adult day health are:

1. To enable the participant to function physically, mentally and socially at the highest possible level.
2. To enable functionally impaired participants to remain in a supportive home environment instead of entering a nursing home.
3. To improve the health, well-being and quality of life for the participants by providing a rehabilitation program among their peers.
4. To provide support for family and other caregivers to enable them to maintain the impaired participant in the community.

The essential elements of an adult day health program are directed toward meeting the health restorative and maintenance needs of participants. The objectives of fostering and sustaining optimal capacity for self-care are achieved by:

1. Maximizing the participant's capacity to function independently;
2. Developing the participant's opportunities for socialization and peer support;
3. Providing treatment options other than institutionalization.

Adult day health providers are required to develop a written individual service plan to guide the delivery of adult day health services provided to each waiver participant in the adult day health facility. There must be a regular, ongoing schedule of services and activities (individual and group) based upon the participant's service plan. Adult day health programs provide health services that cannot be provided by adult day services programs. Adult day health is appropriate only for participants whose service plans specify one or more of the following health services that are not consistently provided by adult day services programs:

1. Rehabilitative therapies;
2. Pharmaceutical supervision;
3. Diagnostic evaluation;
4. Health monitoring.

Participants may also receive any of the following ancillary services in accordance with their service plan. These services, although they are non-medical in nature, are an important supplement to the basic health care functions:

1. Assistance with the activities of daily living;
2. Social work;
3. Recreation therapy;
4. Exercise;
5. Counseling.

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

Adult day health care can be utilized by waiver participants for two (2) or more hours per day, not to exceed ten (10) hours per day, when the service is provided according to the participants written service plan. Adult day health services of less than two (2) hours per day are not reimbursable. Adult day health services may be utilized up to fifty (50) hours (200 units) per week, not to exceed two hundred and thirty (230) hours (920 units) per month. ARChoices waiver participants can receive both adult day health and adult day services, but the two services are not allowed on the same date of service.

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

**Participant-directed as specified in Appendix E**

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Adult Day Health Care

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Adult Day Health**

**Provider Category:**

Agency

**Provider Type:**

Licensed Adult Day Health Care

**Provider Qualifications**

**License** (specify):

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.

**Certificate** (specify):

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Adult Day Health services. To be certified, providers must provide a copy of their current adult day health care agency license through the DHS Division of Provider Services and Quality Assurance.

**Other Standard** (specify):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Adult Day Health Care license at all times.

**Appendix C: Participant Services**

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**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09012 respite, in-home

**Category 2:**

09 Caregiver Support

**Sub-Category 2:**

09011 respite, out-of-home

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Respite Care is provided to waiver participants unable to care for themselves and is furnished on a limited or short-term basis because of the absence of, or need for relief of, those persons normally providing the care.

Specifically, Respite Care consists of temporary care provided for short term relief for the primary caregiver, subject to the following:

1. The participant lives at home and is cared for, without compensation, by their families or other informal support systems;
2. As determined by the independent assessment, the participant has a severe physical, mental, or cognitive impairment(s) that prevents him or her from being left alone safely in the absence or availability of the primary caregiver;
3. The primary caregiver to be relieved is identified and with sufficient documentation that he or she furnishes substantial care of the client comparable to or in excess of services described under the Attendant Care service;
4. No other alternative caregiver (e.g., other member of household, other family member) or source of assistance is available to provide a respite for the primary caregiver(s);
5. Respite Care services are limited to (a) direct human assistance with specific Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks as described under Attendant Care services and (b) supervision necessary to maintain the health and safety of the participant, as supported by the independent assessment and determined medically necessary by the DAABHS registered nurse; and
6. Respite Care solely serves to supplement (not replace) and otherwise facilitate the continued availability of care provided to waiver participants by families and other informal support systems.

Respite Care is available on a short-term basis (8 hours or less per date of service) or a long-term basis (a full 24 hours per date of service) because of the absence or need for relief of those persons who normally provide care for the participant. Respite Care is available to meet an emergency need or to schedule relief periods in accordance with the regular caregiver's need for temporary relief from continuous care giving.

Respite Care is available in the following locations:

1. Participant's home or place of residence;
2. Medicaid certified hospital;
3. Medicaid certified nursing facility;
4. Medicaid certified adult day health facility; and
5. Medicaid certified assisted living facility with a level II state license.

To allow the person who normally provides care for the waiver participant some time away from his or her caregiving of the participant, Respite Care may be provided in or outside the participant's home as follows:

1. In-home respite may be provided for up to 24 hours per date of service.
2. Facility-based respite care may be provided outside the participant's home on:
  - a. A short-term basis (eight (8) hours or less per date of service), or
  - b. A long-term (maximum of 24 hours per date of service and used most often when respite needed exceeds the short-term respite amount).

Reimbursement is only permitted for direct care rendered according to the participant's person-centered service plan



by trained respite care workers employed and supervised by certified in-home respite providers.

Reimbursement is not permitted for Respite Care services provided by a waiver beneficiary's:

1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the beneficiary's care.

Respite care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. In accordance with 42 CFR 441.301(b)(1)(ii), ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.

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

Respite Care is subject to the following limitations:

1. The purpose of Respite Care is to provide respite for unpaid caregivers. The amount, frequency, and duration of Respite Care must be entirely consistent with and shall be limited to amounts, frequencies, and durations of assistance from unpaid caregivers identified and calculated for the beneficiary in the completed form of the Arkansas Medicaid Task and Hour Standards ("THS"). Any amounts, frequencies, or durations in excess of the unpaid caregiver assistance amounts identified for the beneficiary in the THS are not covered.

2. Respite Care excludes:

- a. Skilled health professional services, including physician, nursing, therapist, and pharmacist services.
- b. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
- c. Services provided for any other person other than the participant;
- d. Companion, socialization, entertainment, or recreational services or activities of any kind, including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship;
- e. Habilitation services, including but not limited to, assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and
- f. Services provided for any task not included in a beneficiary's service plans.

3. Participants are limited to no more than 1,200 hours (4,800 quarter-hour units) per year of in-home respite care, facility-based respite care, or a combination thereof. Respite care is not subject to a monthly or weekly limit, but is limited to the annual amount of time identified and calculated for the beneficiary in the completed form of the Arkansas Medicaid Task and Hour Standards.

4. Respite Care services are not covered to provide continuous or substitute care while the primary caregiver(s) is working, attending school, or incarcerated.

5. Respite care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. In accordance with 42 CFR 441.301(b)(1)(ii), ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Adult Day Health Care Agency
Agency	Licensed Level II Assisted Living Facility
Agency	Licensed Medicaid Certified Nursing Facility
Agency	Licensed Acute Care Hospital
Agency	Licensed Class A or Class B Home Health Agency or Licensed Private Care Agency
Agency	Licensed Adult Day Care Agency
Agency	Licensed Residential Care Facility

## Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Licensed Adult Day Health Care Agency

Provider Qualifications

License (specify):

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an Adult Day Health Care agency as required by Ark. Code Ann. 20-10-201, et. seq.

Certificate (specify):

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Adult Day Health services. To be certified, providers must provide a copy of their current adult day health care agency license through the DHS Division of Provider Services and Quality Assurance.

Other Standard (specify):

Verification of Provider Qualifications

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Adult Day Health Care license at all times.

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## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Respite**

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**Provider Category:**

Agency

**Provider Type:**

Licensed Level II Assisted Living Facility

**Provider Qualifications**

**License** (*specify*):

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Level II Assisted Living Facility as required by Ark. Code Ann. 20-10-201, et. seq., Act 1230 of 2001.

**Certificate** (*specify*):

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their level II assisted living facility license through the DHS Division of Provider Services and Quality Assurance.

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Level II Assisted Living Facility license at all times.

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## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Respite**

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**Provider Category:**

Agency

**Provider Type:**

Licensed Medicaid Certified Nursing Facility

**Provider Qualifications**

**License** (*specify*):

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Medicaid Certified Nursing Facility as required by Ark. Code Ann. 20-10-201, et. seq., Act 1230 of 2001

**Certificate** (*specify*):

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their Medicaid certified nursing facility license through the DHS Division of Provider Services and Quality Assurance.

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Medicaid Certified Nursing Facility license at all times.

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Respite**

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**Provider Category:**

Agency

**Provider Type:**

Licensed Acute Care Hospital

**Provider Qualifications**

**License** (*specify*):

Licensed Acute Care Hospital

**Certificate** (*specify*):

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current acute care hospital license.

**Other Standard** (*specify*):

### Verification of Provider Qualifications

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Licensed Acute Care Hospital license at all times.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Licensed Class A or Class B Home Health Agency or Licensed Private Care Agency

**Provider Qualifications**

**License** (*specify*):

Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency as required by Ark. Code Ann. 20-10-807, History: Acts 1987, No. 956, 4; or licensed as a Private Care Agency.

**Certificate** (*specify*):

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their current Class A and/or Class B home health agency license, or Private Care Agency license through the Arkansas Department of Health.

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually for recertification; however, DPSQA must maintain a copy of the agency’s current license at all times.

**Appendix C: Participant Services**

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

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**Service Type: Statutory Service**

**Service Name: Respite**

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**Provider Category:**

Agency

**Provider Type:**

Licensed Adult Day Care Agency

**Provider Qualifications**

**License (specify):**

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et. seq.

**Certificate (specify):**

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Adult Day Services. To be certified, providers must provide a copy of their current adult day care license through the DHS Division of Provider Services and Quality Assurance.

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually for recertification; however, DPSQA must maintain a copy of the agency’s current Adult Day Care license at all times.

**Appendix C: Participant Services**

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

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**Service Type: Statutory Service**

**Service Name: Respite**

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**Provider Category:**

Agency

**Provider Type:**

Licensed Residential Care Facility

**Provider Qualifications**

**License** (*specify*):

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Residential Care Facility as required by Ark. Code Ann. 20-10-201, et. seq., Act 1230 of 2001.

**Certificate** (*specify*):

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Respite Care services. To be certified, providers must provide a copy of their residential care facility license through the DHS Division of Provider Services and Quality Assurance.

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Residential Care Facility license at all times.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Adult Day Services

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04060 adult day services (social model)

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Adult day services are services provided in a group program designed to provide care and supervision to meet the needs of four (4) or more functionally impaired adults for periods of less than twenty-four (24) hours, but more than two (2) hours per day in a place other than the adult's own home.  
  
Adult day care facilities operate on a service day of no more than twelve (12) hours.

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

Adult day services may be utilized by waiver participants for two (2) or more hours per day, not to exceed ten (10) hours per day, when the service is provided according to the participant's written service plan. Adult day services may be utilized up to fifty (50) hours (200 units) per week, not to exceed two hundred and thirty (230) hours (920 units) per month.  
  
ARChoices waiver participants can receive both adult day service and adult day health, but the two services are not allowed on the same date of service.

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

**Participant-directed as specified in Appendix E**

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Adult Day Care



## Appendix C: Participant Services

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

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**Service Type:** Other Service

**Service Name:** Adult Day Services

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**Provider Category:**

Agency

**Provider Type:**

Licensed Adult Day Care

**Provider Qualifications**

**License** (*specify*):

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a provider of Adult Day Care services as required by Ark. Code Ann. 20-10-201, et. seq.

**Certificate** (*specify*):

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Adult Day Services. To be certified, providers must provide a copy of their current adult day care license through the DHS Division of Provider Services and Quality Assurance.

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Adult Day Care license at all times.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Adult Family Home

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02013 group living, other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

**ADULT FAMILY HOME SERVICES ARE TERMINATED 1/01/2019.**

Adult Family Home services are personal care, attendant care, supportive services such as transportation to allow the waiver participant access to the community, and medication oversight (to the extent permitted under State law) provided in a certified private home by a principal care provider who lives in the home. The Adult Family Home provider is responsible for meeting the needs, as described by the waiver service, 24 hours a day, seven days a week. Adult Family Home services shall be included in the service plan only when it is necessary to prevent the permanent institutionalization of a participant as determined by the DAAS RN.

Payment for Adult Family Home services does not include room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for Adult Family Home services does not include payments made, directly or indirectly, to members of the participant's immediate family. The methodology by which the costs of room and board are excluded from payments for Adult Family Home services is described in Appendix I. The waiver participant is responsible for the cost of room and board expenses. Adult Family Home services are provided on a daily basis. Waiver service payments are intended to reimburse the cost of the caregiver in the Adult Family Home who assists with or provides daily living care to the waiver participant.

Adult Family Home services provide a family living environment for no more than three waiver participants who are not related to the principal care provider, who have functional impairments and, due to the severity of their functional impairments, are considered to be at imminent risk of death or serious bodily harm, and as a consequence, are not capable of independent living.

No Adult Family Homes (AFH) provider, employee or family member of the provider may be related to the AFH participant. For the purposes of this section, relative shall be defined as all persons related to the participant by virtue of blood, marriage, or adoption. Individuals who are legally responsible for the participant (i.e., spouse, legal guardian, attorney-in-fact granted authority to direct the participant's care) are prohibited from receiving reimbursement for direct provision of covered services for the ARChoices participant.

Adult Family Home services add a dimension of family living to the provision of supportive services and personal care services. Adult Family Home services provide care in a home-like setting, and the caregiver includes the participant in the life of the family as much as possible. The caregiver also assists the waiver participant in becoming or remaining active in the community.

Each Adult Family Home services provider shall execute with and provide to each waiver participant an admission agreement specifying services to be provided; charges for room and board; and conditions and rules governing waiver participant and grounds for termination of residence in the Adult Family Home.

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

One (1) unit of service equals one (1) day. Adult Family Homes are limited to a maximum of thirty-one (31) units per month.

Adult Family Home participant may receive up to 2,400 units (600 hours) of long-term facility-based respite per state fiscal year. The Adult Family Home service is not allowed on the same date of service as respite service.

Aside from facility-based respite services, a participant receiving Adult Family Home services is not eligible to receive any other ARChoices service.

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

**Participant-directed as specified in Appendix E**

**Provider managed**

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Adult Family Home

## Appendix C: Participant Services

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

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Service Type: Other Service

Service Name: Adult Family Home

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Provider Category:

Individual

Provider Type:

Certified Adult Family Home

Provider Qualifications

License (specify):

Certificate (specify):

Certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Adult Family Home services. To be certified, providers must provide a copy of their current completed adult family home certification requirements checklist.

Other Standard (specify):

To be certified by the Arkansas Department of Human Services, Division of Aging & Adult Services as an ARChoices waiver provider of Adult Family Home services, providers must provide a copy of their completed Adult Family Homes Certification Requirements Checklist.

Verification of Provider Qualifications

Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Aging & Adult Services

Frequency of Verification:

Annually

## C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Attendant Care Services

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08030 personal care

**Category 2:**

08 Home-Based Services

**Sub-Category 2:**

08040 companion

**Category 3:**

08 Home-Based Services

**Sub-Category 3:**

08050 homemaker

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Attendant care services available under the ARChoices program consists of direct human assistance with specific types of tasks, provided such tasks are:

1. Reasonable and medically necessary, supported by the individual's latest independent assessment, and consistent with the individual's Level of Care;
2. Not available from another source (including without limitation family members, a member of the participant's household, or other unpaid caregivers; a Medicaid State Plan covered service; the Medicare program; the participant's Medicare Advantage plan [including targeted or other supplemental benefits offered by the plan]; the participant's Medicare prescription drug plan; and private long-term care, disability, or supplemental insurance coverage);
3. Expressly authorized in the individual's person-centered service plan;
4. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services specified in the Task and Hour Standards;
5. Provided by qualified, Medicaid-certified providers and in compliance with all applicable Arkansas Medicaid program regulations and provider manuals; and
6. Provided in compliance with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.

The specific types of tasks covered under attendant care services are as follows:

1. Activities of Daily Living (ADLs):

- a. Eating (i.e., feeding assistance during meal times and encouraging fluids, excluding tube feeding and total parenteral nutrition and meal preparation);
- b. Toileting;
- c. Personal hygiene and grooming (i.e., face shaving; nail trimming; shampooing, brushing, or combing of hair; and menstrual hygiene);
- d. Dressing;
- e. Bathing or showering; and/or
- f. Mobility/ambulating (i.e., functional mobility, moving from seated to standing, getting in and out of bed).

2. Instrumental Activities of Daily Living (IADLs):

- a. Meal planning and preparation for meals consumed only by the participant;
- b. Laundry for the participant or incidental to the participant's care;
- c. Shopping for food, clothing, and other essential items required specifically for the health and maintenance of the participant;
- d. Housekeeping (i.e., cleaning of areas directly used by the participant); and

e. Assistance with medications (to the extent permitted by nursing scope of practice laws).

3. Health-related tasks, subject to the following:

a. "Health-related tasks" mean the following attendant activities:

i. Performing and recording simple measurements of body weight, blood glucose, heart pulse, blood pressure, temperature (forehead, tympanic, or oral), respiratory rate, and blood oxygen saturation, if in physician's order or medical plan of care. Attendant must use an appropriate weight scale and FDA-approved, hand-held personal health monitoring device(s);

ii. Additional assistance with the participant's self-administration of prescribed medications;

iii. Emptying and replacing colostomy and ostomy bags; and/or

iv. Other tasks DAABHS may specify in the ARChoices provider manual; and

b. Any such health-related tasks performed:

i. Are consistent with all applicable State scope of practice laws and regulations;

ii. Within the documented skills, training, experience, and other relevant competencies of the attendant performing the task;

iii. For the care and safety of the participant, do not require monitoring or supervision of the attendant by a licensed physician, registered nurse, licensed physical therapist, or licensed occupational therapist;

iv. Are necessary to meet specific needs of the participant consistent with a written plan of care by a licensed physician or registered nurse; and

v. Are tasks that the participant is unable to perform for themselves without hands-on assistance, direct supervision, and/or active cueing of the attendant.

In the ARChoices program, attendant care services exclude all of the following:

1. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including without limitation aseptic or sterile procedures; application of dressings; medication administration; injections; observation and assessment of health conditions, other than as permitted for the health-related tasks above; insertion, removal, or irrigation of catheters; tube or other enteral feedings; tracheostomy care; oxygen administration; ventilator care; drawing blood; and care and maintenance of any medical equipment;

2. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;

3. Services provided for any person other than the participant, including without limitation a provider, family member, household resident, or neighbor;

4. Companion, socialization, entertainment, or recreational services or activities of any kind, including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship;

5. Cleaning of any spaces of a home or place of residence (including without limitation the kitchen, bathroom, living

room, dining room, family room, and utility or storage rooms, and the floors, furnishings, and appliances therein) shared by the participant with one or more adults who are, together or separately, physically able to perform housekeeping of these areas; and

6. Habilitation services, including but not limited to, assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills.

Participants may choose to receive authorized attendant care services through any of the following:

1. Home health agency licensed as Class A by the Arkansas State Board of Health, certified by DPSQA, and enrolled as a Medicaid provider;

2. Home health agency licensed as Class B by the Arkansas State Board of Health, certified by DPSQA, and enrolled as a Medicaid provider;

3. Private care agency licensed by the Arkansas State Board of Health, certified by DPSQA, and enrolled as a Medicaid provider; or

4. Consumer-directed attendant care through Independent Choices, the Arkansas self-directed personal assistance benefit under section 1915(j) of the Social Security Act, provided the individual is capable of self-directing the assistance and subject to the requirements of the Independent Choices provider manual and applicable provider qualifications and certification.

Attendant care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. In accordance with 42 CFR 441.301(b)(1)(ii), ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.

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



1. The aggregate amount, frequency, and duration of attendant care services must be consistent with the aggregate amounts, frequencies, and durations calculated by DHS for the beneficiary in accordance with the Arkansas Medicaid Task and Hour Standards (“THS”), as issued by DAABHS and posted publicly on the DHS website with the ARChoices waiver provider manual. DAABHS will publish and periodically update the THS as necessary, following a public notice and comment process. The THS specifies limits on each ADL, IADL, and health-related task at the intensity of human assistance needed for the task, including maximum frequency (by day or week or month), maximum minutes per task allowable, and maximum hours by day, week, or month. Any aggregate amounts, frequencies, or durations in excess of the weekly or monthly limits calculated by DHS for the beneficiary in accordance with the THS are not covered.

2. Attendant care services are not available (not covered and not reimbursable) through the ARChoices program when and to the extent any of the following may apply:

a. When reasonably comparable or substitute services are available to the individual through an Arkansas Medicaid State Plan benefit including without limitation the personal care services, home health services, and private duty nursing services;

b. When assistance with the equivalent ADL, IADL, or health-related task(s) is covered under an Arkansas Medicaid State Plan benefit but determined as medically unnecessary for the individual during adjudication of a prior authorization request or utilization review;

c. When assistance with the comparable ADL, IADL, or health-related task(s) is available through targeted or supplemental benefits offered by the participant’s Medicare Advantage plan;

d. When attendant care services delivered through a home health agency or private care agency are provided by the waiver beneficiary’s (i) spouse; (ii) legal guardian of the person; or (iii) attorney-in-fact granted authority to direct the beneficiary’s care;

e. On dates of service when the participant:

i. Receives Medicare home health aide services, whether through traditional Medicare fee-for-service or a Medicare Advantage plan of any kind for the same tasks;

ii. Receives targeted or other supplemental benefits from a Medicare Advantage plan of any kind, where such supplemental services are reasonably comparable to or duplicative of attendant care services, personal care services, or self-directed personal assistance;

iii. Spends more than five hours at an adult day services or adult day health services facility, unless prior approved in writing by the DAABHS registered nurse;

iv. Receives long-term or short-term, facility-based respite care; and/or

v. Receives services from an inpatient hospital, nursing facility, assisted living facility, hospice facility, or residential care facility, unless approved in writing by a DAABHS registered nurse as reasonable and necessary given the time of day of the facility admission or discharge, the need for transition assistance, or an inpatient hospital admission incident to an emergency department visit or direct inpatient admission by the attending physician;

f. When a duplicate claim for the same performance of the same task is paid or submitted for personal care services, self-directed personal assistance, or home health aide services under the Medicaid State Plan; and/or

g. For a task that was not actually performed.

Attendant care may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities. In accordance with 42 CFR 441.301(b)(1)(ii), ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.

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

**Participant-directed as specified in Appendix E**

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Private Care Agency Enrolled as an Arkansas Medicaid Personal Care Provider
Agency	Licensed Home Health Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Attendant Care Services**

**Provider Category:**

Agency

**Provider Type:**

Licensed Private Care Agency Enrolled as an Arkansas Medicaid Personal Care Provider

**Provider Qualifications**

**License** (specify):

Licensed by the Arkansas Department of Health as a private care agency enrolled as an Arkansas Medicaid Personal Care Provider, as cited in Act 2273 of 2005.

**Certificate** (specify):

Agencies must be certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, to provide ARChoices agency attendant care services.

**Other Standard** (specify):

In order to be certified by DPSQA as an agency attendant care provider and enrolled as a Medicaid provider, the attendants hired by the agency must meet the following minimum qualifications:

- o Be 18 years of age or older;
- o Be a United States citizen or legal alien authorized to work in the U. S.;
- o Be free from evidence of abuse or fraud in any setting; violations in the care of a dependent population; conviction of a crime related to a dependent population; or, conviction of a violent crime;
- o Be free from communicable diseases;
- o Be free from diseases readily transmittable through casual contact;
- o Be able to read and write at a level sufficient to follow written instructions and maintain records;
- o Be in adequate physical health to perform job tasks required; and
- o Have a current signed formal agreement with an eligible ARChoices participant for the provision of agency attendant care services.

Agency attendant care services providers must not hire attendants who are legally responsible for the ARChoices participant.

Agency attendant care providers assure that staff are qualified by education and/or experience to perform ARChoices services, properly trained and in compliance with all applicable licensure requirements, possess the necessary skills to perform the specific services required to meet the needs of the participant, and are bonded to protect the participant from loss due to misconduct or mismanagement of the participant's affairs and are covered under liability insurance.

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

##### **Frequency of Verification:**

Annually for recertification; however, DPSQA must maintain a copy of the provider's current Personal Care Agency license in the provider file at all times.

## **Appendix C: Participant Services**

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

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**Service Type: Other Service**

**Service Name: Attendant Care Services**

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#### **Provider Category:**

Agency

#### **Provider Type:**

Licensed Home Health Agency

## Provider Qualifications

### License (*specify*):

Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency, as cited in Arkansas Code Annotated section 20-10-809.

### Certificate (*specify*):

Agencies must be certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, to provide ARChoices agency attendant care services.

### Other Standard (*specify*):

In order to be certified by DPSQA as an agency attendant care provider and enrolled as a Medicaid provider, the attendants hired by the agency must meet the following minimum qualifications:

- o Be 18 years of age or older;
- o Be a United States citizen or legal alien authorized to work in the U. S.;
- o Be free from evidence of abuse or fraud in any setting; violations in the care of a dependent population; conviction of a crime related to a dependent population; or, conviction of a violent crime;
- o Be free from communicable diseases;
- o Be free from diseases readily transmittable through casual contact;
- o Be able to read and write at a level sufficient to follow written instructions and maintain records;
- o Be in adequate physical health to perform job tasks required; and
- o Have a current signed formal agreement with an eligible ARChoices participant for the provision of agency attendant care services.

Agency attendant care services providers must not hire attendants who are legally responsible for the ARChoices participant.

Agency attendant care providers assure that staff are qualified by education and/or experience to perform ARChoices services, properly trained and in compliance with all applicable licensure requirements, possess the necessary skills to perform the specific services required to meet the needs of the participant, and are bonded to protect the participant from loss due to misconduct or mismanagement of the participant's affairs and are covered under liability insurance.

## Verification of Provider Qualifications

### Entity Responsible for Verification:

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

### Frequency of Verification:

Annually for recertification; however, DPSQA must maintain a copy of the provider's current Home Health Agency license in the provider file at all times.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Environmental Accessibility Adaptations/Adaptive Equipment

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14020 home and/or vehicle accessibility adaptations

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Environmental Accessibility Adaptations/Adaptive Equipment are physical adaptations to the home required by the ARChoices participant's person-centered service plan, that are necessary to ensure the health, welfare and safety of the participant to function with greater independence in the home and postpone or preclude institutionalization. Adaptive equipment also enables the ARChoices participant to increase, maintain and/or improve his or her functional capacity to perform daily life tasks that would not be possible otherwise, and perceive, control or communicate with the environment in which he or she lives.

Excluded are adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, air conditioning and others. Adaptations which add to the total square footage of the home are excluded from this benefit. Any equipment or supply covered by the state plan Durable Medical Equipment (DME) program is excluded. No permanent fixtures are allowed to leased or rented homes. The DHS RN will research the need and will assist individuals in choosing appropriate adaptations that are safe and portable if they lease or rent. Adaptations may not be performed on vehicles. All services must be in accordance with applicable state or local building codes.

Reimbursement is not permitted for Environmental Accessibility Adaptations/Adaptive Equipment provided by a waiver beneficiary's:

1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the beneficiary's care.

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

Medicaid reimbursement for Environmental Accessibility Adaptations/Adaptive Equipment is determined by the job. The Medicaid maximum allowable equals \$7,500 per ARChoices participant for the life of the participant. A waiver participant may access through the waiver several occurrences of this service over a span of years or the whole \$7,500 at one time.

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

**Participant-directed as specified in Appendix E**

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Installer (Builder, Tradesman or Contractor)

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations/Adaptive Equipment**

**Provider Category:**

Individual

**Provider Type:**

Installer (Builder, Tradesman or Contractor)

**Provider Qualifications**

**License** (*specify*):

If the particular trade has a license available, the installer must be licensed as appropriate for the environmental accessibility adaptation/adaptive equipment provided. Proof of a plumber or electrician's license must be provided prior to performing this type of work.

**Certificate** (*specify*):

Environmental Accessibility Adaptations/Adaptive Equipment providers are certified by the Arkansas Department of Human Service, Division of Provider Services and Quality Assurance, as an ARChoices provider of environmental accessibility adaptations/adaptive equipment. Providers must also complete all applicable forms required by DPSQA for certification. Providers must also be enrolled in the Arkansas Medicaid program as an ARChoices environmental accessibility adaptations/adaptive equipment provider before reimbursement may be made for services provided to ARChoices participants.

**Other Standard** (*specify*):

Environmental Accessibility Adaptations/Adaptive Equipment providers must:

- Certify that his or her work meets state and local building codes
- Be knowledgeable of and comply with the Americans with Disabilities Act Accessibility Guidelines

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually.

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## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Home-Delivered Meals

**HCBS Taxonomy:**

**Category 1:**

06 Home Delivered Meals

**Sub-Category 1:**

06010 home delivered meals

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Home-delivered meals are services that provide one (1) meal per day of nutritional content equal to one-third of the Recommended Daily Allowance. This service is designed for participants who are unable to prepare meals, and who lack an informal provider to do meal preparation. Provision of home-delivered meals reduces the need for reliance on paid staff during some meal times by providing meals in a cost-effective manner.

The goals of home-delivered meals are:

1. To facilitate participant independence by allowing them the choice to remain in their own homes rather than entering a nursing facility.
2. To provide one (1) daily nutritious meal to participants at risk of being institutionalized;
3. To provide a daily social contact to homebound participants to insure the participant's safety and well-being.

In order to receive home-delivered meals under the waiver, a participant must:

1. Be homebound which is defined as:
  - a) A participant with normal inability to leave home without assistance (physical or mental) from another person;
  - b) The person is frail, homebound by reason of illness or incapacitating disability or otherwise isolated;
  - c) Leaving home requires considerable and taxing effort by the participant, and
  - d) Absences of the participant from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment; and
2. Be unable to prepare some or all of his/her own meals, or require a special diet and is unable to prepare it; and
3. Have no other person available to prepare his/her meals, and the provision of a home-delivered meal is the most cost-effective method of ensuring a nutritionally adequate meal; and
4. Have the provision of meals included in the participant's person-centered service plan.

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



One unit of service equals one meal. The maximum number of home-delivered meals eligible for reimbursement per month is 31 meals.

Four (4) emergency meals may be supplied per SFY.

Home delivered meals are not allowed on the same date of service when a waiver participant has received more than five (5) hours of adult day health, adult day service, or in-home or facility-based respite. Licensure requirements include provision of a meal while at the day care facility under these circumstances.

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

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

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

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Provider of Food Services

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Home-Delivered Meals**

**Provider Category:**

Agency

**Provider Type:**

Provider of Food Services

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

Food Establishment Permit issued by the Department of Health

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA), as an ARChoices waiver provider of Home Delivered Meals. To be certified, providers must provide a copy of their current food establishment permit issued by the Department of Health.

**Other Standard** (specify):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually for recertification; however, DPSQA must maintain a copy of the agency's current Food Establishment Permit at all times.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Personal Emergency Response System (PERS)

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14010 personal emergency response system (PERS)

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Personal emergency response system (PERS) is an in-home, 24-hour electric support system with two-way verbal and electronic communication with an emergency control center. The system includes an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. PERS enables an elderly, infirm or homebound participant to secure immediate help in the event of physical, emotional or environmental emergency.

PERS services are limited to those participants who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive, routine supervision.

The goals of the personal emergency response system are:

1. To provide a high-risk participant with the security and assurance of immediate assistance in an emergency, making it possible for them to remain in their home.
2. To eliminate the need for costly in-home supervision provided by a paid attendant that also affords the participant the emotional satisfaction or independent living.

PERS is not intended to be a universal benefit. It is specifically for those "high-risk" participants whose needs are determined through the assessment/reassessment process. The criteria for eligibility are based on the participant's level of medical vulnerability, functional impairment and social isolation. Participants receiving PERS services must be physically and mentally capable of utilizing the service or reside in the home with a caregiver who is capable of utilizing the service for the benefit of the waiver participant.

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

One (1) unit of service equals one (1) day. PERS is limited to a maximum of thirty-one (31) units per month.

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

**Participant-directed as specified in Appendix E**

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Alarm or Security Company

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Emergency Response System (PERS)**

**Provider Category:**

Agency

**Provider Type:**

Alarm or Security Company

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Certificate of Compliance for Protective Signaling Services issued by the Underwriters Laboratories Safety Standards

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA) as an ARChoices waiver provider of Personal Emergency Response System services. To be certified, providers must provide a copy of their current certificate of compliance for protective signaling services issued by the Underwriters Laboratories Safety Standards.

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Prevocational Services

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04010 prevocational services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Prevocational services are available to ARChoices waiver participants with physical disabilities who wish to join the general workforce. Prevocational Services comprises a range of learning and experiential type activities that prepare a participant for paid employment or self-employment in the community.

Prevocational services are as follows:

1. Development and teaching of general employability skills (non-job-task-specific strengths and skills) directly relevant to the participant's pre-employment needs and successful participation in individual paid employment. These skills are: ability to communicate effectively with supervisors, coworkers, and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; and skills related to obtaining paid employment. Excluded are services involving development or training of job-specific or job-task oriented skills.

2. Career exploration activities designed to develop an individual career plan and facilitate the participant's experientially based informed choice regarding the goal of individual paid employment. These may include business tours, informational interviews, job shadows, benefits education and financial literacy, assistive technology assessment, and local job exploration events. The expected outcome of career exploration activities is a written, actionable, person-centered career plan designed to lead to community employment or self-employment for the participant.

The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the participant interacts with individuals without disabilities, other than those providing services to the participant or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Prevocational services may be provided one-to-one or in a small group format and may be provided as a site-based service or in a community setting, consistent with requirements of the ARChoices provider manual.

All prevocational services must be prior approved in the participant's person-centered service plan, provided through a DPSQA-certified prevocational services provider, and delivered and documented consistent with requirements of the ARChoices provider manual.

Reimbursement is not permitted for Respite Care services provided by a waiver beneficiary's:

1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the beneficiary's care.

Prevocational services exclude any services otherwise available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 (Rehab Act), the Individuals with Disabilities Education Act (IDEA), or any other federally funded (non-Medicaid) source. Proper documentation shall be maintained in the file of each individual receiving prevocational services under the waiver.

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

The total amount of all prevocational services provided to any participant shall not exceed \$2,500 per lifetime.

The amount of career exploration activities provided per participant shall not exceed 30 hours.

Duration of prevocational services provided to any given participant shall be limited to 180 days (six months). Services not completed within this timeframe are not covered.

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

**Participant-directed as specified in Appendix E**

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified Prevocational Services Vendor

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Prevocational Services**

**Provider Category:**

Agency

**Provider Type:**

Certified Prevocational Services Vendor

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as an ARChoices waiver provider of Prevocational Services.

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Arkansas Department of Human Services, Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

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

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

**As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

**As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

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

Each ARChoices waiver participant's person-centered service plan will include Medicaid State Plan targeted case management, unless refused by the waiver participant. Qualified targeted case managers who can deliver targeted case management services are the employees of providers enrolled in the Medicaid State Plan Targeted Case Management Program. A qualified targeted case manager must be licensed in the State of Arkansas as a social worker, a registered nurse or a licensed practical nurse or have a bachelor's degree from an accredited institution or have performed satisfactorily as a case manager for a period of two (2) years.

The targeted case manager is responsible for monitoring the waiver participant's status on a regular basis for changes in his or her service need, and reporting any waiver participant's complaints or changes to the DHS RN immediately upon learning of the change.

## Appendix C: Participant Services

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

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

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

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



All ARChoices waiver providers employing persons providing direct services (personal assistants, attendants) shall not knowingly employ a person who has been found guilty or has pled guilty or nolo contendere to any disqualifying criminal offense.

Each ARChoices waiver provider must obtain from each employee and from each applicant for employment a signed authorization permitting disclosures to the ARChoices provider of criminal history information as defined in Ark. Code Ann., Section 12-12-1001.

Each provider receiving payment under the ARChoices program must, as a condition of continued participation in the program, comply with the requirement for criminal history checks for new employees, and periodic criminal history checks for agency operators and all employees at least once every five years. The scope of the criminal background checks is national. This requirement applies to any employee who in the course of employment may have direct contact with an ARChoices participant. At the time of initial certification and re-certification, providers must submit a list of all direct care services staff and the dates of their last criminal background check.

If the results of the criminal history check establish that the applicant was found guilty of, or pled nolo contendere (no contest) to a disqualifying offense under Ark. Code Ann., Section 20-33-205 ("disqualifying offense"), then the ARChoices waiver provider may not employ, or continue to employ, the applicant. Disqualifying offenses do not include misdemeanors that did not involve exploitation of an adult, abuse of a person, neglect of a person, theft, or sexual contact.

According to Arkansas Department of Human Services Policy 1088, DHS shall automatically exclude any provider (or, an employee or subcontractor of that provider) that has wrongfully acted or failed to act with respect to, or has been found guilty, or pled guilty or nolo contendere (no contest), to any crime related to:

1. Obtaining, attempting to obtain, or performing a public or private contract or subcontract,
2. Embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty,
3. Dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony,
4. Federal antitrust statutes,
5. The submission of bids or proposals, or
6. Any physical or sexual abuse or neglect when the offense is a felony.

In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's claims processing contractor.

The DPSQA Provider Certification unit sends new applications and a list of providers who are due recertification to the Medicaid Provider Enrollment unit, the Medicaid fiscal agent, which processes all criminal background checks. Certification of new providers and recertification of active providers is contingent upon the completion of the criminal background check. The Medicaid program's fiscal agent submits reports detailing the background checks for new and existing providers to DPSQA.

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

**No. The State does not conduct abuse registry screening.**

**Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which

abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Abuse registry screenings of the direct care of services staff of ARChoices agency providers are monitored at initial certification and re-certification. This is a required part of the certification and re-certification process. In addition, agency providers must submit a list of all direct care of services staff and the dates of their last criminal background checks. Criminal background checks are required for agency providers every five years pursuant to Act 762 of 2009. Providers are required to follow all requirements related to employee criminal background checks discussed in the Medicaid Provider Manual.

The Adult Protective Services unit of the Division of Aging, Adult, and Behavioral Health Services is responsible for maintaining the abuse registry.

As part of the qualified provider review, DPSQA verifies that the provider file contains all required documentation, including information regarding the criminal background checks.

## Appendix C: Participant Services

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

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

**No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

**Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

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

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

**No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

**Self-directed**

**Agency-operated**

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

**The State does not make payment to relatives/legal guardians for furnishing waiver services.**

**The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

All ARChoices services may be reimbursed if provided by a relative of the participant, subject to the limitations specified below.

Individuals who are legally responsible for the participant (i.e., spouse, legal guardian, or attorney-in-fact granted authority to direct the participant's care) are prohibited from receiving any reimbursement for any ARChoices services provided for the participant.

All providers, including relatives, are required to meet all applicable ARChoices provider certification requirements and Arkansas Medicaid enrollment requirements, comply with all applicable ARChoices provider manual requirements, and provide services according to the participant's approved service plan and any established benefit limits for that specific service, as identified in Appendix C-1/C-3.

Controls are maintained through the required documentation for all service providers. This documentation must support each service for which billing is made and include a copy of the participant's person-centered service plan, a brief description of the specific services provided, the signature and title of the individual providing the service, and the date and actual time services were provided. DHS RN supervisory staff conducts chart reviews to ensure that services were provided according to the service plan. DPSQA performs audits and quality reviews of providers.

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

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

**Other policy.**

Specify:

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

ARChoices provider enrollment is open and continuous. Those interested in becoming an ARChoices provider can contact the Division of Provider Services and Quality Assurance (DPSQA) Provider Enrollment Unit for information and to obtain certification materials. There are no restrictions applicable to requesting this information. The provider certification process is open and available to any interested party.

The DPSQA website lists information for potential ARChoices providers.

## Appendix C: Participant Services

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### Quality Improvement: Qualified Providers

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

**a. Methods for Discovery: Qualified Providers**

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percentage of providers, by provider type, which obtain re-certification in accordance with state law and waiver provider qualifications. Numerator: Number of providers with re-certification; Denominator: Total number of providers**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider Certification Unit (DPSQA) Provider Database**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
Specify: <input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percentage of providers, by provider type, which obtained the appropriate license/certification in accordance with state law and waiver provider qualifications prior to delivering services. Numerator: number of providers with appropriate license/certification prior to delivery of services; Denominator: Number of new providers**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider Certification Unit (DPSQA) Provider Database**

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

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

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

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

**Performance Measure:**

**Number and percent of providers certified by the Division of Provider Services and Quality Assurance (DPSQA). Numerator: Number of current providers certified by DPSQA; Denominator: Number of providers participating in the waiver program.**

**Data Source** (Select one):

**Program logs**

If 'Other' is selected, specify:

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



	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>

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

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

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

**Performance Measure:**

**Number and percent of agency providers meeting waiver provider training requirement as evidenced by in-service attendance documentation. Numerator:**  
**Number of agency providers indicating training by in-service documentation;**  
**Denominator: Total number of agency providers**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**In-Service Attendance Documentation**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input data-bbox="446 443 812 527" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input data-bbox="878 726 1243 810" type="text"/>

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

The state identifies and rectifies situations where providers do not meet requirements. This is accomplished by monitoring certification/license expiration dates within MMIS and continuing communication with the Medicaid fiscal agent responsible for provider enrollment functions, and reviewing monthly reports that identify providers whose participation is terminated for inactivity or violations. Participation in provider training is documented and monitored through monthly activity reports.

The state verifies that providers meet required licensing or certification standards and adhere to other state standards. License expiration dates are maintained in the MMIS and tracked for all participating and active providers. Non-certified providers are not allowed to provide services under this waiver.

Each month the DHS RN receives a provider list for each county included in their geographical area. This provider list may be used at each assessment and reassessment to give the participant a choice of providers for each service included on the service plan. In addition, this list is used to identify the providers who are new or who have been reinstated in the program.

Providers are required to follow all guidelines in the Medicaid Provider Manual related to provider training of employees and staff orientation, including documentation requirements, provider participation requirements, and any penalties or sanctions applicable for noncompliance.

Provider training consists of program policy, including documentation requirements, reporting, claims processing and billing, the Medicaid Provider Manual and other areas. This training is scheduled, at a minimum, two times per year based on training needs.

Training requirements are explained in the provider manual. In addition, the Division of Provider Services and Quality Assurance (operating agency) (DPSQA) is responsible for contacting new providers according to program policy. These contacts provide information regarding proper referrals, eligibility criteria, forms, reporting change of status, general information about the program, etc. Within three months of appearing on the provider list, the DHS RNs must meet with each new provider face-to-face to discuss all of the above.

Evaluations from in-services are used to address strengths and weaknesses in the training process, topics for future in-services, and policy enhancements. As a result of in-services, policy clarifications have been issued; forms have been revised; training topics have been chosen; documentation requirements have been revised; training sessions have been redesigned.

The Medicaid fiscal agent provides DPSQA access to Provider License/Certification Status. If needed, this provides a second monitoring tool for monitoring licensure and certification compliance.

The mandatory Medicaid contract, signed by each waiver provider, states compliance with required enrollment criteria. Failure to maintain required certification and/or licensure results in loss of their Medicaid provider enrollment. Each provider is notified in writing at least two months prior to the certification/licensure expiration date that renewal is due and failure to maintain proper certification will result in loss of Medicaid enrollment.

All waiver providers are responsible for all provider requirements, penalties and sanctions as detailed in the Medicaid provider manual.

#### **b. Methods for Remediation/Fixing Individual Problems**

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency, with primary responsibility for waiver program operations), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency with responsibility for provider certification and quality assurance), and the Division of Medical Services (Medicaid agency) – all three of which are part of the Arkansas Department of Human Services (DHS) – participate in team meetings as needed to discuss and address individual problems related to qualified providers, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures regarding qualified provider enrolled to provide services under the waiver.

All providers must meet required provider qualifications prior to Medicaid enrollment and prior to providing services. Because of this, performance measures related to these processes will always result in 100% compliance, and not allow for the possibility of remediation.

To continue Medicaid enrollment, a waiver provider must maintain certification by DPSQA. In cases where providers do not maintain certification, DPSQA’s remediation may include requesting termination of the provider’s Arkansas Medicaid enrollment, recouping payment for services provided after certification/licensure has expired, and allowing the participant to choose another provider.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

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

**No**

**Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

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### C-4: Additional Limits on Amount of Waiver Services

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

**Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable -** The State imposes additional limits on the amount of waiver services.

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

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

*Furnish the information specified above.*

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

*Furnish the information specified above.*

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

*Furnish the information specified above.*

Prospective Individual Budget Amount:

There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

1. Individual Services Budget (ISB):

a. In the ARChoices in Homecare program, there is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant. This limit is called the Individual Services Budget (ISB) and applies to all participants and all waiver services available through the ARChoices program.

b. Each ARChoices person-centered service plan shall include an Individual Services Budget, as determined by DAABHS for the specific participant during the service plan development process. The projected total cost of all authorized services in any ARChoices person-centered service plan (including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.

c. Each participant's Individual Services Budget shall be explained when the DAABHS registered nurse consults with the individual on the person-centered service plan. This may be done through written information.

d. Each participant shall also receive written notice of their Individual Services Budget that includes notice of the right to request a Fair Hearing if they are denied waiver services as a result of a dollar limit.

2. Adjustments, Considerations, and Safeguards Regarding Individual Services Budgets:

a. During the development of each person-centered service plan, after considering the participant's assessed needs, priorities, preferences, goals, and risk factors, and to ensure that the cost of all ARChoices services for each participant does not exceed the applicable Individual Services Budget amount, the DAABHS registered nurse shall, as necessary:

i. Limit and modify the type, amount, frequency, and duration of waiver services authorized for the participant (notwithstanding any service-specific limits established in Appendix C: Participant Services); and

ii. Make referrals to appropriate services available through the Medicaid State Plan or another waiver program, Medicare, the participant's Medicare Advantage (MA) plan (including targeted and other supplemental benefits the MA plan may offer), the participant's Medicare prescription drug plan, and other federal, state, or community programs.

b. Should the DAABHS nurse determine that the ARChoices waiver services authorized for the participant within the limit of the applicable Individual Services Budget, other Medicaid or Medicare covered services, and other available family and community supports, when taken together, are insufficient to meet the participant's needs, the DAABHS nurse shall counsel the participant on Medicaid-covered services in other settings that are available to meet their needs (e.g., nursing facility services and assisted living facility services) and make appropriate referrals. The DAABHS nurse may also order a re-assessment of the participant.

c. In the event that a participant's ISB requires changes or limitations to ARChoices services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, during the person-centered service plan process the participant will be given the opportunity to choose a different mix, type, or amount of ARChoices covered services. (For example, the participant could decide to forego a day of adult day health services in order to have additional attendant care hours.) Any such participant-requested changes and substitutions are subject to the following:

i. The services chosen by participant are otherwise covered and reimbursable under ARChoices and do not exceed any applicable service limitations;

- ii. The services chosen by participant are necessary and appropriate for the individual and consistent with results of the independent assessment;
- iii. The cost of all ARChoices waiver services authorized for or received by the participant, including any participant-requested changes and substitutions, do not exceed the applicable ISB amount;
- iv. The DAABHS nurse determines the changes are reasonable and necessary for the individual and reflected in the approved person-centered service plan.

d. If waiver services are or become limited due to the application of the Individual Services Budget, the affected participant may request an exception in the form of a temporary increase in the person's ISB amount applicable to a period not to exceed one year. Exception requests shall be reviewed and acted on by DAABHS using a panel of at least three registered nurses. The nurse panel will review and act on the exception request within ten (10) working days from the date that the exception request is received by DAABHS. The exceptions process, including request procedures, documentation, and process for determining exceptions, shall be specified in the ARChoices manual, as promulgated by DHS. This exceptions process is intended as a safeguard to address exceptional circumstances affecting a participant's health and welfare and not as means to circumvent the application of the Individual Services Budget policy or permit coverage of services not otherwise medically necessary for the individual, consistent with their level of care, assessment results, and waiver program policy. Approval of an exception request and associated temporary increase in a participant's Individual Services Budget amount for a period not to exceed one year is subject to the following criteria:

- i. In the professional opinion of the nurse panel, unique circumstances indicate that additional time is reasonably needed by the participant (or the participant's family on his or her behalf) to (1) adjust waiver service use costs to within the applicable Individual Services Budget (ISB) amount, (2) arrange for the start of or increase in non-Medicaid services (such as informal family supports and Medicare-covered services), and/or (3) arrange for placement in an alternative residential or facility-based setting.

- ii. Such unique circumstances must be (1) specific to the individual; (2) supported by documentation provided to the nurse panel; (3) relevant to the individual's assessed needs and risk factors; (4) relevant to the temporary need for additional, medically necessary coverable waiver services in excess of the person's pre-exception ISB amount; and (5) not the result of a need for skilled services or other services not covered under the waiver.

- iii. Such unique circumstances may include (1) recent major life events not known at the time the current person-centered service plan was approved, including without limitation death of a spouse or caregiver, and loss of a home or residential placement; and (2) a temporary increase in care needs, for a period not to exceed ninety (90) days after a discharge from inpatient acute treatment or post-acute care.

- iv. If the exception request is due to the participant (or participant's family on his or her behalf) encountering delays or difficulties in arranging new care arrangements or an alternative residential or facility-based placement in the state, an exception may be granted if the nurse panel determines reasonable efforts are being made and the delays or difficulties experienced are exceptional or due to rural or remote location of the participant's home.

- v. The factors considered by the nurse panel must be reasonably relevant to the necessity for additional waiver services in total cost in excess of the person's pre-exception ISB amount and for a temporary period of time not to exceed one year.

e. If the projected cost of services identified in an individual's person-centered service plan (whether such plan is under development, provisional, or final or renewed, amended, or extended) is less than the applicable Individual Services Budget amount, this shall not be construed to permit, suggest, or justify approval, coverage, or reimbursement of different or additional waiver services (including changes in amount, frequency, or duration); coverage and reimbursement of any medically unnecessary Medicaid State Plan or waiver services; or other actions to increase spending to use the remaining "unused" portion of the ISB amount.

f. The Individual Services Budget shall not apply to environmental accessibility adaptations/adaptive



equipment.

3. Transition Process:

a. The Individual Services Budget limit shall apply to the following:

i. New ARChoices participants, including individuals determined newly eligible for ARChoices following a period of ineligibility for this or another HCBS waiver program, when they are determined waiver eligible, and effective for their first person-centered service plan and thereafter; and

ii. Existing ARChoices participants immediately upon any of the following events, whichever may occur first:

(a) Waiver eligibility is re-evaluated;

(b) The Level of Care is reaffirmed or revised;

(c) A new independent assessment or re-assessment is performed;

(d) Expiration, renewal, extension, or revision of the participant's person-centered service plan occurs; or

(e) Admission to or discharge from an inpatient hospital, nursing facility, assisted living facility, or residential care facility, or transfer from a hospice facility occurs.

b. For all other ARChoices participants not otherwise identified above, the Individual Services Budget limit shall apply no later than 60 days after the effective date of this waiver amendment.

c. For the following ARChoices participants, the DAABHS deputy director (or his/her designee) may on a case-by-case basis extend the effective date of the participant's first Individual Services Budget by a maximum of 60 days per participant upon written request of the participant (or legal representative) or the participant's personal physician, if:

i. The specific participant's recent pattern of waiver service expenditures exceeds the average Individual Services Budget amount by an estimated twenty-five (25) percent or more; and/or

ii. DAABHS determines that unique, intervening circumstances indicate that additional time is reasonably needed by the participant and the participant's family and providers. Examples of unique, intervening circumstances include the death of the spouse, loss of home, or unexpected difficulties in accessing or arranging care or placement, among others.

4. Methodology for Determining Individual Services Budgets:

a. The Individual Services Budget amount for a participant is based on that participant's ISB Level. The ISB Level is determined by DAABHS based on a review of the participant's Independent Assessment. The DHS RN will use the results of the ARIA Independent Assessment to determine ISB amounts and assign individuals to grouped levels. The three ISB Levels are:

i. Intensive: The participant requires total dependence or extensive assistance from another person in all three areas of mobility, feeding, and toileting.

ii. Intermediate: The participant requires total dependence or extensive assistance from another person in two of the areas of mobility, feeding, or toileting.

iii. Preventative: The participant meets the functional need eligibility requirements for ARChoices in Section 212.000 but does not meet the criteria for the ISB Levels of Intensive or Intermediate.

b. The maximum Individual Services Budget for a participant, except as modified by the Transitional Allowance in subsection (c) below, is as follows:

i. For an individual with an assessed ISB Level of Intensive, the Individual Services Budget is \$30,000.

- ii. For an individual with an assessed ISB Level of Intermediate, the Individual Services Budget is \$20,000.
- iii. For an individual with an assessed ISB Level of Preventative, the Individual Services Budget is \$5,000.

c. For a participant with total waiver expenditures of more than \$30,000 for calendar year 2018:

- i. The participant will be granted a Transitional Allowance for one year, increasing the participant's maximum Individual Services Budget to the amount of the participant's total waiver expenditures for calendar year 2018.
- ii. In the year following the Transitional Allowance, the participant's maximum Individual Services Budget will be 95% of the participant's total waiver expenditures for calendar year 2019.
- iii. For purposes of this subsection (c), "total waiver expenditures" for a calendar year shall be calculated as the sum total of the value of all waiver services authorized for the participant in the person-centered service plan as of December 31, and then modified by:
  - (a) If the cumulative expenditures are for less than 12 months, annualizing the total to reflect what the expenditures would have been if the participant had received the same monetary amount of services for 12 consecutive months; and
  - (b) Excluding amounts expended for environmental modifications/adaptive equipment.

d. DHS will monitor and update these ISB amounts if circumstances (including without limitation provider rate increases) warrant a change for CY2020.

e. For purposes of determining the projected cost of all waiver services in an individual's person-centered service plan, DAABHS shall assume that:

- i. The individual will receive or otherwise use all services identified in the service plan and in their respective maximum authorized amounts, frequencies, and durations; and
- ii. There are no interruptions in the provision of waiver services due to possible future events such as an inpatient admission, nursing facility admission, or short-term admission to another facility setting.

f. Determination of ISB Amounts

- i. The maximum ISB amount, \$30,000, which is also the threshold for the Transitional Allowance, is based on the average annual state and federal cost of nursing home care, excluding the average resident share, the average revenue from the state-imposed Quality Assurance Fee (QAF), and the average FMAP revenue associated with the QAF. For FY2018, the average amount of state general revenue paid for a nursing home stay was \$24.04 per day; the average amount of the FMAP on that state general revenue was \$57.67, for an average daily total of \$81.71, multiplied by 365 days to produce an annual total average cost of \$29,824.15. This amount is then rounded up to the nearest thousand to produce the \$30,000 ISB amount.
- ii. The ISB amounts for the Preventative and Intermediate levels are based on a DHS review of actual waiver service expenditures during FY2018 by a set of 6,810 ARChoices participants who received an assessment or reassessment during FY2018. The expenditures for each participant were adjusted to produce a projected annual total expenditure amount, and participants were divided into the Preventative, Intermediate, and Intensive ISB levels based on the results of the ArPath assessment or reassessment recorded in FY2018. DHS then reviewed the distribution of projected annual total expenditure amounts by ISB level to determine an appropriate ISB amount.

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

## Appendix C: Participant Services

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### C-5: Home and Community-Based Settings

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

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

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

Please see Attachment 2 for the transition plan to ensure all providers are in compliance.

Arkansas is still assessing settings compliance in accordance with the transition plan.

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**

Service Plan

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

**Registered nurse, licensed to practice in the State**

**Licensed practical or vocational nurse, acting within the scope of practice under State law**

**Licensed physician (M.D. or D.O)**

**Case Manager** (qualifications specified in Appendix C-1/C-3)

**Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

**Social Worker**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

When scheduling the person-centered service plan development visit, the DHS RN explains to the participant or authorized representative the process and informs the participant that they may invite anyone they choose to participate in the service plan development process. Involved in this assessment visit is the participant and anyone they choose to have attend, such as their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment process or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting.

During the service plan development, the DHS RN explains to the participant the services available through the ARChoices waiver.

When developing the person-centered service plan, all services and any applicable benefit limits are reviewed, as well as the comprehensive goals, objectives and appropriateness of the services. The participant and their representatives participate in all decisions regarding the type of services, amount and frequency of the services included on the service plan. All services must be justified, based on need and available support services. This information is recorded on the service plan, which is signed by the participant.

## Appendix D: Participant-Centered Planning and Service Delivery

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

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the

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

(a) DHS RNs will develop initial person-centered service plans for ARChoices in Homecare participants based on the Independent Assessment Contractor's assessment of the participant's needs and information gathered during the service plan development meeting with the participant. The DHS RN will inform participants that they may invite anyone that they choose to participate in the service plan development process. Involved in this service plan development visit is the participant, their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting. The DHS RN will assist in notifying interested parties if requested by the participant or the representative.

The development of the person-centered service plan will begin with an in-person independent assessment conducted by the DHS Independent Assessment Contractor. The Independent Assessment Contractor will contact the waiver participant to schedule a convenient time and location for the assessment. The assessment will be scheduled and completed by the Independent Assessment Contractor within 10 working days of the Independent Assessment Contractor receiving a referral from DHS. Following the assessment and assignment of a tier level by the Independent Assessment Contractor, a DHS RN will schedule a meeting with the participant to develop the service plan. Reassessments, which will be conducted by the Independent Assessment Contractor, will be completed annually or more often, if deemed appropriate by the DHS RN. Following the reassessment by the Independent Assessment Contractor, the DHS RN will develop a person-centered service plan. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Service plans are developed and sent to all providers before services may begin.

(b) The Independent Assessment Contractor will assess the participant's needs. The DHS RN will assess the participant's comprehensive goals and objectives related to the participant's care and reviews the appropriateness of ARChoices services. If necessary, the DHS RN will read any of the information provided during the assessment to the participant. If this is done, it is documented in the participant's record. All forms and information will be provided in an alternate format upon request. If an alternate format is requested and/or provided, the DHS RN will document in the participant's record the format requested and/or provided.

All accommodations are provided on an individualized basis according to the participant's needs. DHS has a contract with an interpreter to accommodate applicants/participants who are hearing impaired. The Independent Assessment Contractor and the DHS RNs will provide written materials to participants and will read any information to participants if needed. DHS RNs may utilize assistance from other divisions within the Arkansas Department of Human Services, such as the Division of Services for the Blind, in these instances. When this occurs, it is documented in the participant's record.

The results of the Independent Assessment Contractor's functional assessment using the ARIA assessment tool will be used by the Office of Long Term Care to evaluate the level of care and by the DHS RN to develop the person-centered service plan. Information collected for the Independent Assessment Contractor's functional assessment using the ARIA tool will include demographic information and information on the waiver participant's ability to perform the activities of daily living; transferring and ambulation; continence status; nutritional status; hearing, vision, speech and language; skin condition; behavior and attitude; orientation level; other medical conditions; psychosocial and cognitive status; and, medications/treatments.

The assessment is a complete functional assessment and includes a medical history. The Independent Assessment Contractor will evaluate the participant's physical, functional, mental, emotional and social status, and will obtain a medical history to ensure that the service plan addresses the participant's strengths, capacities, health care, and other needs. The DHS RN will assess the participant's preferences, goals, desired outcomes, and risk factors. Support systems available to the participant are identified and documented, along with services currently in place. Based on this assessment information, the DHS RN will discuss the service delivery plan with the participant.

When the service plan development process results in an individual being denied the services or the providers of their

choice, the state must afford the individual the opportunity to request a Fair Hearing.

**Provisional (Temporary Interim) Service Plan Policy:** A provisional person-centered service plan may be developed by the DHS RN prior to determination of Medicaid eligibility, based on information obtained during the in-home functional assessment if the applicant is functionally eligible based on the Independent Assessment Contractor's assessment. The DHS RN must discuss the Provisional Service Plan Policy and have approval from the applicant prior to completing and processing a provisional service plan, which will then be signed by the applicant or the applicant's representative and the DHS RN. The provisional service plan will be provided to the waiver applicant and each provider included on the service plan. The provider will notify the DHS RN via form AAS-9510 (Start of Care Form), indicating the date services begin. No provisional service plans will be developed if the waiting list process has been implemented.

Provisional person-centered service plans expire 60 days from the date signed by the DHS RN and the participant. A comprehensive service plan that has been approved with a Medicaid number and waiver eligibility date must be in place no later than the expiration date of the provisional service plan. Prior to its expiration date, the DHS RN will provide a signed, comprehensive service plan to the ARChoices provider.

The Independent Assessment Contractor will complete a face-to-face functional assessment within 10 working days of receiving a referral from DHS. The DHS RN meets with the participant and develops an ARChoices person-centered service plan. Once the service plan is signed by the DHS RN and the applicant, it is considered a provisional service plan.

If services are started based on the provisional service plan, providers will send the Start of Care (AAS-9510) form to the DHS RN indicating the date services started. No additional notification to the DHS RN is required when the comprehensive service plan is received.

(c) During the person-centered service plan development process, the DHS RN explains the services available through the ARChoices waiver to the participant, including any applicable benefit limits. All services the participant is currently receiving are discussed and documented on the person-centered service plan. This includes all medical and non-medical services, such as diapers, under pads, nonemergency medical transportation, family support or other services that are routinely provided.

(d) The DHS RN develops the person-centered service plan based on the information gathered through the assessment process and the discussion of available services with the participant. The service plan addresses the participant's needs, goals and preferences. The participant may invite anyone they choose to participate in the assessment and service plan development process, including family members and caregivers. Also, the DHS RN may contact anyone who may be able to provide accurate and pertinent information regarding the participant's condition and functional ability.

If there is any indication prior to or during the assessment or person-centered service plan development process that the participant is confused or incapable of answering the questions required for a proper assessment and service plan development, the assessment or service plan development will not be conducted without another person present who is familiar with the participant and his or her condition. This may be a family member, friend, neighbor, caregiver, etc. If unavailable for the interview, this person may be contacted by phone. These individuals' participation in the service plan development process also helps to ensure that the participant's goals, preferences and needs are met.

When developing or updating the person-centered service plan, the participant and their representatives participate in all decisions regarding the types, amount and frequency of the services included on the service plan. All services must be justified, based on need and available support services.

(e) The participant must choose a provider for each waiver service selected. During the service plan development process, the DHS RN informs the participant or their legal guardian or family member of the available services. The participant or guardian/family member may choose the providers from which to receive services. Documentation

verifying freedom of choice was assured is included in the participant's record on the person-centered service plan, and on the provider list. Both documents reflect freedom of choice was given to the participant. The freedom of choice form and all related documents are included in the participant's record and reviewed during the DHS RN supervisory review process. Each service included on the service plan is explained by the DHS RN. The amount, frequency, scope and provider of each service is also discussed and entered on the service plan. The DHS RN sends a copy of the service plan to the waiver provider, as well as the participant. The DHS RN tracks the implementation of each service through the Start of Care form, which includes the date services begin.

(f) Implementation, compliance, and monitoring of the person-centered service plan is the responsibility of DAABHS (Operating Agency), DMS (Medicaid Agency), and providers of ARChoices in Homecare waiver services.

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the participant's condition to the DHS RN, who is the only authorized individual who may adjust a participant's service plan. Providers agree to render all services in accordance with the Arkansas Medicaid ARChoices in Homecare Home & Community Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAABHS; to notify the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or necessitate a change in the participant's person-centered service plan; to continually monitor participant satisfaction and quality of service delivery; and, to notify the DHS RN in writing within one week of services being terminated, documenting the termination effective date and the reason for the termination.

Providers assure the Division of Provider Services and Quality Assurance (DPSQA) that adequate staffing levels are maintained to ensure timely and consistent delivery of services to all participants for whom they have accepted an ARChoices in Homecare service plan. Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the service plan developed by the DHS RN. Providers acknowledge that the DHS RN is the only authorized individual who may adjust an ARChoices in Homecare waiver participant's service plan. Providers will implement the service plan with the flexibility to schedule hours to best meet the needs of the participant and will be monitored by DAABHS for compliance.

Service plans are revised by DHS RNs as needed between assessments, based on reports secured through providers, waiver participants and their support systems.

(g) Each reassessment and person-centered service plan development is completed annually or more often, if deemed appropriate by the DHS RN. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Changes are reported to the DHS RN by the participant, the participant's family or representatives, service providers and Targeted Case Managers. The DHS RN has sole authority for all development and revisions to the waiver service plan. Service plan updates must be based on a change in the participant's status or needs.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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



The Independent Assessment Contractor assesses a participant's needs, functional abilities, and performance of activities of daily living during the assessment. The DHS RN assesses a participant's preferences, risks, dangers, and supports during the meeting with the participant to develop a person-centered service plan. In addition, the service plan development process includes assessment of risk factors and strategies to mitigate risk conducted in a manner that is sensitive to the waiver participant's preferences and the responsibilities required to reduce risk. The risk mitigation includes factors regarding the participant's functioning ability, ADL performance, support systems in place, risk of falls, environmental factors, and other dangers. This information is included on the person-centered service plan and in the participant's record. Services are started as soon as possible in order to mitigate risk.

The person-centered service plan also includes contact information for emergency care and backup plans. The name of a backup caregiver, or the person responsible for the participant, must be included on the person-centered service plan. Backup caregivers are often family members, neighbors or others familiar with the participant.

Routine monitoring of ARChoices in Homecare participants also helps to assess and mitigate risk. DHS RNs make at least annual contact with participants and take action to mitigate risks if an issue arises. Targeted Case Managers are required to monitor the participant monthly at a minimum and must follow frequency requirements as described in the Targeted Case Management Medicaid Provider Manual regarding face-to-face or telephone contacts with the participant. Potential risks identified during these monitoring contacts require the Targeted Case Manager to take action to mitigate the risk.

Also, providers, family members and others who have regular contact with participants are required to report any change in participant condition, or perceived risk or other problem concerning the participant. The DHS RNs also re-evaluate potential participant risks during monitoring visits. DHS RNs and Targeted Case Managers refer any high-risk participants to Adult Protective Services immediately if it is felt that the participant is in danger. DHS RNs also provide patient education on safety issues during the assessment and annual reassessment. The annual contact by the DHS RN is a minimum contact standard. Visits are made as needed during the interim.

Service providers are required to follow all guidelines in the Medicaid Provider manual related to emergencies, including the emergency backup plan process and contact information for emergencies. The provider assures DAABHS all necessary safeguards and precautions have been taken to protect the health and welfare of the participants they serve. Providers agree to operate and provide services in full compliance with all applicable federal, state and local standards including, but not limited to, fire, health, safety and sanitation standards prescribed by law or regulations. Providers assure DAABHS that conditions or circumstances which place a person, or the household of a person, in imminent danger will be brought to the attention of appropriate officials for follow-up. Providers agree to inform the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or would necessitate a change in the participant's service plan.

Participants, family members or the participant's representative may also contact the DHS RN or Targeted Case Manager any time a change is needed or a safety issue arises. Additional monitoring is performed by DMS as part of the validation review, by Office of Medicaid Inspector General audits, and in response to any complaints received.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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

The participant must choose a provider for each waiver service selected. When a person-centered service plan is developed, the DHS RN must inform the individual, their representative, or family member of all qualified ARChoices in Homecare qualified providers in the individual's service delivery area. The participant, representative, or guardian/family member may choose the providers from which to receive services. The name of the providers chosen by the participant, representative, or family member/representative must be included on the person-centered service plan prior to securing the individual's signature. Along with signing the service plan, and the Freedom of Choice form, an up-to-date provider listing from DPSQA must be signed and initialed. If a family member/representative chooses a provider for the participant, the DHS RN must identify the individual who chose the providers on the service plan and on the Freedom of Choice form. Documentation is also included in the participant's record and reviewed during the DHS RN supervisory review process.

For reassessments, the participant or representative must sign the Freedom of Choice form to show that no change in providers was made. The provider listing does not need to be initialed if there are no changes in providers. However, if a participant wishes to change providers at reassessment, both the Freedom of Choice form and provider listing must be signed and initialed indicating this change. Participants may request a change of providers at any time during a waiver year.

The participant chooses the provider. However, the participant may invite his or her family members or representative to participate in the decision-making process. Any decision made by a family member or representative is done at the participant's request and is documented.

DHS RNs and Targeted Case Managers leave contact information with participants at each visit. The participant may contact the DHS RN at any time to find out more information about providers.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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

All ARChoices in Homecare person-centered service plans are subject to the review and approval of the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (Operating Agency), and the Division of Medical Services (DMS) (Medicaid Agency).

DMS does not review and approve all service plans prior to implementation; however, all are subject to the Medicaid Agency's approval and are made available by the operating agency upon request. DMS reviews a validation sample of participants' records which includes the person-centered service plan. Reviewed service plans are compared to policy guidelines, the functional assessment, and the case notes detailing the participant's living environment, physical and mental limitations, and overall needs.

A statistically valid random sample of service plans is determined, using the Raosoft software calculations program, for review by the DHS RN supervisory staff. Records are reviewed to assess the appropriateness of the service plan, to validate service provision, to ensure that services are meeting the waiver participant's needs and that necessary safeguards have been taken to protect the health and welfare of the participant and to profile provider billing practices. In the event the service plan is deemed inappropriate or service provision is lacking, the DHS RN addresses any needed corrective action. In the event provider billing practices are suspect, all pertinent information is forwarded to the Office of Medicaid Inspector General.

In addition, DMS completes a validation review of participant records reviewed by DAABHS. For the validation review, DMS reviews 20% of the records reviewed by DAABHS. For the provider file sample, the Raosoft online calculator is used to determine a statistically valid sample size with a 95% confidence level and a margin of error of +/- 5%. Every nth name is selected for review until the sample size is reached. The sample is then divided into twelve groups for monthly review by DMS.

Information reviewed by both DAABHS and DMS during the record review process includes, but is not limited to: development of an appropriate individualized person-centered service plan, completion of updates and revisions to the service plan and coordination with other agencies as necessary to ensure that services are provided according to the service plan.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

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

**Medicaid agency**

**Operating agency**

**Case manager**

**Other**

*Specify:*

The service plan is maintained by the DHS RN in the participant's record and by the ARChoices in Homecare waiver service providers.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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### **D-2: Service Plan Implementation and Monitoring**

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

Waiver participants are monitored through a variety of means and all monitoring by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) waiver staff, Targeted Case Managers, and providers includes compliance with the service plan, the health and welfare of the participant, access to services, effectiveness of backup plans, and complaints or problems. Contact with ARChoices participants is maintained to ensure that services are furnished according to the person-centered service plan and that the services meet the participant's needs. Monitoring is an essential component of Targeted Case Management. Targeted Case Managers are required to conduct routine monitoring and report to the DHS RN. Targeted Case Managers must follow the monitoring guidelines and timeframes outlined in the Medicaid Provider Manual.

#### DHS RNs:

DHS RNs monitor each waiver participant's status on an as-needed basis for changes in service need, reassessment (if necessary), and reporting any participant's complaints of violations of rules and regulations to appropriate authorities for investigation. If participants are unable to participate in a monitoring contact, the participant may invite anyone they choose to participate in the visit. Most often this is the participant's legal guardian, representative or family member.

At each person-centered service planning meeting, the DHS RN provides the participant with their contact information, an Adult Protective Services (APS) brochure to provide information and the toll-free APS hotline for reporting abuse, maltreatment or exploitation. This information may be utilized by the participant or guardians/family members to report any issues they deem necessary, so that DAABHS can ensure prompt follow-up to problems.

#### ARCHOICES IN HOMECARE PROVIDERS:

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting, and documentation requirements. Provider are required to report any change in the participant's condition to the participant's DHS RN.

#### TARGETED CASE MANAGERS:

Targeted Case Management is included on each ARChoices service plan, unless declined by the participant.

Targeted Case Managers must maintain contact with participants as frequently as needed, with a minimum of one contact monthly to help determine whether services are being furnished according to the participant's person-centered service plan, the adequacy of the services in the service plan, and changes in the participant's needs or status. These contacts may be face-to-face or by telephone, according to established policy as outlined in the Targeted Case Management Medicaid Provider Manual. Targeted Case Managers must give participants their office phone numbers, and leave a business card or contact sheet in the participant's home in case of concerns or questions.

Targeted Case Managers must conduct monitoring according to current policy, including initial meetings with participants to discuss the participant's needs and to determine who currently provides for any or all of their needs. Following the initial home visit, Targeted Case Managers must make unannounced face-to-face monitoring visits as required by current policy.

If the participant's circumstances remain stable, no provider changes are made and no problems noted, unannounced face-to-face monitoring visits must continue according to current policy. During months no face-to-face visit is conducted, a telephone contact must be made. An ARChoices in Homecare Monitoring Form must be completed during face-to-face visits. A contact is not considered a face-to-face monitoring contact unless the required monitoring form is completed, dated and signed by the case manager and filed in the participant's record. Documentation in the narrative of the participant's record will suffice for telephone contacts, rather than completing the monitoring form. All face-to-face and telephone contacts must be documented in the participant's case record for review and audit purposes.

During each home visit, the Targeted Case Manager must document the participant's condition, the condition of the home, living environment, adequacy of the participant's person-centered service plan, and overall success of service plan delivery. Any problems, changes, complaints, observations, concerns or other participant issues (e.g., provider changes, information regarding change of condition, hospital admissions, hospital discharges, address changes, telephone number changes, deaths, any change in waiver or non-waiver services) must be documented in the participant's record and reported immediately to the DHS RN via the Change of Client Status form (AAS-9511) or email. The AAS-9511 may be transmitted via fax or email to the DHS RN. Copies of required forms and/or communication must be maintained in the participant's record.

Targeted Case Managers review the person-centered service plan with the participant during all face-to-face visits to ensure that services are being provided according to the plan. The Targeted Case Manager will also measure the participant's progress toward service plan goals.

The contacts listed above are a minimum requirement. In an effort to assure health and safety, compliance with the waiver person-centered service plan, and the integrity of services billed to the Medicaid Program, it is the Targeted Case Manager's responsibility to visit, call and support the waiver participant as much as is needed based on the individual's circumstances and the stability of their services.

#### INFORMATION EXCHANGE:

Both DMS and DAABHS perform regular reviews to support proper implementation and monitoring of the person-centered service plan. Record reviews are thorough and include a review of all required documentation regarding compliance with the service plan development assurance. Reviews include, but are not limited to, completeness of the service plan; timeliness of the service plan development process; appropriateness of all medical and non-medical services; consideration of participants in the service plan development process; clarity and consistency; and, compliance with program policy regarding all aspects of the service plan development, changes and renewal.

The DHS RN maintains an established caseload, covering certain counties in Arkansas. Each participant knows his or her DHS RN and has the DHS RN's contact information. DHS RN supervisors assist in the resolution of problems, monitor the work performed by the DHS RNs by making periodic visits with each DHS RN, and assist in overall program monitoring and quality assurance. Additionally, a record review process is conducted on a monthly basis by DHS RN supervisors. Records are pulled at random and reviewed for accuracy and appropriateness in the areas of medical assessments, service plans, level of care determinations and documentation. Selection begins by reviewing the latest monthly report from the Arkansas Client Eligibility System (ACES). This report reflects all active cases and includes each participant's waiver eligibility date. Records are pulled for review based on established eligibility dates. A comparable pull is made to review new eligibles, established eligibles, recent closures and changes. This method results in all types of charts being reviewed for program and procedural compliance. DAABHS supervisory staff uses the Raosoft Calculation System to determine the appropriate sample size for record review with a 95% confidence level and a margin of error of +/-5%, and selects every name on the list to be included in the sample.

The following reports are used to compile monitoring information and reported as indicated:

1. Monthly Reports - compiled by each DHS RN and reported monthly to RN supervisor. All monitoring visits are reported.
2. RN Supervisor Report - compiled by each RN supervisor and reported monthly to the Nurse Manager. All monitoring visits are reported.
3. Monthly Record Reviews - performed monthly by RN supervisors and reported monthly to Nurse Manager.
4. DMS Monthly Record Reviews - performed monthly by DMS and reported monthly to DAABHS.
5. DMS Annual QA Report - compiled annually by DMS and reported to DAABHS.

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

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

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

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

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to emergencies, including the emergency backup plan process and contact information for emergencies. Providers agree to inform the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or would necessitate a change in the participant's person-centered service plan.

ARChoices in Homecare providers agree to render all services in accordance with the Arkansas Medicaid ARChoices in Homecare Home & Community-Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency); to continually monitor participant satisfaction and quality of service delivery; and, to notify the DHS RN in writing within one week of services being terminated documenting the termination effective date and the reason for termination.

ARChoices in Homecare providers assure the Division of Provider Services and Quality Assurance (DPSQA) (operating agency) that adequate staffing levels are maintained to ensure timely and consistent delivery of services to all participants for whom they have accepted an ARChoices in Homecare waiver person-centered service plan. Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the service plan developed by the DHS RN. Providers acknowledge that the DHS RN is the only authorized individual who may adjust an ARChoices in Homecare waiver participant's service plan. Providers accept full responsibility for the quality and number of service units provided to an ARChoices in Homecare waiver participant by their staff, and assure DAABHS appropriate management and supervision of services takes place at all times.

Person-centered service plans are revised by DHS RNs as needed between assessments, based on information secured through providers, waiver participants and their support systems.

Targeted Case Managers monitor waiver participants' status as needed for changes in service need, referring participants for reassessment if necessary and reporting any participant complaints of violations of rules and regulations to appropriate authorities for investigation. If participants are unable to participate in a monitoring contact, the participant's legal representative, guardian or family member may participate on their behalf. This oversight ensures that participants are receiving the specified services to meet their needs and according to the person-centered service plan.

DHS RNs and Targeted Case Managers must document all contacts (in person, telephone or correspondence) with or on behalf of the participant in the participant's case record. If a monitoring contact produces any information that warrants further action, DHS RNs and Targeted Case Managers are responsible for following through and taking any action deemed appropriate.

## **Appendix D: Participant-Centered Planning and Service Delivery**

### **Quality Improvement: Service Plan**

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of participants reviewed who had service plans that addressed risk factors. Numerator:** Number of service plans that address risk factors;  
**Denominator:** Number of records reviewed

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

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



		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**Number and percent of participants reviewed who had service plans that were adequate and appropriate to their needs as indicated by the assessment(s).**

**Numerator: Number of participants with service plans that address needs;**

**Denominator: Number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

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

		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**Number and percent of participants reviewed who had service plans that addressed personal goals. Numerator: Number of service plans that address personal goals; Denominator: Number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>

<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of service plan development procedures that are completed as described in the waiver application. Numerator: Number of participants' service plans completed according to waiver procedures; Denominator: Number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<p><b>Representative Sample</b> Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.</p> </div>
<b>Other</b>	<b>Annually</b>	<b>Stratified</b>

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of service plans that were reviewed and revised as warranted on or before waiver participants annual review date. Numerator: Number of participants' service plans that were reviewed/revised before annual review date; Denominator: Number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;">             DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.           </div>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:



<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of participants reviewed who received services in the type, scope, amount, frequency and duration specified in the service plan. Numerator:**

**Number of participants' service plans who received services specified in service plan;**

**Denominator: Number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;">             DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.           </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	Annually	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100%; height: 20px;"></div>

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of waiver participant records reviewed with an appropriately completed service plan that specified choice was offered between institutional care and waiver services and among waiver services. Numerator: Number of participants' service plans with choice between institutional care waiver services and among waiver services; Denominator: Number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;">             DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.           </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 30px; margin-top: 5px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100px; height: 30px; margin-top: 5px;"></div>
	<b>Continuously and</b>	<b>Other</b>

	<b>Ongoing</b>	Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of waiver participant records reviewed with appropriately completed and signed freedom of choice forms that specified choice of providers was offered. Numerator: Number of participants with freedom of choice forms with choice of providers; Denominator: Number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;">             DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.           </div>
<b>Other</b> Specify:  <input data-bbox="451 1276 672 1360" type="text"/>	Annually	<b>Stratified</b> Describe Group:  <input data-bbox="1073 1276 1247 1360" type="text"/>
	Continuously and Ongoing	<b>Other</b> Specify:  <input data-bbox="1073 1499 1247 1583" type="text"/>
	<b>Other</b> Specify:  <input data-bbox="737 1724 959 1808" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input data-bbox="444 558 812 642" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input data-bbox="876 842 1243 926" type="text"/>

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

The state currently operates a system of review that assures completeness, appropriateness, accuracy, and freedom of choice. This system focuses on participant-centered service planning and delivery, participant rights and responsibilities, and participant outcomes and satisfaction.

Individual records are reviewed monthly by DAABHS for completeness and accuracy and resulting data is made available for the production of the Record Review Summary Report.

The state monitors service plan development in accordance with its policies and procedures, and takes appropriate action when it identifies inadequacies in the development process. Revisions and updates to records are made as changes in participant needs necessitate. Remediation is performed on service plans that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by the RN supervisor and is a part of the record review process.

DAABHS supervisory staff uses the Raosoft calculation system to determine appropriate sample size for ARChoices in Homecare Record Review, and selects every nth name on the list to be included in the sample.

Record reviews of the overall program files are thorough and include a review of all required documentation regarding compliance with the service plan development assurance and service plan delivery. Reviews include, but are not limited to, completeness of the service plan; timeliness of the service plan development process; appropriateness of all medical and non-medical services; consideration of participants in the service plan development process; clarity and consistency; compliance with program policy regarding all aspects of the service plan development, changes, and renewal.

Some measures have multiple factors that are reviewed to determine if the area is in compliance. These measures are directly related to the CMS waiver assurance areas, including service plan development and delivery of services. Initial verification of service delivery is verified via the Start of Care form. This documentation is a part of every record review.

Record reviews check for the presence of justification for requested changes and proper documentation, and data is summarized for the Record Review Summary. Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers. Records are reviewed to assure that a Freedom of Choice form was presented to the participant and that a complete, up-to-date list of providers has been made available to the participant.

The state monitors service plan development in accordance with its policies and procedures, and takes appropriate action when it identifies inadequacies in the development process. Revisions and updates to records are made as changes in participant needs necessitate. Remediation is performed on person-centered service plans that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by the DHS RN supervisor and is a part of the record review process.

**b. Methods for Remediation/Fixing Individual Problems**

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



The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency, with primary responsibility for waiver program operations), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency with responsibility for provider certification and quality assurance), and the Division of Medical Services (Medicaid agency) – all three of which are part of the Arkansas Department of Human Services (DHS) – participate in team meetings as needed to discuss and address individual problems related to service plans, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures regarding qualified provider enrolled to provide services under the waiver.

If a participant record lacks required documentation regarding this assurance, DAABHS’s remediation includes completing the required documentation according to policy and additional staff training in this area.

The tool used to review waiver participants' records captures and tracks remediation in these areas.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

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

**No**

**Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Applicability** (from Application Section 3, Components of the Waiver Request):

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (select one):

**Yes. The State requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**

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## Appendix E: Participant Direction of Services

**E-1: Overview (1 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

**E-1: Overview (2 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

**E-1: Overview (3 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

**E-1: Overview (4 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

**E-1: Overview (5 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

**E-1: Overview (6 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

**E-1: Overview (7 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (13 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant Direction (1 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant-Direction (2 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant-Direction (3 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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## **E-2: Opportunities for Participant-Direction (4 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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### **Appendix E: Participant Direction of Services**

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#### **E-2: Opportunities for Participant-Direction (5 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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### **Appendix E: Participant Direction of Services**

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#### **E-2: Opportunities for Participant-Direction (6 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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### **Appendix F: Participant Rights**

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#### **Appendix F-1: Opportunity to Request a Fair Hearing**

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The form DCO-707 (Notice of Action) is issued by the DHS County Office to provide notice to an applicant or waiver participant of any action taken with regard to Medicaid and program eligibility, such as approval and eligibility effective dates, denial and denial effective dates, the reason for action taken, and requests that further information be provided to the DHS County Office by the applicant or participant.

Waiver applicants and participants are advised on the DCO-707 (Notice of Action) or the system-generated Notice of Action by the DHS County Office when adverse action is taken to deny, suspend, reduce, or terminate eligibility for ARChoices in Homecare. The notice explains the action taken, the effective date of the action, the reason for the action, and explains the applicant's or participant's right to a hearing if the individual disagrees with the action the DHS County Office plans to take, the 30-day deadline for requesting a hearing, how to file for a hearing, and the applicant's or participant's right to representation.

Fair hearings are the responsibility of the Department of Human Services, Appeals and Hearings Office. This information and the contact information for the Appeals and Hearings Office is provided on the form DCO-707. The form is available in Spanish and large print formats, and advises the applicant or participant of such.

DHS has set guidelines for retention of the form DCO-707 in the applicant's or participant's case record. If the DCO-707 is a request for information only, the form may be discarded when all requested information is received by the LTSS Eligibility Caseworker. If the information requested is not received, the form may be discarded five years from the month of origin of the request. All other DCO-707 forms will be retained in the applicant's or participant's case record for five years from the date of the last approval, closure or denial.

Participants also have the right to appeal if they disagree with a revision to their service plan, which reduces or terminates services, while their eligibility remains active. Information regarding hearings and appeals is included with the participant's service plan. The DHS Appeals and Hearings section is also responsible for these types of appeals. Requests for appeals must be received by the DHS Appeals and Hearings section no later than 30 days from the business day following the postmark on the envelope with the service plan that contains a revision which the participant wishes to appeal.

ARChoices participants have the option of continuing Medicaid eligibility and services during the appeal process. They are informed of their options when notified by the DHS county office of the pending adverse action. If the findings of the appeal are not in the participant's favor, and the participant has elected the continuation of benefits, the participant is liable for payment to the provider. If Medicaid has paid the provider, DHS will consider the services that were provided during the period of ineligibility a Medicaid overpayment and will seek reimbursement from the participant.

Participants have the right to appeal if they were not provided a choice in institutional care or waiver services, or a choice of providers.

The service providers and the Department of Human Services county office inform the participant of their potential payment liability if a participant has been denied eligibility for the program and if the determination of an appeal is not in the participant's favor.

During the service plan development process, the DHS RN explains these rights to the participant, family member or representative. Signatures on the service plan verify that the choice between waiver services or institutional care was exercised. Also, during this process, participants choose a provider from a list provided by the DHS RN. Choices of provider are documented on the Freedom of Choice form, and the participant signs the list of providers showing that the choice was made.

NOTE: For reassessments, the freedom of choice form is utilized showing no changes are requested by the participant. No signatures are required on the provider listing; however, the freedom of choice form is signed by the participant or their representative.

## **Appendix F: Participant-Rights**

### **Appendix F-2: Additional Dispute Resolution Process**

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

**No. This Appendix does not apply**

**Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

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### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

**No. This Appendix does not apply**

**Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Arkansas Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS) and Division of Provider Services and Quality Assurance (DPSQA)

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any dissatisfaction written or verbalized regarding a HCBS program or service is to be considered a complaint. Participants wishing to file a complaint or report any type of dissatisfaction should contact the DAABHS Central Office or their DHS RN. When DAABHS is contacted regarding a complaint or dissatisfaction, DAABHS explains the complaint process to the participant, and completes the HCBS Complaint Intake Report electronically. Any DAABHS staff receiving a complaint must complete the HCBS Complaint Intake report. DPSQA is responsible for investigating complaints pertaining to provider quality or compliance.

The HCBS Complaint database, is used to track any dissatisfaction or complaint, including complaints against DAABHS staff and DPSQA-certified providers (including individual providers, provider organizations, and employees and contractors of provider organizations). The record of complaint includes the date the complaint was filed.

The complaint database was designed to register different types of complaints. Based on the data entered, the complaint can be tracked by type of complaint (service, provider, DAABHS, etc.) and complaint source (participant, county office, family, etc.), and monitored for trends, action taken to address complaint, access, quality of care, health and welfare. The complaint database provides a means to address any type complaint filed by any source. The complaint database also tracks resolution.

Information entered into the database includes the complaint source and contact information, participant information, person or provider against whom the complaint is being made, the person who received the complaint, the person to whom the complaint is assigned for investigation, the complaint being made, and the action taken relative to investigation findings.

Complaints concerning abuse, neglect and exploitation are routed to Adult Protective Services immediately for appropriate action. State law allows HCBS staff and APS staff to share information concerning clients on a need to know basis, but that information may not be re-disclosed to a third party. A.C.A. 12-12-1717(a)(9) allows disclosure of reports to "the department" (DHS) for founded reports and A.C.A. 12-12-1718(a) and (b)(1)(A) allow disclosure of pending and screened out reports to "the department". All APS reports involving waiver participants are reported on the monthly report and tracked by RN supervisory staff.

The HCBS Complaint Intake Report must be completed within five working days from when DAABHS staff received the complaint. Complaints must be resolved within 30 days from the date the complaint was received. If a complaint received by a DHS RN cannot be resolved by a DHS RN supervisor, the information is forwarded to the DAABHS central office administrative staff to resolve. To ensure that participants are safe during these time frames, the DHS RN may put in place the backup plan on the participant's service plan or report the situation to Adult Protective Services, if needed.

DHS RNs and DHS RN supervisors work to resolve any complaints. This involves contacting all parties involved to obtain all sides of the issue, a participant home visit and a review of the participant's person-centered service plan, if necessary. The Nurse Manager at the DAABHS central office may also be asked to assist. Based on the nature of the complaint, the Nurse Manager will use their professional judgment on issues that must be resolved more quickly, such as instances where the participant's health and safety are at risk. Compliance with this policy is tracked and reported through the database. This issue continues to be tracked and reviewed by the DHS RN Supervisors and the Medicaid Quality Assurance staff during the record review process.

A follow-up call or correspondence is made to the reporter, if appropriate, to discuss how the issue was resolved without violating confidentiality rules. The participant or representative is informed of the right to appeal any decision and that filing a complaint is not a prerequisite or substitute for a fair hearing.

If a participant is dissatisfied with the resolution of a complaint, a fair hearing request may be made at the local DHS county office.

DHS RNs follow-up with participants after a complaint has been made at each reassessment or monitoring contact. DHS RN supervisors may also participate in follow-up. Depending on the type of complaint, the DHS RN may take action to assure continued resolution by revising the participants service plan or assisting the participant in changing providers.

A complaint received on a DHS RN is reported to his or her supervisor, who investigates the complaint.

## Appendix G: Participant Safeguards

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### Appendix G-1: Response to Critical Events or Incidents

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

**Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).



Arkansas state law requires that suspected abuse, neglect, and exploitation of endangered and impaired adults be reported to the Adult Maltreatment Hotline for investigation. The method of reporting is primarily by phone to the Hotline; written reports of allegations will be entered into the Adult Protective Services system or routed to the appropriate investigative department.

A.C.A. 12-12-1708(a) specifies mandatory reporters who are required to report suspected adult maltreatment, including abuse, exploitation, neglect, or self-neglect of endangered or impaired adults. Mandated reporters include all physicians, nurses, social workers, case managers, home health workers, DHS employees, facility administrators or owners, employees of facilities, and any employee or volunteer of a program or organization funded partially or wholly by DHS who enters the home of, or has contact with an elderly person. ARChoices in Homecare waiver staff, providers, and DAABHS contractors are mandatory reporters. The statute requires immediate reporting to Adult Protective Services when any mandated reporter has observed or has reasonable cause to suspect adult maltreatment.

According to the statute, adult abuse includes intentional acts to an endangered or impaired adult which result in physical harm or psychological injury; or credible threats to inflict pain or injury which provoke fear or alarm; or unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. Exploitation includes illegal or unauthorized use of the person's funds or property; or use of the person's power of attorney or guardianship for the profit of one's own self; or improper acts or process that deprive the person of rightful access to benefits, resources, belongings and assets. Neglect is an act or omission by the endangered or impaired person (self-neglect), or an act or omission by the person's caregiver (caregiver neglect) constituting failure to provide necessary treatment, care, food, clothing, shelter, supervision or medical services; failure to report health problems and changes in health condition to appropriate medical personnel; or failure to carry out a prescribed treatment plan.

Reporting requirements for providers:

In addition to statutory requirements, the Division of Provider Services and Quality Assurance (DPSQA), the licensing and certification agency, requires home and community-based services (HCBS)/non-institutional providers to report the following incident types:

- (a) Abuse
- (b) Neglect
- (c) Exploitation or Misappropriation of Property
- (d) Unnatural Death
- (e) Unauthorized use of restrictive interventions
- (f) Significant Medication Error
- (g) Elopement/Missing Person
- (h) Other: Includes but is not limited to abandonment, serious bodily injury, incidents that require notification to police or fire department.

In accordance with DPSQA Policy 1001, the above events must be reported to the Division of Provider Services and Quality Assurance by facsimile transmission to telephone number 501-682-8551 of the completed Incident & Accident Intake Form (Form DPSQA-731) no later than 11:00 a.m. on the next business day following discovery by the provider. In addition to the requirement of a facsimile report by the next business day, the provider must conduct a thorough investigation of the alleged or suspected incident and complete an investigation report and submit it to DPSQA on Form DPSQA-742 within five working days.

Reporting requirements for DHS employees and contractors:

DHS employees and contractors are required to report incidents in accordance with DHS Policy 1090 (Incident Reporting). Under this policy, any incident requiring a report to the DHS Communications Director must be reported by telephone within one hour of the incident. All other reports must be filed with the Division Director or Designee and the

DHS Client Advocate no later than the end of the second business day following the incident. Any employee not filing reports within the specified time is subject to disciplinary action unless the employee can show that it was not physically possible to make the report within the required time.

Telephone notifications and informational e-mails to Division Directors or Designees, the DHS Client Advocate and other parties as appropriate for early reporting of unusual or sensitive information are welcomed. All such reports must be followed with completion and submission of Form DHS-1910.

If the incident alleges maltreatment by a hospital, a copy of the report will be sent to the Arkansas Department of Health by the Division Director or Designee, who should note the notification in the appropriate space on the Form DHS-1910, and forward the information to the DHS Client Advocate as a follow up Incident Report.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The DHS RN provides waiver applicants and their families with an Adult Protective Services (APS) brochure when initial contact is made. The brochure includes information on what constitutes abuse, neglect or exploitation, as well as the signs and symptoms, the persons required to report abuse and how to report suspected abuse, including to the Adult Maltreatment Hotline number. The Adult Maltreatment Hotline is accessible 24 hours a day, seven days a week. DHS RNs review this information with participants and family members at the initial assessment and at each annual reassessment. In addition, providers are required to post information about how to report a complaint to APS and the Adult Maltreatment Hotline in a visible area on their premises.

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

For incidents involving alleged abuse, neglect, and exploitation regarding adult clients, Adult Protective Services (APS) receives, investigates, evaluates, and resolves reports. Additionally, all incidents defined in DPSQA Policy 1001 must be reported to Division of Provider Services and Quality Assurance (DPSQA). These include alleged abuse, neglect, and exploitation, unnatural death, unauthorized use of restrictive interventions, significant medication error, elopement/missing person, abandonment, serious bodily injury, and incidents requiring notification to the police or fire department.

#### Adult Protective Services (APS) Responsibilities:

APS visits clients within 24 hours for emergency cases or within three working days for non-emergency cases. Emergency cases are instances when immediate medical attention is necessary or when there is imminent danger to health or safety which means a situation in which death or serious bodily harm could reasonably be expected to occur without intervention, according to Ark. Code Ann. 12-12-1703(8). Non-emergency cases refer to situations when allegations do not meet the definition of imminent danger to health or safety. APS fast tracks waiver participants so they can be seen in 24 hours if possible.

As required by law, investigations are completed and an investigative determination entered within 60 days. APS notifies the client and other relevant parties, including the offender, of the determination.

APS communicates with Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. Operating agency and waiver staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.

Reports to APS are logged into a database, and DPSQA uses this resource to monitor participants of the waiver for critical incidents.

APS communicates with the DAABHS waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. DPSQA and DAABHS waiver program staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.

#### Division of Provider Services and Quality Assurance (DPSQA) Responsibilities:

DPSQA receives and triages incidents to appropriate divisions for investigation. DPSQA will investigate those incidents that relate to providers licensed and/or certified by DPSQA and forwards incidents regarding clients to the Division of Aging, Adult, and Behavioral Health Services.

Reports to DPSQA are entered into a tracking system which DPSQA uses to determine if further investigation is needed in the event of multiple complaints at one provider locations or facility. DPSQA uses this resource to monitor active participants of the waiver for critical incidents.

As required by statute, investigations are completed and an investigative determination entered within 60 days.

Unexpected client deaths must be reported immediately to the DPSQA contact using the DHS Client Unexpected Death Report. The DPSQA contact investigates the report within two days of receiving the notice of the occurrence and prepares a report of the investigation within 30 days of receiving the notice of the occurrence. The investigation includes reviewing a written report of the facts and circumstances of the unexpected death and documentation listing the client's condition, including diagnoses, prescriptions and service plan.

The DPSQA contact will determine the facts and circumstances of the occurrence. DPSQA's role includes performing a thorough investigation, reviewing current policy, making corrections if necessary and identifying patterns during the process. Final results of investigations are electronically made available to .

All reports to the Adult Maltreatment Hotline and instances of unexpected client deaths are investigated and addressed by DPSQA. Incidents reported to the DHS Incident Reporting Information System (IRIS), a system which enables online submission and transmittal of incident reports, are investigated depending on the type of incident reported.

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

The Division of Provider Services and Quality Assurance assumes responsibility for compiling all incident reports from providers for review and action. Incidents are reported to DPSQA staff through submission of Form DPSQA-731.

DPSQA staff review the reports as incidents occur and identify patterns and make systematic corrections when necessary. Current policy is reviewed at each occurrence and revisions may be made if necessary.

The Adult Protective Services unit tracks APS incidents. APS informs DPSQA of the outcomes of incidents reported to APS applicable to waiver participants. There is a Memorandum of Understanding between DPSQA and APS unit detailing the relationship and activities of each unit, as they relate to the waiver program.

Final results of APS investigations, final results of unexpected death findings, and results of incident reports are electronically made available to DPSQA.

## Appendix G: Participant Safeguards

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

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

**The State does not permit or prohibits the use of restraints**

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

The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restraints. This oversight is conducted through incident reports received; monitoring of the participant by the DHS RN, if needed; and monitoring by the Targeted Case Manager.

DHS RNs reassess participants annually.

Targeted Case Managers make regular contact with the waiver participant, at least monthly, and a face-to-face monitoring contact with the waiver participant must be completed once every three months. The Targeted Case Manager is required to immediately contact the DHS RN regarding any concerns for the participant's health and welfare.

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

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

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

## Appendix G: Participant Safeguards

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

**b. Use of Restrictive Interventions.** *(Select one):*

**The State does not permit or prohibits the use of restrictive interventions**

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

The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restrictive interventions. This oversight is conducted through incident reports received; monitoring of the participant by the DHS RN, if needed; and monitoring by the Targeted Case Manager.

DHS RNs reassess participants annually.

Targeted Case Managers make regular contact with the waiver participant, at least monthly, and a face-to-face monitoring contact with the waiver participant must be completed once every three months. The Targeted Case Manager is required to immediately contact the DHS RN regarding any concerns for the participant's health and welfare.

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

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

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

**The State does not permit or prohibits the use of seclusion**

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

The Division of Aging, Adult and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of seclusion. This oversight is conducted through incident reports received; monitoring of the participant by the DHS RN, if needed; and monitoring by the Targeted Case Manager.

DHS RNs reassess participants annually.

Targeted Case Managers make regular contact with the waiver participant, at least monthly, and a face-to-face monitoring contact with the waiver participant must be completed once every three months. The Targeted Case Manager is required to immediately contact the DHS RN regarding any concerns for the participant's health and welfare.

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

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

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

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## Appendix G: Participant Safeguards

## Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

**No. This Appendix is not applicable** (*do not complete the remaining items*)

**Yes. This Appendix applies** (*complete the remaining items*)

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The allowed provider types for Respite Care include licensed facilities that may provide respite care in a licensed facility on a round-the-clock basis for a period of time. Medication oversight must be conducted in accordance with state law and the licensure and scope of practice requirements applicable to the particular type of facility and staff.

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

The DHS RN reviews the medication regimens at the time of assessment and reassessment. All medications are documented. Any potentially harmful practices the DHS RN discovers during the assessment or during a monitoring visit are documented in the participant record, addressed, and tracked for resolution.

## Appendix G: Participant Safeguards

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### Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

**Not applicable.** (*do not complete the remaining items*)

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** (*complete the remaining items*)

**Do not complete the rest of this section**

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**iii. Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

*Complete the following three items:*

(a) Specify State agency (or agencies) to which errors are reported:

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

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

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## **Appendix G: Participant Safeguards**

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### **Quality Improvement: Health and Welfare**

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

**a. Methods for Discovery: Health and Welfare**

*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis,*



identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of complaints addressed within required time frame.**

**Numerator: Number of complaints addressed in required time frame; Denominator: Number of complaints**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Complaint Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of unpreventable and preventable causes. Numerator: Number of deaths with unpreventable causes; Denominator: Number of deaths**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Unexpected Death Report**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number of substantiated complaints. Numerator: Number of substantiated complaints; Denominator: Number of complaints**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Complaint Database**

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

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of critical incidents that were reported within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Number of critical incidents reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">             DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.           </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<b>Other</b> Specify:	

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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of participant records reviewed where the participant and/or family or legal guardian received information about how to report abuse, neglect, exploitation and other critical incidents as specified in the waiver application.**

**Numerator: Number of participants receiving information on abuse/neglect/exploitation/critical incidents; Denominator: Number of records reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid	Weekly	100% Review

<b>Agency</b>		
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other Specify:</b>  <input type="text"/>
	<b>Other Specify:</b>  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>



<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of critical incident reviews/investigations that were initiated and completed according to program policy and state law. Numerator: Number of critical incident investigations completed according to policy/law; Denominator: Number of critical incidents reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b>	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
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<i>(check each that applies):</i>		
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;"> DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<b>Other Specify:</b>  <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input style="width: 100%; height: 20px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other Specify:</b>  <input style="width: 100%; height: 20px;" type="text"/>
	<b>Other Specify:</b>  <input style="width: 100%; height: 20px;" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**Performance Measure:**

**Number and percent of critical incidents requiring reviews/investigation where the state adhered to the follow-up methods as specified. Numerator: Number of critical incident reviews/investigations that had appropriate follow-up; Denominator: Number of critical incidents reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

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

		DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of the use of restrictive interventions requiring investigations.**

**Numerator is the number of investigations for the use of restrictive interventions.**

**Denominator is the reported uses of restrictive interventions.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		<input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of changes in Level of Care Tier Levels and ISB Levels.**

**Numerator - number of changes in Level of Care Tier Levels and ISB Levels.**

**Denominator - Number of records reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<p><b>Representative Sample</b> Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>DAABHS uses the Raosoft Calculation System to determine a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.</p> </div>

<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

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



Arkansas addresses this assurance with a three-step process that involves record review, ongoing communication with Adult Protective Services (APS), and Division of Medical Services (DMS) audits of waiver participants' records. Monthly record reviews are performed by DHS RN supervisors to assure that DHS RNs report incidences of abuse or neglect, and that safety and protection are addressed at each assessment and reassessment and reported in the Record Review Summary Report. APS reports specific cases of abuse and neglect affecting waiver participants to DAABHS waiver staff. Findings are reported to DMS.

DAABHS staff are required to review the APS information with participants and other interested parties at each assessment and reassessment. This must include providing APS brochures, as well as information on how to identify possible abuse and neglect and a toll-free number for reporting abuse. Compliance with this requirement is documented in the participant record and reviewed by RN supervisors during each record review. Compliance is a part of the record review and annual reporting process.

Policy requires compliance and mandates the DHS RN to report alleged abuse to APS and/or the DPSQA Office of Long Term Care (OLTC). All reports of alleged abuse, follow-ups and actions taken to investigate the alleged abuse, along with all reports to APS or OLTC must be documented in the nurse narrative. Record reviews include verification of this requirement and are included on the annual report.

The process for reporting abuse as established in Arkansas Code Annotated 12-12-1701 et seq (the Adult and Long-Term Care Facility Resident Maltreatment Act) is as follows: The Department of Human Services (DHS) maintains a single statewide telephone number that all persons may use to report suspected adult maltreatment and long-term care facility resident maltreatment. Upon registration of a report, the Adult Maltreatment Hotline refers the matter immediately to the appropriate investigating agency. Under this statute, a resident of an assisted living facility is identified as a long-term care facility resident, and for the purposes of the statute is presumed to be an impaired person. A report for a long-term care facility resident is to be made immediately to the local law enforcement agency for the jurisdiction in which the long-term care facility is located, and to OLTC under the regulations of that office. DHS has jurisdiction to investigate all cases of suspected maltreatment of an endangered person or an impaired person. The APS unit of DHS shall investigate all cases of suspected adult maltreatment if the act or omission occurs in a place other than a long-term care facility; and all cases of suspected adult maltreatment if a family member of the adult person is named as the suspected offender, regardless of whether or not the adult is a long-term care facility resident. The OLTC unit of DHS shall investigate all cases of suspected maltreatment of a long-term care facility resident.

**b. Methods for Remediation/Fixing Individual Problems**

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

The Division of Aging, Adult, and Behavioral Health Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in team meetings to discuss and address individual problems related to participant health and welfare, as well as problem correction and remediation. DAABHS and DMS have an Interagency Agreement that includes measures related to participant health and welfare for the waiver.

DAABHS’s remediation efforts in cases where participants or their family members or legal guardians have not received information about how to report abuse, neglect, exploitation or critical incidents include providing the appropriate information to the participant and family member/legal guardian upon discovery that this information was not provided, providing additional training for DHS RNs and considering this remediation as part of RNs’ performance evaluations.

In cases where critical incidents were not reported within required time frames, DAABHS provides remediation, including reporting the critical incident immediately upon discovery, and providing additional training and counseling to staff.

If critical incident reviews and investigations are not initiated and completed according to program policy and state law, DAABHS’s remediation includes initiating and completing the investigation immediately upon discovery, and providing additional training and counseling to staff. When appropriate follow-up to critical incidents is not conducted according to methods discussed in the waiver application, DAABHS provides immediate follow-up to the incident and staff training as remediation.

DAABHS provides remediation in cases of investigation and review of unexplained, suspicious and untimely deaths that did not result in identification of preventable and unpreventable causes to include staff and provider training, implementing additional services and imposing provider sanctions. The Unexpected Death Report ensures that remediation of preventable deaths is captured and that remediation data is collected appropriately.

The DAABHS complaint database collects complaints, the outcomes and the resolution for substantiated complaints. Remediation for complaints that were not addressed during the required time frame includes DAABHS addressing the complaint immediately upon discovery, and providing additional staff training and counseling.

All substantiated incidents are investigated by the DAABHS Deputy Director or his/her designee. DAABHS plans to continue this process and reviewing remediation plans remains in development.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
	<p><b>Other</b> Specify:</p> <div data-bbox="824 348 1221 436" style="border: 1px solid black; height: 40px; margin-top: 10px;"></div>

**c. Timelines**

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

**No**

**Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix H: Quality Improvement Strategy (1 of 2)**

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Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

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

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the

assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 2)

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### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, the Division of Medical Services (DMS) (Medicaid agency) will meet with the operating agencies (DAABHS and the Division of Provider Services and Quality Assurance (DPSQA)) to discuss what system or program changes are necessary, if any, based on the nature of the problem (health and safety issue, etc.), complexity of the solution (does it require an amendment to the waiver application), and the financial impact. If it is determined that a system change is needed, a computer service request will be submitted to the Medicaid Management Information and Performance Unit (MMIP) within DMS and a priority status is assigned. MMIP prioritizes system changes to MMIS and coordinates implementation with the state fiscal agent. An action plan is developed and information is shared with the appropriate stakeholders for comment. Implementation of the plan is the final step. The MMIP Unit and DMS monitor the system changes.

As a result of the discovery processes:

The interagency agreements were revised to provide a more visible product to clarify roles and responsibilities between DMS, DAABHS, and DPSQA.

The agreement between the three divisions has been modified and is updated at least annually.

Medicaid related issues are documented by DAABHS waiver staff and reviewed by DMS, and recorded on a monthly report to identify, capture and resolve billing and claims submission problems. Error reports are worked and billing issues are resolved by DAABHS waiver staff and DMS. DMS reviews reports for proper resolution. These activities occur on a daily basis, and reviews occur monthly by DMS.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
<b>Other</b> Specify: <input type="text"/>	<b>Other</b> Specify: <input type="text" value="Ongoing, as needed"/>

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of Medical Services (DMS) both employ staff to assist in system design. When an issue arises that requires development of a Computer Service Request (CSR), meetings with the DHS information technology consultants, DMS Program Development and Quality Assurance staff, DMS Program Integrity staff, and DAABHS waiver staff are held to address needs and resolve issues, including developing new elements and testing system changes. Meetings are scheduled on an as-needed basis with the assigned DHS information technology consulting firm, the Medicaid program's fiscal agent, the DAABHS Deputy Director, DMS staff, and others as may be appropriate depending on the issue for discussion.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DAABHS and DMS monitor the Quality Improvement Strategy on an ongoing basis and review the Quality Improvement Strategy annually. A review consists of analyzing reports and progress toward stated initiatives, resolution of individual and systematic issues found through discovery and notating desired outcomes. When change in the strategy is indicated, a collaborative effort between DMS and DAABHS is set in motion to complete a revision to the Quality Improvement Strategy which may include submission of a waiver amendment. DMS utilizes the Quality Improvement Strategy during all levels of QA reviews.

**Appendix I: Financial Accountability**

**I-1: Financial Integrity and Accountability**

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request

through the Medicaid agency or the operating agency (if applicable).

MMIS claims data are audited periodically for program policy alignment, and claims processing worksheets are audited, processed and returned on a daily basis. Discovery and monitoring also includes an ongoing review of annual CMS-372S reports and quarterly CMS-64 reports. Division of Medical Services (DMS) (Medicaid agency) reviews are validation reviews of 20% of the records reviewed by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) and include a review of the services billed and paid when compared with the services listed on a participant's person-centered service plan.

The Arkansas Office of Medicaid Inspector General (OMIG) conducts an annual random review of HCBS waiver programs. If the review finds errors in billing, OMIG recoups the money from the waiver provider. If fraud is suspected, the Office of Medicaid Inspector General refers the waiver provider to the Medicaid Fraud Control Unit and Arkansas Attorney General's Office for appropriate action.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

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

#### a. Methods for Discovery: Financial Accountability Assurance:

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

##### i. Sub-Assurances:

##### a. Sub-assurance: *The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*

*(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

##### Performance Measures

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

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

##### Performance Measure:

**Number and percent of reviewed claims with services specified in the participant's service plan. Numerator: Number of claims with services specified in service plan; Denominator: Number of claims**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Recipient Profiles**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-top: 5px;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; width: 100px; height: 30px; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">             DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.           </div>
	<b>Other</b> Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number of failed MMIS edit checks which are corrected to assure appropriate payment. Numerator: Number of corrected MMIS edit checks; Denominator: Number of edit checks**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Weekly Worksheets**

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



<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Daily LTC Update Error Report**

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

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Daily Waiver Update Error Report**

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

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of waiver claims that were paid using the correct rate as specified in the waiver application. Numerator: Number of claims paid at correct rate; Denominator: Number of claims**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Recipient Claims History Profile (Chart Reviews)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/> DMS performs a validation review of 20% of charts reviewed by DAABHS during the Chart Record Review process.
	<b>Other</b>	

	Specify:  <input style="width: 100%;" type="text"/>	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>

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

N/A
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**b. Methods for Remediation/Fixing Individual Problems**

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

The Division of Aging, Adult and Behavioral Health Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in team meetings as needed to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DAABHS and DMS have an Interagency Agreement that includes measures related to financial accountability for the waiver.

The performance measure for number and percent of waiver claims paid using the correct rate specified in the waiver application will always result in 100% compliance because the rates for services are already set in MMIS; therefore, claims will not be paid at any other rate.

DAABHS' remediation for failed MMIS checks not corrected to assure appropriate payment includes correcting the issue upon discovery, making system changes and training staff.

DAABHS remediation for claims for services not specified in the participant's service plan includes adding services to the participant's service plan if necessary, recouping payment to the provider, imposing provider sanctions, training providers and conducting a participant monitoring visit.

The tool used for record review captures and tracks remediation in these areas.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**c. Timelines**

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

**No**

**Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) is responsible for the rate determination with oversight conducted by the Division of Medical Services (DMS) (Medicaid agency) Financial Section prior to implementation. There is an established procedure followed by both divisions that ensures DMS reviews and approves all reimbursement rates and methodologies. As ARChoices is not a participant-directed program, payment rates are not routinely sent separately to waiver participants. Rates are published for comment and are made available to all providers. Additionally, providers are notified any time a rate changes via a Provider Information Memorandum from DAABHS and/or an Official Notice from DMS. The public is afforded an opportunity to comment on the rate determination process through the DMS website, in the Proposed Rules for Public Comment section. Upon certification, new providers are referred to the Medicaid Provider Manual, which lists rate information.

Various methodologies are used for rate determination depending on the waiver service. The following are the methods used for rate setting for the ARChoices waiver services:

**Attendant Care** - Attendant Care service is a fee-for-service rate established and approved by DMS and is equivalent to a rate modeled by actuaries under contract with DMS. The assumptions used to develop the model rate are based on feedback from DAABHS and DPSQA and on responses to provider surveys developed by the contracted actuaries. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

**Adult Day Health** – Adult Day Health is a fee-for-service rate established and approved by DMS and is equivalent to a rate modeled by actuaries under contract with DMS. The assumptions used to develop the model rate are based on feedback from DAABHS and DPSQA and on responses to provider surveys developed by the contracted actuaries. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

**Respite** - Respite service is a fee-for-service rate established and approved by the Division of Medical Services (Medicaid agency) and is equivalent to a rate modeled by actuaries under contract with DMS. The assumptions used to develop the model rate are based on feedback from DAABHS and DPSQA and on responses to provider surveys developed by the contracted actuaries. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

**Adult Day Services** – Adult Day Services is a fee-for-service rate established and approved by DMS and is equivalent to a rate modeled by actuaries under contract with DMS. The assumptions used to develop the model rate are based on feedback from DAABHS and DPSQA and on responses to provider surveys developed by the contracted actuaries. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

**Home-Delivered Meals** - The home delivered meal rate was established using the cost for the meal, plus the cost for delivery. The rate is sufficient to secure a sufficient number of providers.

**Personal Emergency Response System (PERS)** - The rate for the PERS service was established using usual and customary rates and is sufficient to secure a sufficient number of providers.

**Prevocational Services** – Prevocational services is a fee-for-service rate established and approved by DMS and is equivalent to the rate established for state plan supportive employment services that are services similar to prevocational services. The rate is consistent with efficiency, economy, and quality of care and is sufficient to enlist a sufficient number of providers.

**Environmental Accessibility Adaptations/Adaptive Equipment** - A maximum amount of \$7,500 per lifetime of each active participant was approved by the Medicaid agency to cover this service. The amount may be utilized all at once or for separate services. The amount was established utilizing usual and customary charges for adaptive equipment and environmental accessibility adaptations. The rate is consistent with efficiency, economy and quality of care, and is sufficient to enlist plenty of providers.

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from



providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver providers bill for the services and are reimbursed directly through the MMIS.

## Appendix I: Financial Accountability

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

#### c. Certifying Public Expenditures *(select one)*:

**No. State or local government agencies do not certify expenditures for waiver services.**

**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

#### **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

#### **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

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

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) staff verifies services were provided according to the person-centered service plan through an internal monthly monitoring system. Adjustments are made or referred to the Office of Medicaid Inspector General when claims are paid incorrectly.

All waiver claims are processed through the MMIS, using all applicable edits and audits, to assure claims are processed appropriately, timely, and compared to the Medicaid maximum allowable.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

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### I-3: Payment (1 of 7)

- a. Method of payments -- MMIS** (*select one*):

**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

**Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

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### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

**Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

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### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

**No. The State does not make supplemental or enhanced payments for waiver services.**

**Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

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### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive*

payment for the provision of waiver services.

**No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

**Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

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## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

#### e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

---

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

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**The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

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## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

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### I-3: Payment (7 of 7)

#### g. Additional Payment Arrangements

##### i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

**No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

##### ii. Organized Health Care Delivery System. *Select one:*

**No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

##### iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

**The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

**The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

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

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

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

**Appropriation of State Tax Revenues to the State Medicaid agency**

**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

**Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

*Check each that applies:*

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

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### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Facility-Based Respite care is available in licensed facilities, as indicated in Appendix C. Reimbursement does not include the cost for room and board. Rates are a fee for service, 1 unit equals 15 minutes of service as described in the service definition.

## Appendix I: Financial Accountability

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### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

**Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

**No. The State does not impose a co-payment or similar charge upon participants for waiver services.**

**Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

---

*Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

---



Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

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## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

---

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

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## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

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Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

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## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

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## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

**No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

**Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups

of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8504.21	9666.00	18170.21	47580.00	2520.00	50100.00	31929.79
2	7726.73	9934.00	17660.73	48898.00	2590.00	51488.00	33827.27
3	8248.90	10209.00	18457.90	50252.00	2662.00	52914.00	34456.10
4	4704.78	10492.00	15196.78	51644.00	2735.00	54379.00	39182.22
5	5503.42	10782.00	16285.42	53075.00	2811.00	55886.00	39600.58

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	11350		11350
Year 2	11350		11350
Year 3	11350		11350
Year 4	11350		11350
Year 5	11350		11350

## Appendix J: Cost Neutrality Demonstration

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

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in

item J-2-a.

Data from the annual reports (CMS-372) for the 2013 reporting year for each of the two existing DAAS 1915(c) waivers which are being replaced with the new ARChoices in Homecare waiver were tabulated to estimate the average length of stay on the waiver.

A total of 9,374 unduplicated participants were served by the two waivers, with a total of 2,591,698 days of waiver coverage. The average length of stay on the waiver(s) is estimated at 276 days.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

For Waiver Years 1 through 3, historic utilization and cost data from SFYs 2011, 2012 and 2013 were used to derive utilization rates and cost for the elderly in home-based settings (ElderChoices waiver - EC), and adults with physical disabilities in home-based services (Alternatives for Adults with Physical Disabilities waiver - AAPD). The utilization rates for the existing EC and AAPD were used to estimate the future utilization of these services for individuals, assuming that the elderly will have similar utilization rates to those found among adults with physical disabilities and vice versa.

For Waiver Years 4 and 5, the average costs/unit for Adult Day Health, Respite In-Home, Adult Day Services, Personal Emergency Response System (PERS) Unit Monitoring, and Attendant Care Services were modified to reflect the new payment rates to be effective January 1, 2019. The number of users for Adult Day Health was modified to reflect expected use based on experience to date, and the number of users for Attendant Care was modified to reflect changes expected due to the expected transition of service hours to state plan Personal Care services and modifications made to the Attendant Care service definitions. The number of users for the new service of Prevocational Services was projected as 1% of the unduplicated cap, and the average units/user was projected as the maximum number of units permitted for this service under the limits on amount, frequency, and duration identified in Appendix C-1/C-3 for this service. The number of users and average units per user for all components of Adult Family Home were changed to 0 to reflect the elimination of that service effective with Waiver Year 4.

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

Weighted average of factor D from historic waivers, less current D, plus historic D prime.

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

Weighted average of historic waivers forward to forecast the combined waivers.

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

Weighted average of historic waivers forward to forecast the combined waivers.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Adult Day Health	
Respite	
Adult Day Services	
Adult Family Home	
Attendant Care Services	
Environmental Accessibility Adaptations/Adaptive Equipment	
Home-Delivered Meals	
Personal Emergency Response System (PERS)	
Prevocational Services	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

#### d. Estimate of Factor D.

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							<b>799606.08</b>
Adult Day Health		15 Minutes	63	4068.00	3.12	799606.08	
<b>Respite Total:</b>							<b>6441773.60</b>
Respite In-Home		15 Minutes	1147	1228.00	4.50	6338322.00	
<b>GRAND TOTAL:</b>							<b>96522751.30</b>
Total: Services included in capitation:							
Total: Services not included in capitation:							96522751.30
<b>Total Estimated Unduplicated Participants:</b>							<b>11350</b>
<b>Factor D (Divide total by number of participants):</b>							<b>8504.21</b>
Services included in capitation:							
Services not included in capitation:							8504.21
<b>Average Length of Stay on the Waiver:</b>							<b>276</b>

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Short-Term Facility-Based		15 Minutes	75	779.00	1.68	98154.00	
Respite Long-Term Facility-Based		15 Minutes	10	946.00	0.56	5297.60	
<b>Adult Day Services Total:</b>							2176785.00
Adult Day Services		15 Minutes	234	3721.00	2.50	2176785.00	
<b>Adult Family Home Total:</b>							12000.40
Adult Family Home - Level A		Day	1	76.00	56.25	4275.00	
Adult Family Home - Level C		Day	1	76.00	48.22	3664.72	
Adult Family Home - Level B		Day	1	76.00	53.43	4060.68	
<b>Attendant Care Services Total:</b>							77957590.50
Attendant Care Services		15 Minutes	6577	2291.00	4.50	67805581.50	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	1050	3806.00	2.43	9711009.00	
CSM Transition Costs-1st Year		1 Month	1050	6.00	70.00	441000.00	
<b>Environmental Accessibility Adaptations/Adaptive Equipment Total:</b>							715864.00
Environmental Accessibility Adaptations/Adaptive Equipment		Package	172	1.00	4162.00	715864.00	
<b>Home-Delivered Meals Total:</b>							6927038.76
Home-Delivered Meals		Meal	5422	214.00	5.97	6927038.76	
<b>Personal Emergency Response System (PERS) Total:</b>							1492092.96
PERS Installation		One Installment	938	1.00	29.90	28046.20	
PERS Unit Monitoring		Day	5324	257.00	1.07	1464046.76	
<b>GRAND TOTAL:</b>							96522751.30
Total: Services included in capitation:							
Total: Services not included in capitation:							96522751.30
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							8504.21
Services included in capitation:							
Services not included in capitation:							8504.21
Average Length of Stay on the Waiver:							276

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Prevocational Services Total:</b>							<b>0.00</b>
Prevocational Services - Skill Development		15 Minutes	0	0.00	6.40	0.00	
Prevocational Services - Career Exploration		15 Minutes	0	0.00	6.40	0.00	
<b>GRAND TOTAL:</b>							<b>96522751.30</b>
Total: Services included in capitation:							
Total: Services not included in capitation:							96522751.30
<b>Total Estimated Unduplicated Participants:</b>							<b>11350</b>
<b>Factor D (Divide total by number of participants):</b>							<b>8504.21</b>
Services included in capitation:							
Services not included in capitation:							8504.21
<b>Average Length of Stay on the Waiver:</b>							<b>276</b>

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							<b>799606.08</b>
Adult Day Health		15 Minutes	63	4068.00	3.12	799606.08	
<b>Respite Total:</b>							<b>6574397.60</b>
Respite In-Home		15 Minutes	1171	1228.00	4.50	6470946.00	
Respite Short-Term Facility-Based		15 Minutes	75	779.00	1.68	98154.00	
Respite Long-Term Facility-Based		15 Minutes	10	946.00	0.56	5297.60	
<b>GRAND TOTAL:</b>							<b>87698432.44</b>
Total: Services included in capitation:							
Total: Services not included in capitation:							87698432.44
<b>Total Estimated Unduplicated Participants:</b>							<b>11350</b>
<b>Factor D (Divide total by number of participants):</b>							<b>7726.73</b>
Services included in capitation:							
Services not included in capitation:							7726.73
<b>Average Length of Stay on the Waiver:</b>							<b>276</b>

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Services Total:</b>							2176785.00
Adult Day Services		15 Minutes	234	3721.00	2.50	2176785.00	
<b>Adult Family Home Total:</b>							12000.40
Adult Family Home - Level A		Day	1	76.00	56.25	4275.00	
Adult Family Home - Level C		Day	1	76.00	48.22	3664.72	
Adult Family Home - Level B		Day	1	76.00	53.43	4060.68	
<b>Attendant Care Services Total:</b>							68857150.50
Attendant Care Services		15 Minutes	6679	2291.00	4.50	68857150.50	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0.00	0.01	0.00	
CSM Transition Costs-1st Year		1 Month	0	0.00	0.01	0.00	
<b>Environmental Accessibility Adaptations/Adaptive Equipment Total:</b>							753322.00
Environmental Accessibility Adaptations/Adaptive Equipment		Package	181	1.00	4162.00	753322.00	
<b>Home-Delivered Meals Total:</b>							7033077.90
Home-Delivered Meals		Meal	5505	214.00	5.97	7033077.90	
<b>Personal Emergency Response System (PERS) Total:</b>							1492092.96
PERS Installation		One Installment	938	1.00	29.90	28046.20	
PERS Unit Monitoring		Day	5324	257.00	1.07	1464046.76	
<b>Prevocational Services Total:</b>							0.00
Prevocational Services - Skill Development		15 Minutes	0	0.00	0.01	0.00	
<b>GRAND TOTAL:</b>							87698432.44
Total: Services included in capitation:							
Total: Services not included in capitation:							87698432.44
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							7726.73
Services included in capitation:							
Services not included in capitation:							7726.73
Average Length of Stay on the Waiver:							276

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services - Career Exploration		15 Minutes	0	0.00	0.01	0.00	
<b>GRAND TOTAL:</b>							87698432.44
Total: Services included in capitation:							
Total: Services not included in capitation:							87698432.44
<b>Total Estimated Unduplicated Participants:</b>							11350
<b>Factor D (Divide total by number of participants):</b>							7726.73
Services included in capitation:							
Services not included in capitation:							7726.73
<b>Average Length of Stay on the Waiver:</b>							276

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							863066.88
Adult Day Health		15 Minutes	68	4068.00	3.12	863066.88	
<b>Respite Total:</b>							6707021.60
Respite In-Home		15 Minutes	1195	1228.00	4.50	6603570.00	
Respite Short-Term Facility-Based		15 Minutes	75	779.00	1.68	98154.00	
Respite Long-Term Facility-Based		15 Minutes	10	946.00	0.56	5297.60	
<b>Adult Day Services Total:</b>							2223297.50
Adult Day Services		15 Minutes	239	3721.00	2.50	2223297.50	
<b>Adult Family Home</b>							24000.80
<b>GRAND TOTAL:</b>							93624977.78
Total: Services included in capitation:							
Total: Services not included in capitation:							93624977.78
<b>Total Estimated Unduplicated Participants:</b>							11350
<b>Factor D (Divide total by number of participants):</b>							8248.90
Services included in capitation:							
Services not included in capitation:							8248.90
<b>Average Length of Stay on the Waiver:</b>							276



Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Total:</b>							
Adult Family Home - Level A		Day	2	76.00	56.25	8550.00	
Adult Family Home - Level C		Day	2	76.00	48.22	7329.44	
Adult Family Home - Level B		Day	2	76.00	53.43	8121.36	
<b>Attendant Care Services Total:</b>							74331495.00
Attendant Care Services		15 Minutes	7210	2291.00	4.50	74331495.00	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0.00	0.01	0.00	
CSM Transition Costs-1st Year		1 Month	0	0.00	0.01	0.00	
<b>Environmental Accessibility Adaptations/Adaptive Equipment Total:</b>							844886.00
Environmental Accessibility Adaptations/Adaptive Equipment		Package	203	1.00	4162.00	844886.00	
<b>Home-Delivered Meals Total:</b>							7139117.04
Home-Delivered Meals		Meal	5588	214.00	5.97	7139117.04	
<b>Personal Emergency Response System (PERS) Total:</b>							1492092.96
PERS Installation		One Installment	938	1.00	29.90	28046.20	
PERS Unit Monitoring		Day	5324	257.00	1.07	1464046.76	
<b>Prevocational Services Total:</b>							0.00
Prevocational Services - Skill Development		15 Minutes	0	0.00	0.01	0.00	
Prevocational Services - Career Exploration		15 Minutes	0	0.00	0.01	0.00	
<b>GRAND TOTAL:</b>							93624977.78
Total: Services included in capitation:							
Total: Services not included in capitation:							93624977.78
Total Estimated Unduplicated Participants:							11350
Factor D (Divide total by number of participants):							8248.90
Services included in capitation:							
Services not included in capitation:							8248.90
Average Length of Stay on the Waiver:							276

## Appendix J: Cost Neutrality Demonstration

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

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							<b>983561.04</b>
Adult Day Health		15 Minutes	77	4068.00	3.14	983561.04	
<b>Respite Total:</b>							<b>7223886.80</b>
Respite In-Home		15 Minutes	1280	1228.00	4.53	7120435.20	
Respite Short-Term Facility-Based		15 Minutes	75	779.00	1.68	98154.00	
Respite Long-Term Facility-Based		15 Minutes	10	946.00	0.56	5297.60	
<b>Adult Day Services Total:</b>							<b>2343671.85</b>
Adult Day Services		15 Minutes	255	3721.00	2.47	2343671.85	
<b>Adult Family Home Total:</b>							<b>0.00</b>
Adult Family Home - Level A		Day	0	0.00	56.25	0.00	
Adult Family Home - Level C		Day	0	0.00	48.22	0.00	
Adult Family Home - Level B		Day	0	0.00	53.43	0.00	
<b>Attendant Care Services Total:</b>							<b>32724720.00</b>
Attendant Care Services		15 Minutes	4200	1720.00	4.53	32724720.00	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0.00	0.01	0.00	
<b>GRAND TOTAL:</b>							<b>53399240.43</b>
Total: Services included in capitation:							53399240.43
Total: Services not included in capitation:							11350
<b>Total Estimated Unduplicated Participants:</b>							<b>11350</b>
<b>Factor D (Divide total by number of participants):</b>							<b>4704.78</b>
Services included in capitation:							4704.78
Services not included in capitation:							4704.78
<b>Average Length of Stay on the Waiver:</b>							<b>276</b>

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CSM Transition Costs-1st Year		1 Month	0	0.00	0.01	0.00	
<b>Environmental Accessibility Adaptations/Adaptive Equipment Total:</b>							<b>915640.00</b>
Environmental Accessibility Adaptations/Adaptive Equipment		Package	220	1.00	4162.00	915640.00	
<b>Home-Delivered Meals Total:</b>							<b>7429127.70</b>
Home-Delivered Meals		Meal	5815	214.00	5.97	7429127.70	
<b>Personal Emergency Response System (PERS) Total:</b>							<b>1495548.24</b>
PERS Installation		One Installment	938	1.00	29.90	28046.20	
PERS Unit Monitoring		1 Month	5324	8.45	32.62	1467502.04	
<b>Prevocational Services Total:</b>							<b>283084.80</b>
Prevocational Services - Skill Development		15 Minutes	114	268.00	6.40	195532.80	
Prevocational Services - Career Exploration		15 Minutes	114	120.00	6.40	87552.00	
<b>GRAND TOTAL:</b>							<b>53399240.43</b>
Total: Services included in capitation:							53399240.43
Total: Services not included in capitation:							11350
<b>Total Estimated Unduplicated Participants:</b>							<b>11350</b>
<b>Factor D (Divide total by number of participants):</b>							<b>4704.78</b>
Services included in capitation:							4704.78
Services not included in capitation:							4704.78
<b>Average Length of Stay on the Waiver:</b>							<b>276</b>

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Health Total:</b>							996334.56
Adult Day Health		15 Minutes	78	4068.00	3.14	996334.56	
<b>Respite Total:</b>							8030498.60
Respite In-Home		15 Minutes	1425	1228.00	4.53	7927047.00	
Respite Short-Term Facility-Based		15 Minutes	75	779.00	1.68	98154.00	
Respite Long-Term Facility-Based		15 Minutes	10	946.00	0.56	5297.60	
<b>Adult Day Services Total:</b>							2499916.64
Adult Day Services		15 Minutes	272	3721.00	2.47	2499916.64	
<b>Adult Family Home Total:</b>							0.00
Adult Family Home - Level A		Day	0	0.00	56.25	0.00	
Adult Family Home - Level C		Day	0	0.00	48.22	0.00	
Adult Family Home - Level B		Day	0	0.00	53.43	0.00	
<b>Attendant Care Services Total:</b>							40516320.00
Attendant Care Services		15 Minutes	5200	1720.00	4.53	40516320.00	
Self-directed Attendant Care Transitioning-1st Year		15 Minutes	0	0.00	2.43	0.00	
CSM Transition Costs-1st Year		15 Minutes	0	0.00	70.00	0.00	
<b>Environmental Accessibility Adaptations/Adaptive Equipment Total:</b>							1040500.00
Environmental Accessibility Adaptations/Adaptive Equipment		Package	250	1.00	4162.00	1040500.00	
<b>Home-Delivered Meals Total:</b>							7601601.00
Home-Delivered Meals		Meal				7601601.00	
<b>GRAND TOTAL:</b>							62463803.84
Total: Services included in capitation:							62463803.84
Total: Services not included in capitation:							11350
<b>Total Estimated Unduplicated Participants:</b>							5503.42
Factor D (Divide total by number of participants):							5503.42
Services included in capitation:							5503.42
Services not included in capitation:							
Average Length of Stay on the Waiver:							276

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			5950	214.00	5.97		
<b>Personal Emergency Response System (PERS) Total:</b>							1495548.24
PERS Installation		One Installment	938	1.00	29.90	28046.20	
PERS Unit Monitoring		1 Month	5324	8.45	32.62	1467502.04	
<b>Prevocational Services Total:</b>							283084.80
Prevocational Services - Skill Development		15 Minutes	114	268.00	6.40	195532.80	
Prevocational Services - Career Exploration		15 Minutes	114	120.00	6.40	87552.00	
<b>GRAND TOTAL:</b>							62463803.84
Total: Services included in capitation:							62463803.84
Total: Services not included in capitation:							11350
<b>Total Estimated Unduplicated Participants:</b>							5503.42
Factor D (Divide total by number of participants):							5503.42
Services included in capitation:							5503.42
Services not included in capitation:							5503.42
Average Length of Stay on the Waiver:							276

**TOC required****201.000 Arkansas Medicaid Certification Requirements for ARChoices HCBS Waiver Program 1-1-19**

All ARChoices Home and Community-Based Services (HCBS) Waiver providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

ARChoices HCBS Waiver providers must be licensed and/or certified by the Division of Provider Services and Quality Assurance (DPSQA) as having met all Centers for Medicare and Medicaid Services (CMS) approved provider criteria for the service(s) they wish to enroll to provide.

Certification by DPSQA does not guarantee enrollment in the Medicaid program.

All providers must maintain their provider files at the Provider Enrollment Unit by submitting current certification, licensure, all DPSQA-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider, etc.

Copies of licensure/certifications and renewals required by DPSQA must be maintained by DPSQA to avoid loss of provider certification. These copies must be submitted to DPSQA Provider Certification. [View or print the Division of Provider Services and Quality Assurance Provider Certification contact information.](#) Payment cannot be authorized for services provided beyond the certification period.

**201.100 Providers of ARChoices HCBS Waiver Services in Bordering and Non-Bordering States 1-1-19**

An ARChoices provider must be physically located in the State of Arkansas or physically located in a bordering state and serving a trade-area city. The trade-area cities are limited to Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee; and Texarkana, Texas.

All providers must be licensed and/or certified by their states' appropriate licensing/certifying authorities. Copies of all appropriate licenses and certifications must be submitted to the Division of Provider Services and Quality Assurance (DPSQA) for certification as a potential ARChoices provider.

Arkansas Medicaid does not provide ARChoices Waiver services in non-bordering states.

**201.105 Provider Assurances 1-1-19****A. Agency Staffing**

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries for whom they have accepted an ARChoices Waiver Person-Centered Service Plan (PCSP).

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Department of Human Services (DHS), Division of Provider Services and Quality Assurance (DPSQA), requires mandatory training. The provider must attend one of the two provider workshop trainings in the calendar year. "Provider" in this context means at least one provider representative who will be

able to inform the rest of the provider staff of what was covered in training. Failure to attend one of these trainings could jeopardize the provider's licensure/certification for the waiver. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS. Direct care workers must be trained prior to providing services to an ARChoices beneficiary.

2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any ARChoices Waiver service(s). This orientation shall include, but not be limited to:
  - a. Description of the purpose and philosophy of the ARChoices Waiver Program;
  - b. Discussion and distribution of the provider agency's written code of ethics;
  - c. Discussion of activities which shall and shall not be performed by the employee;
  - d. Discussion, including instructions, regarding ARChoices Waiver record keeping requirements;
  - e. Discussion of the importance of the PCSP;
  - f. Discussion of the agency's procedure for reporting changes in the beneficiary's condition;
  - g. Discussion, including potential legal ramifications, of the beneficiary's right to confidentiality;
  - h. Discussion of the beneficiary's rights regarding HCBS Settings as discussed in C of this section.

#### B. Code of Ethics

The Provider agrees to follow and/or enforce for each employee providing services to an ARChoices Waiver beneficiary a written code of ethics that shall include, but not be limited to, the following:

1. No consumption of the beneficiary's food or drink;
2. No use of the beneficiary's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;
4. No acceptance of gifts or tips from the beneficiary or their caregiver;
5. No friends or relatives of the employee or unauthorized beneficiaries are to accompany the employee to beneficiary's residence;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery;
7. No smoking in the beneficiary's residence;
8. No solicitation of money or goods from the beneficiary;
9. No breach of the beneficiary's privacy or confidentiality of records.

#### C. Home and Community-Based Services (HCBS) Settings

All providers must meet the following Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR 441.301(c) (4)-(5).

Settings that are HCBS must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control

personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

1. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
  - a. Choice must be identified and included in the PCSP.
  - b. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.
2. Ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.
3. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
4. Facilitates individual choice regarding services and supports and who provides them.
5. The setting is integrated in and supports full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.
6. In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:
  - a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
  - b. Each individual has privacy in their sleeping or living unit:
    - i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
    - ii. Beneficiaries sharing units have a choice of roommates in that setting.
    - iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
  - c. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
  - d. Beneficiaries are able to have visitors of their choosing at any time.
  - e. The setting is physically accessible to the individual.
  - f. Any modification of the additional conditions specified in items 6.a. through 6.e. above must be supported by a specific assessed need and justified in the PCSP. The following requirements must be documented in the PCSP:
    - i. Identify a specific and individualized assessed need.
    - ii. Document the positive interventions and supports used prior to any modifications to the PCSP.
    - iii. Document less intrusive methods of meeting the need that have been



- tried but did not work.
- iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
  - v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
  - vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
  - vii. Include the informed consent of the individual.
  - viii. Include an assurance that interventions and supports will cause no harm to the individual.

**211.000****Scope****1-1-19**

The Arkansas Medical Assistance (Medicaid) Program offers certain home and community-based outpatient services as an alternative to nursing home placement. These services are available to persons age 21 through 64 who are determined to have a physical disability through the Social Security Administration or the DHS Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or are 65 years of age or older and require an intermediate level of care in a nursing facility. The community-based services offered through the ARChoices Home and Community-Based Waiver, described herein as ARChoices, are as follows:

- A. Attendant Care Services
- B. Home-Delivered Meals
- C. Personal Emergency Response System
- D. Adult Day Services
- E. Adult Day Health Services
- F. Prevocational Services
- G. Respite Care
- H. Environmental Accessibility Adaptations/Adaptive Equipment

These services are designed to maintain Medicaid eligible beneficiaries at home in order to preclude or postpone institutionalization of the individual.

In accordance with 42 CFR 441.301(b) (1) (ii) ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.

**212.000****Eligibility for the ARChoices Program****1-1-19**

- A. To qualify for the ARChoices Program, a person must be age 21 through 64 and have been determined to have a physical disability through the Social Security Administration or the Department of Human Services (DHS) Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or be 65 years of age or older and require an intermediate level of care in a nursing facility. Persons determined to meet the skilled level of care, as determined by the Office of Long Term Care (OLTC), are not eligible for the ARChoices Program.

The ARChoices Program processes for beneficiary intake, assessment and service plan development include:

1. Determination of categorical eligibility,
  2. Determination of financial eligibility,
  3. Determination of nursing facility level of care determination,
  4. Development of a person-centered service plan (PCSP),
  5. Development of an individual services budget (ISB),
  6. Notification to the beneficiary of his or her choice between home- and community-based services and institutional services, and
  7. Choice by the beneficiary among certified providers.
- B. Applicants for participation in the program (or their representatives) must make application for services at the DHS office in the county of their residence. Medicaid eligibility is determined by the DHS Division of County Operations, the results of the independent assessment, and the Division of Provider Services and Quality Assurance (DPSQA) OLTC Eligibility Specialist, and is based on non-functional and functional criteria. Income and resources comprise the non-functional criteria. The individual must be an individual with a functional need.
- C. To be determined an individual with a functional need; an individual must meet at least one of the following three criteria, as determined by a licensed medical professional:
1. The individual is unable to perform either of the following:
    - a. At least 1 of the 3 activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon another person; or
    - b. At least 2 of the 3 ADLs of transferring/locomotion, eating, or toileting without limited assistance from another person; or
  2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to themselves or others; or
  3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.
- D. Individuals who require a skilled level of care as defined in Department of Human Services regulations are not eligible for the ARChoices waiver.
- E. The Arkansas Independent Assessment (ARIA) is the assessment instrument used by registered nurses of the Independent Assessment Contractor to collect information used in determining level of care and developing the PCSP. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each waiver applicant or participant is assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment. The tiers are intended to help inform waiver program oversight and administration and person-centered service planning. Tier levels are also a population-based factor used in determining participants' prospective individual services budgets. The tiers do not replace the Level of Care criteria described in Section C above, waiver eligibility determinations, or the person-centered service plan process.
1. Tier 0 (zero) and Tier 1 (one) indicate the individual's assessed needs, if any, do not support the need for either ARChoices waiver services or nursing facility services.
  2. Tier 2 (two) indicates the individual's assessed needs are consistent with services available through either the ARChoices waiver program or a licensed nursing facility.
  3. Tier 3 (three) indicates the individual needs skilled care available through a licensed nursing facility and therefore is not eligible for the ARChoices waiver program.

These indications notwithstanding, the final determination of Level of Care and functional eligibility is made by the Office of Long-Term Care (OLTC).

For more information on ARIA, please see the ARIA Manual.

- F. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition that is temporary and expected to last no more than 21 days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition that would render the individual ineligible if the condition or change in condition is expected to last more than 21 days.
- G. Beneficiaries diagnosed with a serious mental illness or intellectual disability are not eligible for the ARChoices Program unless they have medical needs unrelated to the diagnosis of mental illness or intellectual disability and meet the other qualifying criteria. A diagnosis of severe mental illness or intellectual disability must not bar eligibility for beneficiaries having medical needs unrelated to the diagnosis of serious mental illness or intellectual disability when they meet the other qualifying criteria.
- H. Eligibility for the ARChoices Waiver program begins the date the DHS Division of County Operations approves the application unless there is a provisional plan of care. (If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process.)
- I. The ARChoices Waiver provides for the entrance of all eligible persons on a first-come, first-served basis, once beneficiaries meet all functional and financial eligibility requirements. However, the waiver dictates a maximum number of unduplicated, and active, beneficiaries who can be served in any waiver year. Once the maximum number of unduplicated, or active, beneficiaries is projected to be reached considering the number of active cases and the number of pending applications, a waiting list will be implemented for this program and the following process will apply:
  - 1. Each ARChoices application will be accepted and medical and financial eligibility will be determined.
  - 2. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services, that all waiver slots are filled and that the applicant is number X in line for an available slot.
  - 3. Entry to the waiver will then be prioritized based on the following criteria:
    - a. Waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error;
    - b. Waiver application determination date for persons being discharged from a nursing facility after a 90- day stay; waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;
    - c. Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);
    - d. Waiver application determination date for all other persons.

**212.050****Definitions****1-1-19**

- A. ARIA ASSESSMENT TOOL means the Arkansas Independent Assessment (ARIA) instrument used by registered nurses of the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan (PCSP).

- B. DHS RN means a registered nurse authorized by DHS to develop the person-centered service plan for a participant.
- C. EATING means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.
- D. EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.
- E. INDEPENDENT ASSESSMENT CONTRACTOR means the DHS vendor responsible for administering the ARIA assessment tool for the purpose of collecting information used in determining level of care and developing the person-centered service plan.
- F. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.
- G. LIMITED ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.
- H. LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.
- I. INTELLECTUAL AND DEVELOPMENTAL DISABILITIES means a level of intellectual disability as described in the American Association on Intellectual and Developmental Disabilities' Manual on Intellectual Disability: Definition Classification, and systems and supports. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.
- J. PCSP means a person-centered service plan.
- K. SERIOUS MENTAL ILLNESS OR DISORDER means schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other psychotic disorder. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.
- L. SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount.
  - 1. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure.
  - 2. Intravenous injections and hypodermoclysis or intravenous feedings.
  - 3. Levin tubes and nasogastric tubes.
  - 4. Nasopharyngeal and tracheostomy aspiration.
  - 5. Application of dressings involving prescription medication and aseptic techniques.
  - 6. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV.

7. Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.
  8. Initial phases of a regimen involving administration of medical gases.
  9. Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.
  10. Ventilator care and maintenance.
  11. The insertion, removal and maintenance of gastrostomy feeding tubes.
- M. SUBSTANTIAL SUPERVISION means the prompting, reminding or guidance of another person to perform the task.
- N. TOILETING means the act of voiding of the individual's bowels or bladder and includes the use of a toilet, commode, bedpan or urinal; transfers on and off a toilet, commode, bedpan or urinal; the cleansing of the individual after the act; changes of incontinence devices such as pads or diapers; management of ostomy or catheters and adjustment to clothing.
- O. TOTAL DEPENDENCE means the individual needs another person to completely and totally perform the task for the individual.
- P. TRANSFERRING means the act of an individual in moving from one surface to another and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids and chairs.

**212.200 Prospective Individual Services Budget**

1-1-19

- A. Individual Services Budget (ISB)
1. In the ARChoices in Homecare program, there is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant. This limit is called the Individual Services Budget (ISB) and applies to all participants and all waiver services available through the ARChoices program.
  2. Each ARChoices person-centered service plan shall include an Individual Services Budget, as determined by the Division of Aging, Adult and Behavioral Health Services (DAABHS) for the specific participant during the service plan development process. The projected total cost of all authorized services in any ARChoices person-centered service plan (including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.
  3. Each participant's Individual Services Budget shall be explained when the Department of Human Services Registered Nurse (DHS RN) consults with the individual on the person-centered service plan. This may be done through written information.
  4. Each participant shall also receive written notice of their Individual Services Budget that includes notice of the right to request a Fair Hearing if they are denied waiver services as a result of a dollar limit.
- B. Adjustments, Considerations, and Safeguards Regarding Individual Services Budgets
1. During the development of each person-centered service plan, after considering the participant's assessed needs, priorities, preferences, goals, and risk factors, and to ensure that the cost of all ARChoices services for each participant does not exceed the applicable Individual Services Budget amount, the DHS RN shall, as necessary
    - a. Limit and modify the type, amount, frequency, and duration of waiver services authorized for the participant (notwithstanding any service-specific limits

- established in Appendix C: Participant Services); and
- b. Make referrals to appropriate services available through the Medicaid State Plan or another waiver program, Medicare, the participant's Medicare Advantage (MA) plan (including targeted and other supplemental benefits the MA plan may offer), the participant's Medicare prescription drug plan, and other federal, state, or community programs.
2. Should the DHS RN determine that the ARChoices waiver services authorized for the participant within the limit of the applicable Individual Services Budget, other Medicaid or Medicare covered services, and other available family and community supports, when taken together, are insufficient to meet the participant's needs, the DHS RN shall counsel the participant on Medicaid-covered services in other settings that are available to meet their needs (e.g., nursing facility services and assisted living facility services) and make appropriate referrals. The DHS RN may also order a re-assessment of the participant.
  3. In the event that a participant's ISB requires changes or limitations to ARChoices services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, during the person-centered service plan process the participant will be given the opportunity to choose a different mix, type, or amount of ARChoices covered services. (For example, the participant could decide to forego a day of adult day health services in order to have additional attendant care hours.) Any such participant-requested changes and substitutions are subject to the following:
    - a. The services chosen by participant are otherwise covered and reimbursable under ARChoices and do not exceed any applicable service limitations;
    - b. The services chosen by participant are necessary and appropriate for the individual and consistent with the results of the independent assessment;
    - c. The cost of all ARChoices waiver services authorized for or received by the participant, including any participant-requested changes and substitutions, do not exceed the applicable ISB amount; and
    - d. The DHS RN determines the changes are reasonable and necessary for the individual and reflected in the approved person-centered service plan.
  4. If waiver services are or become limited due to the application of the Individual Services Budget, the affected participant may request an exception in the form of a temporary increase in the person's ISB amount applicable to a period not to exceed one year. Exception requests shall be reviewed and acted on by DAABHS using a panel of at least three registered nurses. This exceptions process is intended as a safeguard to address exceptional circumstances affecting a participant's health and welfare and not as means to circumvent the application of the Individual Services Budget policy or permit coverage of services not otherwise medically necessary for the individual, consistent with their level of care, assessment results, and waiver program policy. Approval of an exception request and associated one-time temporary increase in a participant's Individual Services Budget amount for a period not to exceed one year is subject to the following criteria:
    - a. In the professional opinion of the nurse panel, unique circumstances indicate that additional time is reasonably needed by the participant (or the participant's family on his or her behalf) to (1) adjust waiver service use costs to within the applicable Individual Services Budget (ISB) amount, (2) arrange for the start of or increase in non-Medicaid services (such as informal family supports and Medicare-covered services), and/or (3) arrange for placement in an alternative residential or facility-based setting.
    - b. Such unique circumstances must be (1) specific to the individual; (2) supported by documentation provided to the nurse panel; (3) relevant to the individual's assessed needs and risk factors; (4) relevant to the temporary need for additional, medically necessary coverable waiver services in excess of the

- person's pre-exception ISB amount; and (5) not the result of a need for skilled services or other services not covered under the waiver.
- c. Such unique circumstances may include (1) recent major life events not known at the time the current person-centered service plan was approved, including without limitation death of a spouse or caregiver, and loss of a home or residential placement; and (2) A temporary increase in care needs, for a period not to exceed ninety (90) days after a discharge from inpatient acute treatment or post-acute care.
  - d. If the exception request is due to the participant (or participant's family on his or her behalf) encountering delays or difficulties in arranging new care arrangements or an alternative residential or facility-based placement in the state, an exception may be granted if the nurse panel determines reasonable efforts are being made and the delays or difficulties experienced are exceptional or due to rural or remote location of the participant's home.
  - e. The factors considered by the nurse panel must be reasonably relevant to the necessity for additional waiver services in total cost in excess of the person's pre-exception ISB amount and for a temporary period of time not to exceed one year.
5. If the projected cost of services identified in an individual's person-centered service plan (whether such plan is under development, provisional, or final or renewed, amended, or extended) is less than the applicable Individual Services Budget amount, this shall not be construed to permit, suggest, or justify approval, coverage, or reimbursement of different or additional waiver services (including changes in amount, frequency, or duration); coverage and reimbursement of any medically unnecessary Medicaid State Plan or waiver services; or other actions to increase spending to use the remaining "unused" portion of the ISB amount.
  6. The Individual Services Budget shall not apply to environmental accessibility adaptations/adaptive equipment.
- C. Transition Process
1. The Individual Services Budget limit shall apply to the following:
    - a. New ARChoices participants, including individuals determined newly eligible for ARChoices following a period of ineligibility for this or another HCBS waiver program, when they are determined waiver eligible, and effective for their first person-centered service plan and thereafter; and
    - b. Existing ARChoices participants immediately upon any of the following events, whichever may occur first:
      - i. Waiver eligibility is re-evaluated;
      - ii. The Level of Care is reaffirmed or revised;
      - iii. A new independent assessment or re-assessment is performed;
      - iv. Expiration, renewal, extension, or revision of the participant's person-centered service plan occurs; or
      - v. Admission to or discharge from an inpatient hospital, nursing facility, assisted living facility, or residential care facility, or transfer from a hospice facility occurs.
  2. For all other ARChoices participants not otherwise identified above, the Individual Services Budget limit shall apply no later than 60 days after the effective date of this waiver amendment.
  3. For the following ARChoices participants, the DAABHS deputy director (or his/her designee) may on a case-by-case basis extend the effective date of the participant's first Individual Services Budget by a maximum of 60 days per participant upon written

request of the participant (or legal representative) or the participant's personal physician, if:

- i. The specific participant's recent pattern of waiver service expenditures exceeds the average Individual Services Budget amount by an estimated twenty-five (25) percent or more; and/or
- ii. DAABHS determines that unique, intervening circumstances indicate that additional time is reasonably needed by the participant and the participant's family and providers. Examples of unique, intervening circumstances include the death of the spouse, loss of home, or unexpected difficulties in accessing or arranging care or placement, among others.

D. Methodology for Determining Individual Services Budgets

1. The Individual Services Budget amount for a participant is based upon that participant's ISB Level. The ISB Level is determined by DAABHS based on a review of the participant's Independent Assessment. The three (3) ISB Levels are:
  - a. Intensive: The participant requires total dependence or extensive assistance from another person in all three (3) areas of mobility, feeding and toileting.
  - b. Intermediate: The participant requires total dependence or extensive assistance from another person in two (2) of the area of mobility, feeding and toileting.
  - c. Preventative: The participant meets the functional need eligibility requirements for ARChoices in section 212.000 but does not meet the criteria for the ISB Levels of Intensive or Intermediate.
2. The maximum Individual Services Budget for a participant, except as modified by the Transitional Allowance in subsection (3) below, is as follows:
  - a. For an individual with an assessed ISB Level of Intensive, the Individual Services Budget is \$30,000 annually.
  - b. For an individual with an assessed ISB Level of Intermediate, the Individual Services Budget is \$20,000 annually.
  - c. For an individual with an assessed ISB Level of Preventative, the Individual Services Budget is \$5,000 annually.
3. For a participant with total waiver expenditures of more than \$30,000 for calendar year 2018:
  - a. The participant will be granted a Transitional Allowance for one year, increasing the participant's maximum Individual Services Budget to the amount of the participant's total waiver expenditures for calendar year 2018.
  - b. In the year following the Transitional Allowance for one year, increasing the participant's maximum Individual Services Budget to the amount of the participant's total waiver expenditures for calendar year 2019.
  - c. For purposes of this subsection (3), "total waiver expenditures" for a calendar year shall be calculated as the sum total of the value of all waiver services authorized for the participant in the person-centered service plan as of December 31, and then modified by:
    - i. If the cumulative expenditures are for less than 12 months, annualizing the total to reflect what the expenditures would have been if the participant had received the same monetary amount of services for 12 consecutive months; and
    - ii. Excluding amounts expended for environmental accessibility adaptations/adaptive equipment services.
4. For purposes of determining the projected cost of all waiver services in an individual's person-centered service plan, DAABHS shall assume that:



- a. The individual will receive or otherwise use all services identified in the service plan and in their respective maximum authorized amounts, frequencies, and durations;
- b. There are no interruptions in the provision of waiver services due to possible future events such as an inpatient admission, nursing facility admission, or short-term admission to another facility setting.

**212.300 Person-Centered Service Plan (PCSP)**

1-1-19

- A. Each beneficiary in the ARChoices Program must have an individualized ARChoices PCSP. The authority to develop an ARChoices PCSP is given to the Medicaid State agency's designee, the Department of Human Services Registered Nurse (DHS RN). At the discretion of the beneficiary, the ARChoices PCSP is developed with the ARChoices beneficiary, representative, the participant's family or anyone requested by the participant, including the provider, if requested by the beneficiary. At the request of the beneficiary or their representative, the DHS RN can assist in coordinating and inviting any requested beneficiaries.
- B. When developing the waiver PCSP, the beneficiary may freely choose a family member or individual to appoint as a representative. The beneficiary and representative may participate in all decisions regarding the types, amount and frequency of services included in the PCSP. The representative may participate in choosing the provider(s) for the beneficiary. If anyone other than the beneficiary chooses the provider, the DHS RN will identify that individual on the PCSP. Should the self-directed service delivery model be selected by an individual other than the beneficiary, that individual may not be the paid employee.
- C. The ARChoices PCSP developed by the DHS RN includes, but is not limited to:
  1. Beneficiary identification and contact information, including full name and address, phone number, date of birth, Medicaid number and the effective date of ARChoices Waiver eligibility;
  2. Contact person;
  3. Physician's name and address;
  4. The amount, frequency and duration of ARChoices Waiver services to be provided and the name of the service provider chosen by the beneficiary or representative to provide the services.

**NOTE: Attendant Care, Respite Care and State Plan Personal Care hours are authorized based on the number of hours calculated by application of the Arkansas Medicaid Task and Hour Standards (THS) which is described below in Section D. Attendant Care, Respite Care and State Plan Personal Care hours are authorized in a monthly amount in the waiver PCSP. The beneficiary's chosen, Medicaid-certified provider is responsible for properly delivering Attendant Care, Respite Care and State Plan Personal Care services to support the needed activity of daily living (ADL) and instrumental activity of daily living (IADL) tasks, consistent with the approved PCSP, this manual and other applicable Arkansas Medicaid policy.**

5. Other services outside the ARChoices services, regardless of payment source, identified and/or ordered to meet the beneficiary's needs including the option for the self-directed service delivery model;
6. The election of community services by the waiver beneficiary or representative;
7. The name and title of the DHS RN responsible for the development of the beneficiary's PCSP; and,

8. The individual services budget for the participant.
- D. Task and Hour Standards (THS):

**1. Background on THS**

The Arkansas Medicaid Task and Hour Standards (THS) is the written methodology used by DHS RNs as the basis for calculating the number of Attendant Care, Respite Care and State Plan Personal Care hours that are reasonable and medically necessary to perform needed ADL and IADL tasks.

The current Division of Aging, Adult and Behavioral Health Services (DAABHS)-approved THS is located on the web at [insert website address]

The THS includes the following four components, described in a grid format:

- a. The participant's Needs Intensity Score (0, 1, 2, or 3) for each task;
- b. The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score;
- c. The frequency with which a task is necessary and reasonably performed; and,
- d. The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.

The THS provides a standardized process for calculating the amount of reasonable, medically necessary Attendant Care, Respite Care and State Plan Personal Care services hours, with the minute ranges and frequencies providing DHS nurses with the ability to adjust PCSPs based on unique factors related to a given beneficiary's needs, preferences, and risks.

The number of Attendant Care, Respite Care and State Plan Personal Care hours/minutes that are authorized for each necessary task by week/month are calculated by the DHS RN consistent with the THS grid and based on:

- a. Responses by the participant and their representatives to certain relevant questions in the ARIA assessment instrument, and
- b. As appropriate, information obtained by the DHS RN during their PCSP meeting with the participant and participant's representatives or from participant's physician.

The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.

The Arkansas THS is also used to calculate the reasonable quantity of hours to perform medically necessary tasks covered under Independent Choices self-directed personal assistance or State Plan personal care services for adults aged 21 or older.

DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the ARIA assessments and electronic visit verification system; DPSQA audits of providers; and beneficiary and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.

**2. Needs Intensity Score**

For each task, the DHS RN will assign a Needs Intensity Score to the participant based on the participant's and/or representative's responses to questions during the ARIA assessment and information collected by the DHS RN during the PCSP meeting with the participant. The four Impairment Scores are defined as follows:

- a. Needs Intensity Score 0 – The participant has no functional impairment with regard to the task and can perform it without assistance.
- b. Needs Intensity Score 1 – (Mild): Minimal/mild functional impairment. The participant is able to conduct activities with minimal difficulty and need minimal assistance.
- c. Needs Intensity Score 2 – (Severe): Extensive/severe functional impairment. The participant has extensive difficulty carrying out activities and needs extensive assistance.
- d. Needs Intensity Score 3 – (Total): The participant is completely unable to carry out any part of the activity.

A Needs Intensity Score is separate and distinct from a Tier Level under the ARIA system.

### **3. Number of minutes allowed for each Needs Intensity Score for each task**

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. The DHS RN preparing the PCSP will determine the number of minutes within the range that are appropriate for the participant based on conditions specific to the participant. For example, if a participant has cognitive or behavioral issues, the DHS RN may find that the maximum number of minutes in the range for bathing is warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a participant who is bald.

If the participant has extenuating circumstances and requires time outside the range (either more or less) for the task, the DHS RN must obtain supervisory approval. For supervisory approval, the DHS RN must document the participant's extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the participant's assessed or observed medical needs, and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor's approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the PCSP must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the PCSP.

### **4. The frequency with which a task is performed**

The THS methodology takes into account the frequency with which each ADL and IADL is performed and reasonably necessary. The frequency with which a given task is performed for a beneficiary will be determined based on the ARIA assessment results and information collected by the DHS RN during the PCSP meeting with the participant.

### **5. The amount of assistance with ADLs and IADLs provided by other sources**

ARChoices does not cover assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.

If instances of a needed assistance with an ADL or IADL are generally provided through another source, then ARChoices attendant care is not necessary and no time for that task is included in the PCSP. When another source is available to provide assistance with a needed ADL or IADL task, the time associated with the assistance from that other source is deducted from the total minutes per week.

The amount of support with ADLs and IADLs provided by other sources is informed by the ARIA assessment results and information gathered by the DHS RN during the PCSP meeting with the participant.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g., supplemental services). Other support is calculated for each task based on how much support is provided with the task. For example, the participant's daughter may bathe her mother once a week and prepare all meals on weekends, eliminating the need for an attendant care aide to perform those tasks. For this participant, the total minutes per week for the tasks of bathing and meal preparation would be adjusted by the minutes associated with an aide assisting with one bath and six meals per week.

#### 6. Calculation of total hours of attendant care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of attendant care hours approved for the participant for a month. **The projected total cost of attendant care plus all other authorized services in the PCSP (including provisional plans) shall not exceed the participant's Individual Services Budget applicable to the time period covered by the service plan.**

- E. If waiver eligibility is approved by the DHS Division of County Operations, a copy of the PCSP signed by the DHS RN and the waiver beneficiary or representative, will be forwarded to the beneficiary or representative and the Medicaid enrolled service provider(s) included in the PCSP. The service provider and the ARChoices beneficiary must review and follow the signed authorized PCSP. Services cannot begin until the Medicaid provider receives the authorized PCSP from the DHS RN. The original PCSP will be maintained by the DHS RN.

The implementation of the PCSP by a provider must ensure that services are:

1. Individualized to the beneficiary's unique circumstances;
2. Provided in the least restrictive environment possible;
3. Developed within a process ensuring participation of those concerned with the beneficiary's welfare;
4. Monitored and adjusted as needed, based on changes authorized and reported by the DHS RN regarding the waiver PCSP;
5. Provided within a system that safeguards the beneficiary's rights to quality services as authorized on the waiver PCSP; and,
6. Documented carefully, with assurance that required information is recorded and maintained.

**NOTE: Each service included on the ARChoices PCSP must be justified by the DHS RN. This justification is based on medical necessity, the beneficiary's physical, cognitive and functional status, other support services available to the beneficiary and other factors deemed appropriate by the DHS RN.**

Each ARChoices service must be provided according to the beneficiary PCSP. For services included in the waiver PCSP, Medicaid reimbursement is limited to the amount and frequency that is authorized in the PCSP, subject to the participant's individual services budget. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

**NOTE: PCSPs are updated annually by the DHS RN and sent to the ARChoices provider prior to the expiration of the current PCSP. However, the provider has the responsibility for monitoring the PCSP expiration date and ensuring that services are delivered according to a valid PCSP. At least 30 and no more than 45 days**

before the expiration of each PCSP, the provider shall notify the DHS RN via email and copy the RN supervisor of the PCSP expiration date.

Services are not compensable unless there is a valid and current PCSP in effect on the date of service.

**REVISIONS TO A BENEFICIARY PCSP MAY ONLY BE MADE BY THE DHS RN.**

**NOTE:** All revisions to the waiver PCSP must be authorized by the DHS RN. A revised PCSP will be sent to each appropriate provider. Regardless of when services are provided, unless the provider and the service are authorized on an ARChoices PCSP, services are considered non-covered and do not qualify for Medicaid reimbursement. Medicaid expenditures paid for services not authorized on the ARChoices PCSP are subject to recoupment.

All revisions to the PCSP must be consistent with and not exceed participant's updated individual services budget.

**212.305 Targeted Case Management Services (Non-Waiver Service)**

**1-1-19**

Each ARChoices Person-Centered Service Plan (PCSP) will include Targeted Case Management, unless refused by the waiver beneficiary. The Targeted Case Manager is responsible for monitoring the beneficiary's status on a regular basis for changes in their service need, referring the beneficiary for reassessment, if necessary, and reporting any beneficiary complaints and changes in status to the Department of Human Services Registered Nurse (DHS RN) or Nurse Manager immediately upon learning of the change.

**NOTE:** As stated in this manual, the service provider and the ARChoices beneficiary must review and follow the signed authorized PCSP. Each service included on the ARChoices PCSP must be justified by the DHS RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary and other factors deemed appropriate by the DHS RN.

For ARChoices beneficiaries whose waiver PCSP includes TCM at the time the DHS RN signs the PCSP, the ARChoices PCSP, signed by a DHS RN, will serve as the authorization for TCM services for one year from the date of the DHS RN's signature, as described above.

**212.310 Provisional Person-Centered Service Plan (PCSP)**

**1-1-19**

The ARChoices registered nurse (DHS RN) may develop a provisional PCSP prior to establishment of Medicaid eligibility, based on information obtained during the in-home functional assessments administered by the Independent Assessment Contractor and the DHS RN, when recommending functional approval based on the nursing home criteria. The DHS RN must discuss the provisional PCSP policy and have the approval of the applicant prior to completing and processing the provisional PCSP. The PCSP will be developed by the applicant and the DHS RN and signed by the applicant or the applicant's representative and the DHS RN.

The provisional PCSP will include all current PCSP information, except for the waiver eligibility date and the Medicaid beneficiary ID number.

The provisional PCSP will be mailed to the waiver applicant and each provider included on the PCSP. If the beneficiary and the provider accept the risk of ineligibility, the provider must begin services within an established time frame as determined by the Division of Aging, Adult and Behavioral Health Services (DAABHS) and notify the DHS RN, via Start Services form AAS-9510, that services have started. The DHS RN will track the start of care dates and give the applicant options when services are not started.

The provisional PCSP will expire 60 days from the date signed by the applicant and the DHS RN. A PCSP that has been approved with a Medicaid number and waiver eligibility date must be in place no later than the expiration date of the provisional PCSP.

- A. A provisional PCSP may be developed and sent to providers only when the assessment outcome indicates functional eligibility and the DPSQA Office of Long Term Care determines based on the results of the ARIA assessment, that the applicant meets the level of care criteria for an adult with a functional need, as explained in Section 212.000, Eligibility for the ARChoices Program.

The waiver eligibility date will be established retroactively, effective on the day the provisional PCSP was signed by the applicant or applicant's representative and the DHS RN, if:

1. At least one waiver service begins within 30 days of the development of the provisional PCSP

**AND**

2. The waiver application is approved by the Division of County Operations.
- B. If waiver services begin within 31 through 60 days of the development of the provisional PCSP, the retroactive eligibility date will be the effective date that a waiver service is started.
- C. If waiver services do not begin within sixty (60) days from the date the provisional PCSP is signed by the DHS RN, the Division of County Operations will establish the waiver eligibility date as the date the application is entered into the system as an approved application. There will be no retroactive eligibility.
- D. Provisional PCSPs are subject to the participant's individual services budget.
- E. Provisional PCSPs may not include the non-waiver self-directed service delivery model

**212.311 Denied Eligibility Application**

**1-1-19**

- A. If the DHS Division of County Operations denies the Medicaid eligibility application for any reason, Medicaid and waiver services provided during a period of ineligibility will be the financial responsibility of the applicant. The DHS Division of County Operations will notify the DHS RN. The DHS RN will notify the providers via form AAS-9511 immediately upon learning of the denial. Reasons for denial include but are not limited to:
1. Failure to meet the nursing home admission criteria
  2. Failure to meet financial eligibility criteria
  3. Withdrawal of the application by the applicant
  4. Death of the applicant when no waiver services were provided

**NOTE: If waiver services were provided and the applicant dies prior to approval of the application, waiver eligibility will begin (if all other eligibility requirements are met) on the date waiver service(s) began and end on the date of death.**

- B. The applicant has the right to appeal by filing for a fair hearing. When an appeal ruling is made in favor of the applicant, the actions to be taken by the DHS Division of County Operations are as follows:
1. If the individual has no unpaid ARChoices Waiver charges, Medicaid coverage will begin on the date of the appeal decision. However, the waiver portion of the case will not be approved until the date the DHS Division of County Operations completes the case.

2. If the individual has unpaid waiver charges and services were authorized by the DHS RN, eligibility for both Medicaid and waiver services will begin on the date service began unless the hearing decision sets a begin date.

**NOTE: Under no circumstances will waiver eligibility begin prior to the date of application or the date the provisional PCSP is signed by the DHS RN and the applicant or the applicant's representative, whichever is later.**

#### 212.312 Comprehensive Person-Centered Service Plan (PCSP) 1-1-19

Prior to the expiration date of the provisional PCSP, the DHS RN will send the comprehensive PCSP to the waiver beneficiary and all providers included on the PCSP. The comprehensive PCSP will replace the provisional PCSP. The comprehensive PCSP will include the Medicaid beneficiary ID number, the waiver eligibility date established according to policy and the comprehensive PCSP expiration date.

The comprehensive PCSP expiration date will be 365 days from the date of the DHS RN's signature on form AAS-9503, the ARChoices PCSP. Once the application is either approved or denied by the DHS Division of County Operations the providers will be notified by the DHS RN. The notification for the approval will be in writing via a PCSP that includes the waiver eligibility date and Medicaid ID number. The notification for a denial will be via a form AAS-9511 reflecting the date of denial.

#### 212.313 ARChoices Applicants Leaving an Institution 1-1-19

The policy regarding retroactive eligibility applies to applicants entering the waiver program from the community and to applicants entering the program from an institution. The same process and the same policy determining the waiver eligibility date will apply to applications of each type.

**EXCEPTION:** No waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if a provisional PCSP is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest waiver eligibility date will be the day the applicant is discharged from the facility.

**NOTE:** For inpatients, if a waiver application is filed at the local DHS Division of County Operations prior to discharge AND if a provisional PCSP is developed by the DHS RN prior to discharge, it may be possible to establish retroactive eligibility back to the date the applicant returned to his or her home if the applicant is ultimately found eligible for the program. (Note: Medicaid beneficiaries in nursing facilities do not have to complete a new application when applying for ARChoices. Their signature on the PCSP electing waiver services serves as the application.)

If no waiver application is filed and no functional assessment or provisional PCSP is completed by the Independent Assessment Contractor and DHS RN prior to an applicant's discharge from an institution, retroactive eligibility will not be possible back to the date the applicant returned to his home.

Functional assessments and PCSPs may be completed during a period of institutionalization; however, a discharge date must be scheduled. Since the purpose of the assessment and the PCSP is to depict the applicant's condition and needs in the home, premature assessments and PCSP development do not meet the intent of the program.

This policy applies to applicants leaving hospitals or nursing facilities.

#### 212.320 Authorization Of The ARChoices Person-Centered Service Plan (PCSP) with Personal Care Services 1-1-19



The following applies to individuals receiving both personal care services and ARChoices services.

- A. The DHS RN is responsible for developing an ARChoices PCSP that includes both waiver and non-waiver services. Once developed, the PCSP is signed by the DHS RN authorizing the services.
- B. PCSP developed on or after the effective date of this Provider Manual may not include attendant care services unless the PCSP provides for at least 64 hours per month of personal care services. Attendant care services are intended to supplement personal care services available under the Medicaid state plan.
- C. The ARChoices PCSP signed by the DHS RN will suffice as the “Personal Care Authorization” for services required in the Personal Care Program. The PCSP developed by the personal care provider is still required.

The responsibility of developing a personal care service plan is not placed with the DHS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care Provider Manual.

**NOTE: For ARChoices participants who have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices PCSP, signed by a DHS RN, will serve as the authorization for personal care services for one year from the date of the DHS RN’s signature, as described above.**

- D. The ARChoices PCSP is effective for one (1) year, once signed by the DHS RN.

#### 212.400 Temporary Absences from the Home

1-1-19

Once an ARChoices eligibility application has been approved, waiver services must be provided in a home and community-based services setting for eligibility to continue. Unless stated otherwise below, the DHS Division of County Operations must be notified immediately by the DHS RN when waiver services are discontinued and action will be initiated by the DHS Division of County Operations to close the waiver case. Providers will be notified by the DHS RN.

- A. Absence from the Home due to Institutionalization

An individual cannot receive ARChoices Waiver services while in an institution. The following policy applies to any inpatient stay where Medicaid pays the facility for the date of admission, i.e., hospitals, nursing homes, rehab facilities, etc., for active waiver cases when the beneficiary is hospitalized or enters a nursing facility for an expected stay of short duration.

- 1. When a waiver beneficiary is admitted to a hospital, the DHS Division of County Operations will not take action to close the waiver case unless the beneficiary does not return home within 30 days from the date of admission. If, after 30 days, the beneficiary has not returned home, the DHS RN will notify the DHS Division of County Operations and action will be initiated to close the waiver case.
- 2. If the DHS Division of County Operations becomes aware that a beneficiary has been admitted to a nursing facility and it is anticipated that the stay will be short (30 days or less), the waiver case will be closed effective the date of the admission, but the Medicaid case will be left open. When the beneficiary returns home, the waiver case may be reopened effective the date the beneficiary returns home. A new assessment and medical eligibility determination will not be required unless the last review was completed more than 6 months prior to the beneficiary’s admission to the facility.



**NOTE:** Nursing facility admissions, when referenced in this section, do not include ARChoices beneficiaries admitted to a nursing facility to receive facility-based respite services.

**NOTE:** The Arkansas Medicaid Program considers an individual an inpatient of a facility beginning with the date of admission. Therefore, payment to the inpatient facility begins on the date of admission. Payment to the inpatient facility does not include the date of discharge.

Payment for ARChoices services may be allowed for the date of a beneficiary's admission to an inpatient facility if the provider can provide verification that services were provided before the beneficiary was admitted. In order for payment to be allowed, providers are responsible for obtaining the following:

- Copies of claim forms or timesheets listing the times that services were provided
- A statement from the inpatient facility showing the time that the beneficiary was admitted
- This information must be submitted to DAABHS within 10 working days of receiving a request for verification.

If providers are unable to provide proof that ARChoices services were provided before the beneficiary was admitted to the inpatient facility, then payments will be subject to recoupment. ARChoices services provided on the same day the beneficiary is discharged from the inpatient facility are billable when provided according to policy and after the beneficiary was discharged.

B. Absence due to Reasons Other than Institutionalization

When a waiver beneficiary is absent from the home for reasons other than institutionalization, the DHS Division of County Operations will not be notified unless the beneficiary does not return home within 30 days. If, after 30 days, the beneficiary has not returned home and the providers can no longer deliver services as authorized on the Person-Centered Service Plan (PCSP) (e.g., the beneficiary has left the state and the return date is unknown), the DHS RN will notify the DHS Division of County Operations. Action will be taken by the DHS Division of County Operations to close the waiver case.

**NOTE:** It is the responsibility of the provider to notify the DHS RN immediately via form AAS-9511 upon learning of a change in the beneficiary's status.

**212.500 Reporting Changes in Beneficiary's Status**

**1-1-19**

Because the provider has more frequent contact with the beneficiary, many times the provider becomes aware of changes in the beneficiary's status sooner than DHS RN or Case Manager. It is the provider's responsibility to report these changes immediately so proper action may be taken. Providers must complete the Waiver Provider Communication – Change of Participant Status Form (AAS-9511) and send it to the DHS RN. A copy must be retained in the provider's beneficiary case record. Regardless of whether the change may result in action by the DHS Division of County Operations, providers must immediately report all changes in the beneficiary's status to the DHS RN.

The Targeted Case Manager is responsible for monitoring the beneficiary's status on a regular basis for changes in service need, referring the beneficiary for reassessment if necessary and reporting any beneficiary complaints and changes in status to the DHS RN, or DHS RN Supervisor immediately upon learning of the change.

**212.600 Relatives Providing ARChoices Services**

1-1-19

All ARChoices services may be provided by a beneficiary's relative, unless stated otherwise in this manual.

For the purposes of this section, a relative or family member shall be defined as all persons related to the beneficiary by virtue of blood, marriage, or adoption.

The following is applicable for all waiver services:

- A. Under no circumstances may Medicaid payment be made for any waiver service rendered by the waiver beneficiary's:
  - 1. Spouse
  - 2. Legal guardian of the person
  - 3. Attorney-in-fact granted authority to direct the beneficiary's care
- B. All providers, including relatives, are required to meet all ARChoices provider certification requirements, Arkansas Medicaid enrollment requirements and provide services according to the beneficiary's PCSP and any established benefit limits for that specific service.

**213.210 Attendant Care Services**

1-1-19

Procedure Code	Modifier	Description
S5125	U2	Attendant Care Services
S5125		Attendant Care Self-Directed Model

Attendant Care services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible beneficiary's functioning in his or her own home or elsewhere in the community where the beneficiary engages in activities, including work-related activities. Attendant Care services may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities, subject to the restrictions on travel time in section 213.220.

Attendant Care services consists of assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks through hands-on assistance, supervision and/ or cueing.

Hands-on assistance, supervision and/or cueing are defined as:

- A. "Hands-on assistance" means a provider physically performs all or part of an activity because the individual is unable to do so.
- B. "Set-up", a form of hands on assistance, means getting personal effects, supplies, or equipment ready so that an individual can perform an activity.
- C. "Supervision" means a provider must be near the individual to observe how the individual is completing a task.
- D. "Cueing and/or reassurance" means giving verbal or visual clues and encouragement during the activity to help the individual complete activities without hands-on assistance.
- E. "Monitoring", a form of supervision, means a provider must observe the individual to determine if intervention is needed.

- F. "Stand-by", a form of supervision, means a provider must be at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.
- G. "Support", a form of supervision, means to enhance the environment to enable the individual to be as independent as possible.
- H. The following forms of assistance combine elements of Hands-on assistance, supervision and/or cueing:
- I. "Redirection", a form of supervision or cueing, means to divert the individual to another more appropriate activity.
- J. "Memory care support", a blend of supervision, cueing and hands-on assistance. Includes services related to observing behaviors, supervision and intervening as appropriate in order to safeguard the service beneficiary against injury, hazard or accident. These specific supports are designed to support beneficiaries with cognitive impairments.

Activities of daily living include:

- A. Eating
- B. Bathing
- C. Dressing
- D. Personal hygiene (grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, menstrual hygiene, etc.)
- E. Toileting
- F. Mobility/ambulating, including functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive aids and equipment

Instrumental activities of daily living include:

- A. Meal planning and preparation consumed only by the participant
- B. Laundry for the participant or incidental to the participant's care
- C. Shopping for food, clothing and other essential items required specifically for the health and maintenance of the participants
- D. Housekeeping (cleaning of furniture, floors and areas directly used by the participant)
- E. Assistance with medications (to the extent permitted by nursing scope of practice laws)

Health-related tasks are limited to the following activities:

- A. Performing and recording simple measurements of body weight, blood glucose, heart pulse, blood pressure, temperature (forehead, tympanic or oral), respiratory rate and blood oxygen saturation, if in physician's order or medical plan of care. Attendant must use and appropriate weight scale and FDA approved, handheld personal health monitoring device(s);
- B. Additional assistance with self-administration of prescribed medications, and/or
- C. Emptying and replacing colostomy and ostomy bags.

Health-related tasks must be:

- A. Consistent with all applicable State scope of practice laws and regulations;

- B. Within the documented skills, training, experience, and other relevant competencies of the attendant performing the task;
- C. For the care and safety of the participant, do not require monitoring or supervision of the attendant by a licensed physician, nurse, or therapist;
- D. Necessary to meet specific needs of the participant consistent with a written plan of care by a physician or registered nurse; and
- E. Tasks that the participant is unable to perform for themselves without hands-on assistance, direct supervision, and/or active cueing of the attendant.

The provision of assistance with ADLs, IADLs or health-related tasks does not entail nursing care.

Attendant care services tasks must be:

- A. Reasonable and medically necessary, supported by the individual's latest independent assessment, and consistent with the individual's Level of Care;
- B. Not available from another source (including without limitation family members, a member of the participant's household, or other unpaid caregivers; a Medicaid State Plan covered service; the Medicare program; the participant's Medicare Advantage plan or Medicare prescription drug plan; or private long-term care, disability, or supplemental insurance coverage);
- C. Expressly authorized in the individual's person-centered service plan;
- D. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services;
- E. Provided by qualified, Medicaid-certified providers and in compliance with all applicable Arkansas Medicaid program regulations and provider manuals; and
- F. Provided in compliance with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.

Attendant care services exclude all of the following:

- A. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including without limitation: aseptic or sterile procedures; application of dressings; medication administration; injections, observation and assessment of health conditions, other than as permitted for health-related tasks above; insertion, removal, or irrigation of catheters; tube or other enteral feedings; tracheostomy care; oxygen administration; ventilator care; drawing blood; and care and maintenance of any medical equipment;
- B. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
- C. Services provided for any person other than the participant, including without limitation a provider, family member, household resident, or neighbor;
- D. Companion, socialization, entertainment, or recreational services or activities of any kind (including without limitation game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship);
- E. Cleaning of any spaces of a home or place of residence (including without limitation kitchen, bathroom, living room, dining room, family room, and utility or storage rooms, and the floors, furnishings, and appliances therein) shared by the participant with one or more

adults who are, together or separately, physically able to perform housekeeping of these areas; and

- F. Habilitation services, including assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills.

Participants may choose to receive authorized attendant care services through any of the following:

- A. Home health agency licensed as Class A by the Arkansas State Board of Health, certified by DPSQA, and enrolled as a Medicaid provider;
- B. Home health agency licensed as Class B by the Arkansas State Board of Health, certified by DPSQA, and enrolled as a Medicaid provider;
- C. Private care agency licensed by the Arkansas State Board of Health, certified by DPSQA, and enrolled as a Medicaid provider; or
- D. Consumer-directed attendant care through Independent Choices, the Arkansas self-directed personal assistance benefit under section 1915(j) of the Social Security Act, provided the individual is capable of self-directing the assistance and subject to the requirements of the Independent Choices provider manual and applicable provider qualifications and certification.

The aggregate amount, frequency, and duration of attendant care services must be consistent with the aggregate amounts, frequencies, and durations calculated by DHS for the beneficiary in accordance with the Arkansas Medicaid Task and Hour Standards ("THS"), as issued by DAABHS and posted publicly on the DHS website with the ARChoices waiver provider manual. DAABHS will publish and periodically update the THS as necessary, following a public notice and comment process. The THS specifies limits on each ADL, IADL, and health-related task at the intensity of human assistance needed for the task, including maximum frequency (by day or week or month), maximum minutes per task allowable, and maximum hours by day, week, month, and year. Any aggregate amounts, frequencies, or durations in excess of the weekly or monthly limits calculated by DHS for the beneficiary in accordance with the THS specifications are not covered.

Attendant care services are not available (not covered and not reimbursable) through the ARChoices program when and to the extent any of the following may apply:

- A. When reasonably comparable or substitute services are available to the individual through an Arkansas Medicaid State Plan benefit including without limitation personal care services, home health services, and private duty nursing services;
- B. When assistance with the equivalent ADL, IADL, or health-related task(s) is covered under an Arkansas Medicaid State Plan benefit but determined as medically unnecessary for the individual during adjudication of a prior authorization request or utilization review;
- C. When assistance with the comparable ADL, IADL, or health-related task(s) is available through targeted or supplemental benefits offered by the participant's Medicare Advantage plan;
- D. When attendant care services delivered through a home health agency or private care agency are provided by the waiver beneficiary's (i) spouse, (ii) legal guardian of the person; or (iii) attorney-in-fact granted authority to direct the beneficiary's care;
- E. On dates of service when the participant:
  - 1. Receives Medicare home health aide services, whether through traditional Medicare fee-for-service or a Medicare Advantage plan of any kind for the same tasks;

2. Receives targeted or other supplemental benefits from a Medicare Advantage plan of any kind, where such supplemental services are reasonably comparable to or duplicative of attendant care services, personal care services, or self-directed personal assistance;
  3. Spends more than five hours at an adult day services or adult day health services facility, unless prior approved in writing by the DHS RN;
  4. Receives long-term or short-term facility-based respite care; and/or
  5. Receives services from an inpatient hospital, nursing facility, assisted living facility, hospice facility, or residential care facility, unless approved in writing by a DHS RN as reasonable and necessary given the time of day of the facility admission or discharge, the need for transition assistance, or an inpatient hospital admission incident to an emergency department visit or direct inpatient admission by the attending physician.
- F. When a duplicate claim for the same performance of the same task is paid or submitted for personal care services, self-directed personal assistance, or home health aide services under the Medicaid State Plan; and/or
- G. For a task that was not actually performed.

Beneficiaries may choose to self-direct this service through Arkansas's IndependentChoices program under 1915(j) authority; or may receive services through an agency. The IndependentChoices Medicaid Provider Manual describes the self-directed service delivery model.

Attendant Care services must be provided according to the beneficiary ARChoices written PCSP.

A brief description of the service(s) provided, including the signature and title of the individual rendering the service, must be documented in the beneficiary's case record. See Section 214.000 for additional documentation requirements.

Benefit limits will be determined on a client basis based on application of the Arkansas Medicaid Task and Hour Standards (THS) and the service limitations described in this manual.

DAABHS will update the Person-Centered Service Plan to take into the account any changes in the participant's condition and/or living arrangements that would affect the number of hours of attendant care that could be approved under the Task and Hour Standards.

Fifteen (15) minutes of service equals one (1) unit.

An ARChoices beneficiary who spends more than five (5) hours (20 units) at an adult day services or adult day health services facility or who is receiving short-term, facility-based respite care will not be eligible for Attendant Care services on the same date of service unless authorized by the DHS RN.

An ARChoices beneficiary receiving long-term, facility-based respite care is not eligible for Attendant Care services on the same date of service.

### **213.220 Travel Time of Attendant Accompanying Participant**

**1-1-19**

- A. The Attendant Care benefit only covers attendant travel time when all of the following apply:
1. The attendant accompanies the participant in the same vehicle as the participant travels to and returns from a community location for medical appointment or community activity;

2. The travel time billed is solely for necessary time in transit from the participant's home to the community location and the return travel from the community location to the participant's home;
  3. The participant's participation in the local community activity is the the benefit of the participant and to meet the participant's goals for independent living in the community, and the travel, including stops, is not for the benefit or convenience of any other person (including the attendant, a family member, the driver, or other passengers);
  4. The traveling activity itself is for practical transit within the community and not for diversional or recreational purposes of any kind;
  5. The participant's approved patient-centered service plan includes Attendant Care service hours for one or both of the following activities of daily living (ADLs): toileting and mobility / ambulating;
  6. While in transit to and from the community location, the participant requires, or is likely to need given assessed functional limitations, hands-on assistance with the ADL task of toileting or the ADL task of mobility / ambulating; and,
  7. The travel time is reasonable given driving distances, traffic conditions and weather with time and location documented.
- B. Travel time is not reimburseable if any other adult person accompanying (or driving) the participant is a family member and is reasonable able to assist the participant in transit if needed.
- C. Travel time accompanying a participant will count against the total number of Attendant Care hours per month authorized in the participant's person-centered service plan.
- D. **Requesting Hours for Travel Time of Attendant Accompanying Participant:**

Participants vary in their medical appointments, participation in community activities, the availability of family or other assistance they may need while traveling, and the time involved when traveling to medical appointments and local community activities. When covered, travel time of an attendant accompanying a participant is incident to but itself not the ADL task of toileting or the ADL task of mobility / ambulating. Therefore, the Task and Hour Standards are not currently used to help determine the number of Attendant Care hours, if any, associated solely with travel time of an attendant accompanying a participant to a medical visit or community activity. During the home visit to discuss the person-centered service plan, the participant (or their legal representative) should inform the DHS nurse of the individual's community activities, need for an attendant to accompany them, and the distances and roundtrip travel times typically involved. Based on this information, consistent with the above requirements, and within the person's applicable Individual Services Budget, the DHS nurse may increase the number of Attendant Care hours per month covered in the PCSP to reasonably accommodate the travel time of an attendant accompanying the participant.

**213.230****Attendant Care Services Certification Requirements**

1-1-19

The following requirements must be met prior to certification by the Division of Provider Services and Quality Assurance (DPSQA) by providers of attendant care services. The provider must:

- A. Hold a current Arkansas State Board of Health Class A and/or Class B license, Or Private Care Agency license.
- B. All owners, principals, employees, and contract staff of an attendant care services provider must have national and state criminal background checks and central registry checks. Criminal background and central registry checks must comply with Arkansas Code

Annotated §§20-33-213 and 20-38-101 *et seq.* Criminal background checks shall be repeated at least once every five (5) years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

- C. Employ and supervise direct care staff who:
1. Prior to providing an ARChoices service, have received instruction regarding the general needs of the elderly and adults with physical disabilities;
  2. Possess the necessary skills to perform the specific services required to meet the needs of the beneficiary the direct care staff member is to serve; and
  3. Are placed under bond by the provider or are covered by the professional medical liability insurance of the provider.

Each provider must maintain adequate documentation to support that direct care staff meets the training and, as applicable, testing requirements according to licensure, agency policy and DPSQA certification.

Attendant Care service providers who hold a current Arkansas State Board of Health Class A and/or Class B license or Private Care Agency license must recertify with DPSQA annually.

Providers are required to submit copy of renewed license to DPSQA.

#### **213.240 Environmental Accessibility Adaptations/Adaptive Equipment 1-1-19**

Environmental Accessibility Adaptations/Adaptive Equipment services enable the individual to increase, maintain and/or improve his or her functional capacity to perform daily life tasks that would not be possible otherwise. Environmental Accessibility Adaptations/Adaptive Equipment is physical adaptations to the home that are necessary to ensure the health, welfare and safety of the beneficiary, to function with greater independence in the home and preclude or postpone institutionalization. Adaptive equipment also enables the ARChoices beneficiary to increase, maintain and/or improve his/her functional capacity to perform daily life tasks that would not be possible otherwise and perceive, control or communicate with the environment in which he or she lives.

Excluded are adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, air conditioning and others. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be in accordance with applicable state or local building codes. All dwellings that receive adaptations must be in good repair and have the appearance of sound structure.

Permanent fixtures are not allowed on rented or leased properties.

Reimbursement is not permitted for Environmental Accessibility Adaptations/Adaptive Equipment services provided by a waiver beneficiary's:

- A. Spouse;
- B. Legal guardian of the person; or,
- C. Attorney-in-fact granted authority to direct the beneficiary's care.

#### **213.280 Provider Qualifications Environmental Accessibility Adaptations/Adaptive Equipment 1-1-19**



Individuals or businesses seeking certification by the Division of Provider Services and Quality Assurance (DPSQA) and enrollment as Medicaid providers of environmental accessibility adaptations/adaptive equipment services must meet the following criteria:

- A. The provider of services must be a builder, tradesman or contractor.
- B. The provider must be licensed (where applicable) as appropriate for home improvement contracting or adaptation and equipment provided.
- C. The provider must certify that his or her work meets state and local building codes.
- D. The provider must obtain all applicable permits.
- E. The provider must be knowledgeable of and comply with the Americans with Disabilities Act Accessibility Guidelines.
- F. Contractors are required to adhere to the Uniform Federal Accessibility Standards.

**NOTE: All environmental modifications requiring electrical or plumbing work must be completed by an appropriately licensed professional. If the proposed work requires a plumbing or electrical license, the contractor must submit a copy of the contractor's plumbing or electrical license with the claim form. If a contractor subcontracts with an electrician or plumber, the contractor must submit a copy of the subcontractor's license with the claim form.**

#### 213.290 Environmental Modifications/Adaptive Equipment

1-1-19

Prior to payment for this service, the waiver beneficiary is required to secure 3 separate itemized bids for the same service. Each bid must itemize the work to be done and must specifically identify any work that requires a plumbing or electrical license. The bids are reviewed by the Division of Aging, Adult and Behavioral Health Services Registered Nurse (DHS RN) or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided. All modification funds must be verified by the DAABHS prior to receiving services.

Each claim must be signed by the provider, the waiver beneficiary and DHS RN, or designee. A statement of satisfaction form must be signed by the waiver beneficiary prior to any claim being submitted. All claim forms, bids and client satisfaction statement forms must be submitted to the DAABHS Unit prior to submission for payment.

**NOTE: The Environmental Modification provider's Alternatives for Adults with Physical Disabilities (AAPD) certification will be valid as an ARChoices Environmental Modification provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under AAPD.**

#### 213.310 Hot Home-Delivered Meals

1-1-19

Hot Home-Delivered Meals provide one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with the Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.

Hot Home-Delivered Meal services provide one daily nutritious meal to eligible beneficiaries who are homebound. Homebound is defined as a person with normal inability to leave home without assistance (physical or mental) from another person; a person who is frail, homebound by reason of illness or incapacitating disability or otherwise isolated; or for whom leaving home requires considerable and taxing effort by the individual and absences from the home are

infrequent, relatively short in duration or are attributable to the need to receive medical treatment.

Additionally, the beneficiary must:

- A. Be unable to prepare some or all of his or her own meals;
- B. Have no other individual to prepare his or her own meals; and
- C. Have the provision of the Home-Delivered Meals included on his or her PCSP

The provision of a Home-Delivered Meal is the most cost-effective method of ensuring a nutritiously adequate meal.

The Home-Delivered Meals provider must maintain a log sheet signed by the beneficiary that includes date and time of delivery each time a meal is delivered to document receipt of the meal.

Hot Home-Delivered Meals must be provided according to the beneficiary's written ARChoices PCSP.

Procedure Code	Required Modifier	Description
S5170	U2	Hot Home-Delivered Meal
S5170	—	Frozen Home-Delivered Meal
S5170	U1	Emergency Home-Delivered Meal

### 213.311 Hot Home-Delivered Meal Provider Certification Requirements

1-1-19

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of Hot Home-Delivered Meal services, a provider must:

- A. Be a nutrition services provider whose kitchen is approved by the Arkansas Department of Health and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.\*
- B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;\*
- C. If applicable, assure that the provider's intermediate source of delivery meets or exceeds federal, state and local laws regarding food transportation and delivery;\*
- D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law;\*

**\*NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.**

- E. All owners, principals, employees, and contract staff of a hot, home-delivered meal services provider must have national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with Arkansas Code Annotated §§ 20-33-213 and 20-38-101 *et seq.* Criminal background shall

be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry, the Adult and Long-Term Care Facility Resident Maltreatment Central Registry and the Certified Nursing Assistant/Employment Clearance Registry.

- F. Notify the DHS RN immediately if:
1. There is a problem with delivery of service
  2. The beneficiary is not consuming the meals
  3. A change in the individual's condition is noted

**NOTE: Changes in service delivery must receive prior approval by the DHS RN who is responsible for the individual's Person-Centered Service Plan (PCSP). Requests must be submitted in writing to the DHS RN. Any changes in the individual's circumstances must be reported to the DHS RN via form AAS-9511.**

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary's PCSP only when they are necessary to prevent the institutionalization of an individual.

Hot Home-Delivered Meals providers must recertify with DPSQA annually and the provider shall attach a copy of the agency's current Food Establishment Permit to the annual recertification.

#### 213.320 Frozen Home-Delivered Meals

1-1-19

Frozen Home-Delivered Meals service provides one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.

The goal of the Frozen Home-Delivered Meals service is to supplement, not replace, the Hot Home-Delivered Meal service by providing one daily nutritious meal to homebound persons at risk of being institutionalized who:

- A. Reside in remote areas where daily hot meals are not available;
- B. Choose to receive a frozen meal rather than a hot meal; or
- C. Are at nutritional risk and are certified to receive a meal for use on weekends or holidays when the hot meal provider is not in operation.

**NOTE: While the individual has freedom of choice regarding this service, it is the responsibility of the DHS RN developing the PCSP to ensure the appropriateness of the service. A hot meal delivered daily remains the food service of choice, when available. Therefore, a frozen meal must be approved by the DHS RN. The service must be included on the PCSP. If the individual responsible for developing the PCSP does not think the frozen meals are appropriate for the individual, other options will be considered. Those options include removing the Home-Delivered Meal service rather than authorizing a frozen meal.**

**It is the certified provider's responsibility to deliver the meals regardless if they are hot or frozen. Meals may not be left on the doorstep. The meals cannot be mailed to the individual or delivered to a warehouse via United States Postal Service or delivered by paid carrier such as Fed Ex or UPS.**

#### 213.321 Beneficiary Requirements for Frozen Home-Delivered Meals

1-1-19

The beneficiary must:

- A. Be homebound, which is defined by the following requirements:
  1. The person is normally unable to leave home without assistance (physical or mental) from another person;
  2. The person is frail, homebound by reason of illness or incapacitating disability or otherwise isolated;
  3. Leaving home requires considerable and taxing effort by the individual; and
  4. Absences of the individual from home are infrequent, of relatively short duration or attributable to the need to receive medical treatment.
- B. Be unable to prepare some or all of his or her meals or require a special diet and be unable to prepare it.
- C. Have no other individual available to prepare his or her meals and the provision of a Frozen Home-Delivered Meal is the most cost-effective method of ensuring a nutritionally adequate meal.
- D. Have adequate and appropriate storage and be able to perform the simple tasks associated with storing and heating a Frozen Home-Delivered Meal or have made other appropriate arrangements approved by DAABHS.
- E. Have the provision of frozen meals included on his or her PCSP as developed by the appropriate DHS RN.

Frozen Home-Delivered Meals must be documented on the ARChoices PCSP by the DHS RN and must be provided in accordance with the beneficiary's written ARChoices PCSP.

**213.323****Frozen Home-Delivered Meal Provider Certification Requirements****1-1-19**

In order to become approved providers of frozen meals, providers must meet all applicable requirements of the Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.

To be certified by Division of Provider Services and Quality Assurance (DPSQA) as a provider of Home-Delivered Meal services, a meal provider must:

- A. Be a nutrition services provider whose kitchen is approved by the Arkansas Department of Health and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and DAABHS Nutrition Services Program Policy Number 206.\*
- B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;\*
- C. If applicable, ensure that intermediate sources of delivery meet or exceed federal, state and local laws regarding food transportation and delivery\*
- D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law\*

**\*NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.**

- E. All owners, principals, employees, and contract staff of a home-delivered meal services provider must have national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with Arkansas Code Annotated §§ 20-33-213 and 20-38-101 *et seq.* Criminal background shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.
- F. Provide frozen meals that:
1. Were prepared or purchased according to the Department of Health and DAABHS Nutrition Services Program Policy guidelines in freezer-safe containers that can be reheated in the oven or microwave.
  2. Are kept frozen from the time of preparation through placement in the individual's freezer.
  3. Have a remaining freezer life of at least three months from the date of delivery to the home.
  4. Are part of a meal cycle of at least four weeks (i.e., four weeks of menus that differ).
  5. Are properly labeled, listing food items included and non-frozen items that are delivered with the frozen components to complete the meal (which must include powdered or fluid milk, whichever is preferred by the ARChoices beneficiary), menu analysis as required by DAABHS Nutrition Services Program Policy if other than DAABHS menus are used and both packaging and expiration dates.

**NOTE: The milk must be delivered to the beneficiary at least seven (7) days prior to its expiration date.**

- G. Instruct each individual, both verbally and in writing, in the handling and preparation required for frozen meals and provide written re-heating instructions with each meal, preferably in large print.
- H. Ensure that meals that are not commercially prepared but produced on-site in the production kitchen:
1. Are prepared and packaged only in a central kitchen or on-site preparation kitchen;
  2. Are prepared specifically to be frozen;
  3. Are frozen as quickly as possible;
  4. Are cooled to a temperature of below 40 degrees Fahrenheit within four hours;
  5. Have food temperatures taken and recorded at the end of food production, at the time of packaging and throughout the freezing process, with temperatures recorded and kept on file for audit;
  6. Are packaged in individual trays, properly sealed and labeled with the date, contents and instructions for storage and reheating;
  7. Are frozen in a manner that allows air circulation around each individual tray;
  8. Are kept frozen throughout storage, transport and delivery to the beneficiary; and
  9. Are discarded after 30 days.
- I. Verify quarterly that all beneficiaries receiving Frozen Home-Delivered Meals continue to have the capacity to store and heat meals and are physically and mentally capable of performing simple associated tasks unless other appropriate arrangements have been made and approved by DAABHS. Any changes in the individual's circumstances must be reported to the DHS RN via form AAS-9511.

- J. Notify the appropriate DHS RN immediately if:
1. There is a problem with delivery of service
  2. The individual is not consuming the meals
  3. A change in an individual's condition is noted

**NOTE: Changes in service delivery must receive prior approval by the DHS RN who is responsible for the individual's Person-Centered Services Plan (PCSP). Requests must be submitted in writing to the DHS RN. Any changes in the individual's circumstances must be reported to the DHS RN via form AAS-9511.**

- K. Contact each individual daily Monday through Friday, either in person or by the phone, to ensure the individual's safety and well-being. This is not required for:
1. Individuals receiving Frozen Home-Delivered Meals only for weekends; or,
  2. Individuals who receive Attendant Care services or Personal Care services at least three (3) times per week.

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary's PCSP only when they are necessary to prevent the institutionalization of an individual.

Frozen Home-Delivered Meals providers must recertify with DPSQA annually; however, DPSQA must maintain a copy of the agency's current Food Establishment Permit at all times.

### 213.330 Limitations on Home-Delivered Meals (HDMs)

1-1-19

One unit of service equals one meal. The maximum number of HDMs eligible for Medicaid reimbursement per month equals 31 meals. This includes hot, frozen or a combination of the two. There is no separate benefit limit for frozen meals.

The maximum number of emergency meals per State Fiscal Year is four (4).

Frozen HDMs may be provided daily to eligible beneficiaries. A maximum of seven (7) meals may be delivered at one time.

HDM providers may deliver more than seven meals at one time, if:

- A. The waiver beneficiary receives Attendant Care services or Personal Care services at least three (3) times per week,
- B. Frozen HDMs are ordered on the Person-Centered Services Plan (PCSP),
- C. The waiver beneficiary has the means of storing 14 frozen meals (as verified by the DHS RN).

HDM providers delivering frozen meals may deliver 14 at one time if the DHS RN enters 14 meals delivery approved in the comments section of the HDM entry on the PCSP. If this statement is not on the PCSP, or if any of the other factors above are not in place, the meal providers cannot deliver more than seven (7) meals at one time.

An ARChoices beneficiary may not be provided with a Hot or Frozen HDM on any day during which the individual receives more than five (5) hours of in-home or facility-based Respite care or more than five (5) hours of Adult Day Services or Adult Day Health Services. (Licensure mandates that providers of these services provide a meal or meals; therefore, a HDM on these dates is a duplicative service and prohibited under waiver guidelines.)

**NOTE: Medicaid reimbursement for HDMs is not allowed on the same day to beneficiaries who are also attending Adult Day Services, Adult Day Health Services, or facility-based Respite care for more than five (5) hours. When**

**applying this policy, the time of day the beneficiary receives day services or respite services are also a factor. Whether there is duplication of services will be determined by comparing the time of day during which services occur.**

When considering whether a HDM is billable for an individual receiving Adult Day Services, Adult Day Health Services or facility-based Respite services, on a specific date of service, the following must be applied:

If an ARChoices beneficiary is receiving Adult Day Services, Adult Day Health Services or facility-based Respite at any time between the hours of 11:00 a.m. and 1:30 p.m. **and** the noon meal is routinely served to others at the facility during this timeframe, the noon meal must also be served to this individual. A HDM is not allowable on the same date of service. This is true **regardless of the total number of Adult Day Services, Adult Day Health Services or Respite hours provided.**

#### 213.340      **Combination of Hot and Frozen Home-Delivered Meals**      1-1-19

In instances where the ARChoices beneficiary wishes to receive a combination of hot and frozen meals, the DHS RN shall evaluate the beneficiary's situation based on the criteria set forth in Section 213.320, Frozen Home-Delivered Meals. If the criteria are met, the DHS RN may prescribe on the PCSP a combination of hot and frozen meals to be delivered.

#### 213.350      **Emergency Meals**      1-1-19

Beneficiaries may receive up to four (4) emergency meals per state fiscal year. The meals must:

- A. Contain 33 1/3 percent of the Dietary Reference intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and Division of Aging, Adult and Behavioral Health Services (DAABHS) Nutrition Services Program Policy Number 206.
- B. Be labeled "Emergency Meal" in large print, with instruction on use of the meal.
- C. Be used within the limits of their shelf life, usually within six months.

#### 213.400      **Personal Emergency Response System**      1-1-19

Procedure Code	Required Modifier	Description
S5161	UA	PERS Unit
S5160	—	PERS Installation

The Personal Emergency Response System (PERS) is an in-home, 24-hour electric support system with two-way verbal and electronic communication with an emergency control center. PERS enables an elderly, infirm or homebound individual to secure immediate help in the event of a physical, emotional or environmental emergency.

PERS is specifically designed for high-risk beneficiaries whose needs have been carefully determined based on their level of medical vulnerability, functional impairment and social isolation. PERS is not intended to be a universal benefit. The DHS RN must verify that the individual is capable, both physically and mentally, of operating the PERS unit.

PERS must be included in the beneficiary's written ARChoices PCSP.

PERS providers must contact each beneficiary at least once per month to test the system's operation. The provider shall maintain a log of test calls that includes the date and time of the test, specific test results, corrective actions and outcomes.



A log of all beneficiary calls received must be maintained by the emergency response center. The log must reflect the date, time and nature of the call and the response initiated by the center. All calls must be documented in the beneficiary's record. See Section 214.000 for other documentation requirements.

One (1) unit of service equals one (1) month. PERS is limited to a maximum of twelve (12) units per year.

The installation of PERS will be allowed once per lifetime or period of eligibility. Claims submitted for the installation of PERS should use procedure code **S5160**. Procedure code **S5160** may be billed for ARChoices beneficiaries who are accessing PERS services for their first time or for the current period of re-eligibility for ARChoices Waiver Services. In the event of extenuating circumstances that result in the need for reinstallation, the provider may contact the Division of Aging, Adult and Behavioral Health Services for extension of the benefit.

### 213.410 Personal Emergency Response System (PERS) Certification Requirements

1-1-19

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of personal emergency response services, a provider must:

- A. Provide, install and maintain Federal Communications Commission (FCC) approved equipment which meets all Underwriter Laboratories Safety Standards;
- B. Designate or operate an emergency response center to receive signals and respond according to specified operating protocol;
- C. Establish a response system for each beneficiary and ensure responders receive necessary instruction and training; and
- D. Ensure that equipment is installed by qualified providers who also provide instruction and training to beneficiaries.

PERS providers must recertify annually with DPSQA.

### 213.500 Adult Day Services

1-1-19

Procedure Code	Required Modifier	Description
S5100	U1	Adult Day Services, 8-20 Units Per Date of Service
S5100	—	Adult Day Services, 21-40 Units Per Date of Service

Adult day services facilities are licensed by the Division of Provider Services and Quality Assurance (DPSQA) to provide care and supervision to meet the needs of four (4) or more functionally impaired adults for periods of less than 24 hours but more than two (2) hours per day, in a place other than the beneficiaries' own homes.

When provided according to the beneficiary's written ARChoices Person-Centered Service Plan (PCSP), ARChoices beneficiaries may receive adult day services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day, according to the beneficiary's written PCSP. Adult day services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month. One (1) unit of service equals 15 minutes.

As required, beneficiaries who are present in the facility for more than 20 units (5 hours) a day (procedure code **S5100**) must be served a nutritious meal that equals one-third of the Recommended Daily Allowance. Therefore, ARChoices beneficiaries are not eligible to receive a



home-delivered meal on the same day they receive more than 20 units (5 hours) of adult day services. Additionally, beneficiaries who attend an adult day service for more than 20 units (5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the Department of Human Services Registered Nurse (DHS RN).

**NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for an individual who attends adult day services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the beneficiary is receiving day services, day health services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the DHS RN and/or Department of Human Services (DHS) audit staff and considered when determining any duplication in services for beneficiaries participating in the ARChoices Program.**

Providers must consider the following to determine whether a home-delivered meal is billable for an individual receiving day services, day health services or facility-based respite services on a specific date of service.

If an ARChoices beneficiary is receiving day services, day health services or **facility-based** respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to this individual. A home-delivered meal is not allowable on the same date of service. This is true **regardless of the total number of day services or respite units provided.**

Adult day services and day health services providers are required to maintain a daily attendance log of beneficiaries. Section 214.000 contains information regarding additional documentation requirements.

### 213.510 Adult Day Services Certification Requirements

1-1-19

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of adult day services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by the Arkansas Department of Human Services, DPSQA as a long-term adult day care facility. Providers in the designated trade area cities in states that border Arkansas must be licensed and/or certified by the appropriate state agency as an Adult Day Care Facility.

In order to be certified by DPSQA, Adult Day Services providers must meet the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

Adult Day Services providers must recertify with DPSQA annually; however, DPSQA must maintain a copy of the agency's current Adult Day Care license at all times.

In order to be recertified by DPSQA, Adult Day Services providers must meet the HCBS Settings rules found in section C of 201.105.

Providers are required to submit copy of renewed license to DPSQA.

### 213.600 Adult Day Health Services (ADHS)

1-1-19

Procedure Code	Required Modifier	Description
S5100	TD, U1	Adult Day Health Services, 8-20 Units Per Date of Service
S5100	TD	Adult Day Health Services, 21-40 Units Per Date of Service

Adult day health services facilities are licensed to provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, social services and activities to

beneficiaries who are functionally impaired and who, due to the severity of their functional impairment, are not capable of fully independent living.

Adult day health services programs provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the beneficiary that cannot be provided by adult day care programs. Adult day health services are appropriate only for beneficiaries whose facility-developed care plans specify one or more of the following health services:

- A. Rehabilitative therapies (e.g., physical therapy, occupational therapy),
- B. Pharmaceutical supervision,
- C. Diagnostic evaluation or
- D. Health monitoring

ARChoices beneficiaries may receive adult day health services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day when the service is provided according to the beneficiary's written ARChoices Person-Centered Service Plan (PCSP). Adult day health services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day health services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month.

Beneficiaries who are present in the facility for more than 20 units (5 hours) a day (procedure code **S5100**, modifier **TD**) must be served a nutritious meal that equals one-third of the Recommended Daily Dietary Allowances. Therefore, ARChoices beneficiaries are not eligible to receive a home-delivered meal on the same day they receive more than five (5) hours of adult day health services. Additionally, beneficiaries who attend an adult day health services for more than 20 units (5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the Department of Human Services Registered Nurse (DHS RN).

Adult day health services providers are required by licensure to maintain a daily attendance log of beneficiaries. See Section 214.000 for additional documentation requirements.

**NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for an individual who attends adult day services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the beneficiary is receiving day services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the DHS RN and/or Department of Human Services (DHS) audit staff and considered when determining any duplication in services for beneficiaries participating in the ARChoices Program.**

Providers must consider the following to determine whether a home-delivered meal is billable for an individual receiving day services or facility-based respite services on a specific date of service.

If an ARChoices beneficiary is receiving day services or facility-based respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to the individual. A home-delivered meal is not allowable on the same date of service. **This is true regardless of the total number of day services or respite units provided.**

**213.610****Adult Day Health Services (ADHS) Provider Certification Requirements****1-1-19**

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of adult day health services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by Arkansas Department of Human Services, DPSQA as an adult day health care facility. Providers in the designated trade area cities in

states that border Arkansas must be licensed and/or certified by the appropriate state agency as an Adult Day Health Care Facility.

In order to be certified by DPSQA, Adult Day Health Services providers must meet the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

Adult Day Health Services providers must recertify with DPSQA annually; however, DPSQA must maintain a copy of the agency's current Adult Day Health Care license at all times. In order to be recertified, Adult Day Health Services providers must meet the HCBS Settings rules found in section C of 201.105.

Providers are required to submit copy of renewed license to DAABHS.

**NOTE: Adult day services and adult day health services are not allowed on the same date of service.**

213.620

## Prevocational Services

1-1-19

Procedure Code	Modifier	Description
T2015		Prevocational Services Skills Development
T2015	U3	Prevocational Services Career Exploration

Prevocational services are available to ARChoices waiver participants with physical disabilities who wish to join the general workforce. Prevocational Services comprise a range of learning and experiential type activities that prepare a participant for paid employment or self-employment in the community.

Prevocational services are as follows:

- A. Development and teaching of general employability skills (non-job-task-specific strengths and skills) directly relevant to the participant's pre-employment needs and successful participation in individual paid employment. These skills are: ability to communicate effectively with supervisors, coworkers, and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; and skills related to obtaining paid employment. Excluded are services involving development or training of job-specific or job-task oriented skills.
- B. Career exploration activities designed to develop an individual career plan and facilitate the participant's experientially-based informed choice regarding the goal of individual paid employment. These may include business tours, informational interviews, job shadows, benefits education and financial literacy, assistive technology assessment, and local job exploration events. The expected outcome of career exploration activities is a written, actionable, person-centered career plan designed to lead to community employment or self-employment for the participant.

The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the participant interacts with individuals without disabilities, other than those providing services to the participant or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the participant is compensated at or above the minimum wage, but not less than the customary wage and level of

benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Prevocational services may be provided one-to-one or in a small group format and may be provided as a site-based service or in a community setting, consistent with requirements of the ARChoices provider manual.

All prevocational services must be prior approved in the participant's person-centered service plan, provided through a DPSQA-certified prevocational services provider, and delivered and documented consistent with requirements of the ARChoices provider manual.

Prevocational services exclude any services otherwise available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 (Rehab Act), the Individuals with Disabilities Education Act (IDEA), or any other federally funded (non-Medicaid) source. Proper documentation shall be maintained in the file of each individual receiving prevocational services under the waiver.

The amount of all prevocational services provided to any participant shall not exceed \$2,500 per lifetime.

The amount of career exploration activities provided per participant shall not exceed 30 hours.

The duration of prevocational services provided to any given participant shall be limited to 180 days (six months). Services not completed within this timeframe are not covered.

Fifteen (15) minutes of services equals one (1) unit.

Providers of Prevocational Services under the ARChoices waiver program must be certified by the Division of Provider Services and Quality Assurance and must recertify annually.

Reimbursement is not permitted for prevocational services provided by a waiver beneficiary's:

- A. Spouse;
- B. Legal guardian of the person; or,
- C. Attorney-in-fact granted authority to direct the beneficiary's care.

## 213.700 Respite Care

1-1-19

Procedure Code	Description
T1005	Long-Term Facility-Based Respite Care
S5135	Short-Term Facility-Based Respite Care
S5150	In-Home Respite Care

Respite Care is provided to waiver participants unable to care for themselves and is furnished on a limited or short-term basis because of the absence of, or need for relief of, those persons normally providing the care.

Specifically, Respite Care consists of temporary care provided for short term relief for the primary caregiver, subject to the following:

- A. The participant lives at home and is cared for, without compensation, by their families or other informal support systems;
- B. As determined by the independent assessment, the participant has a severe physical, mental, or cognitive impairment(s) that prevents him or her from being left alone safely in the absence or unavailability of the primary caregiver;

- C. The primary caregiver to be relieved is identified and with sufficient documentation that he or she furnishes substantial care of the client comparable to or in excess of services described under the Attendant Care service;
- D. No other alternative caregiver (e.g., other member of household, other family member) is available to provide a respite for the primary caregiver(s);
- E. Respite Care services are limited to (a) direct human assistance with specific Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks as described under Attendant Care services and (b) supervision necessary to maintain the health and safety of the participant, as supported by the independent assessment and determined medically necessary by the Department of Human Services Registered Nurse (DHS RN); and
- F. Respite Care solely serves to supplement (not replace) and otherwise facilitate the continued availability of care provided to waiver participants by families and other informal support systems.

Respite Care is available on a short-term basis (8 hours or less per date of service) or a long-term basis (a full 24 hours per date of service) because of the absence or need for relief of those persons who normally provide care for the participant. Respite Care is available to meet an emergency need or to schedule relief periods in accordance with the regular caregiver's need for temporary relief from continuous care giving.

Respite Care is available in the following locations:

- A. The Participant's home or place of residence;
- B. Medicaid-certified hospital;
- C. Medicaid-certified nursing facility;
- D. Medicaid-certified adult day health facility; and
- E. Medicaid-certified assisted living facility with a level II state license.

To allow the person who normally provides care for the waiver participant some time away from his or her caregiving of the participant, Respite Care may be provided in or outside the participant's home as follows:

- A. In-home respite may be provided for up to 24 hours per date of service.
- B. Facility-based respite care may be provided outside the participant's home on:
  - 1. A short-term basis (eight (8) hours or less per date of service), or
  - 2. A long-term (maximum of 24 hours per date of service and used most often when respite needed exceeds the short-term respite amount).

Reimbursement is only permitted for direct care rendered according to the participant's person-centered service plan by trained respite care workers employed and supervised by certified in-home respite providers.

Respite care is subject to the following limitations:

- C. The purpose of Respite Care is to provide respite for unpaid caregivers. The amount, frequency, and duration of Respite Care must be entirely consistent with the amounts, frequencies, and durations of assistance from unpaid caregivers identified and calculated for the beneficiary in the completed form of the Arkansas Task and Hour Standards (THS). Any amounts, frequencies, or durations in excess of the unpaid caregiver assistance amounts identified for the beneficiary in the THS are not covered.

- D. Respite Care excludes:
1. Skilled health professional services, including physician, nursing, therapist, and pharmacist services.
  2. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
  3. Services provided for any other person other than the participant;
  4. Companion, socialization, entertainment, or recreational services or activities of any kind, including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship; and
  5. Habilitation services, including but not limited to, assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and,
  6. Services provided for any tasks not included in a beneficiary's service plans.
- E. Participants are limited to no more than 1,200 hours (4,800 quarter-hour units) per year of in-home respite care, facility-based respite care, or a combination thereof. Respite Care is not subject to a monthly or weekly limit, but is limited to the annual amount of time identified and calculated for the beneficiary in the completed form of the Arkansas Medicaid Task and Hour Standards.
- F. Respite Care services are not covered to provide continuous or substitute care while the primary caregiver(s) is working or attending school.
- G. Reimbursement is not permitted for Respite Care services provided by a waiver beneficiary's:
1. Spouse;
  2. Legal guardian of the person; or,
  3. Attorney-in-fact granted authority to direct the beneficiary's care.

In the event the in-home functional assessments performed by the Independent Assessment Contractor and the DHS RN substantiates a need for respite care services, the service will be authorized as needed, via the beneficiary's PCSP, not to exceed an hourly maximum. The DHS RN will establish the service limitation based on the beneficiary's medical need, other services included on the PCSP and support services available to the beneficiary. Respite care services must be provided according to the beneficiary's written PCSP subject to the participant's Individual Services Budget.

An individual living in the home with the beneficiary is prohibited from serving as a Respite Services provider for the beneficiary.

### 213.711 Facility-Based Respite Care

1-1-19

Facility-based respite care may be provided outside the beneficiary's home on a short- or long-term basis by residential care facilities, nursing facilities, adult day care facilities, adult day health care facilities, Level I and Level II Assisted Living Facilities and hospitals.

Facility-based providers rendering services for eight (8) hours or less per date of service must bill **S5135** for short-term, facility-based respite care. One (1) unit of service for procedure code **S5135** equals 15 minutes. Eligible beneficiaries may receive up to 32 units (8 hours) of short-term, facility-based respite care per date of service.

Facility-based providers rendering services for more than 32 units (8 hours) per day must bill **T1005** for long-term, facility-based respite care. One (1) unit of service for procedure code **T1005**

equals 15 minutes. A beneficiary may receive up to 96 units (24 hours) of service per date of service if the provider bills procedure code **T1005**.

Facility-based respite care services include short-term and long-term respite care services and can include any combination of billing codes **S5135** or **T1005**. A single provider may provide both long-term and short-term facility-based respite care services for a particular beneficiary, but not on the same date of service.

Eligible beneficiaries may receive up to 4800 units (1200 hours) per State Fiscal Year of Facility-Based Respite Care- or In-Home Respite Care, or a combination of the two. Beneficiaries receiving long-term, facility-based respite care services may receive only ARChoices Personal Emergency Response System (PERS) services concurrently.

Please refer to the NOTE found in Section 213.500 regarding Home-Delivered Meals and facility-based respite services.

### **213.712 In-Home Respite Care Certification Requirements**

**1-1-19**

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of in-home respite care services, a provider must:

- A. Hold a current Class A and/or Class B Home Health Agency license or a Private Care Agency license to provide personal care and/or home health services as issued by the state licensing authority;
- B. Employ and supervise direct care staff trained and qualified to provide respite care services; and
- C. Agree to the minimum Assurances of Providers of ARChoices Waiver Services.

In-Home Respite Care providers as described in A. above must recertify with DPSQA annually; however, DPSQA must maintain a copy of the agency's current license at all times.

Providers are required to submit copy of renewed license to DPSQA.

### **213.713 Facility-Based Respite Care Certification Requirements**

**1-1-19**

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) as a provider of facility-based respite care services, a provider must be licensed in their state as one or more of the following:

- A. A licensed adult day care facility
- B. A licensed adult day health care facility
- C. A licensed nursing facility
- D. A licensed residential care facility
- E. A licensed Level I or Level II Assisted Living Facility
- F. A licensed hospital

Facility-Based Respite Care providers as listed above, must recertify with DPSQA annually; however, DPSQA must maintain a current copy of the facility's current license at all times.

### **214.000 Documentation**

**1-1-19**



In addition to the service-specific documentation requirements previously listed, ARChoices providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

- A. A copy of the beneficiary's PCSP
- B. A brief description of the specific service(s) provided
- C. The signature and title of the individual rendering the service(s)
  1. For records created through an electronic data system such as telephony, computer or other electronic devices, a unique identifier such as a PIN number assigned to and entered by the employee at the time of data input may suffice as an electronic signature and title, and
- D. The date and actual time the service(s) was rendered. For Attendant Care or In-Home Respite Care, it is not necessary to itemize the time spent on each individual ADL or IADL task.

A provider's failure to maintain sufficient documentation to support his or her billing practices may result in recoupment of Medicaid payment.

No documentation for ARChoices services, as with all Medicaid services, may be made in pencil.

#### 215.000 ARChoices Forms

1-1-19

ARChoices providers are required to utilize all program forms as appropriate and as instructed by the Division of Medical Services and the Division of Aging, Adult and Behavioral Health Services. These forms include but are not limited to:

- A. Person Centered Service Plan — AAS–9503
- B. Start Services — AAS–9510
- C. Beneficiary Change of Status — AAS–9511

Providers may request form AAS–9511 by writing to the Division of Aging, Adult and Behavioral Health Services.

Forms AAS–9503 and AAS–9510 will be mailed to the provider by the DHS RN.

Instructions for completion and retention are included with each form. If there are questions regarding any ARChoices form, providers may contact the DHS RN in your area.

#### 240.000 PRIOR AUTHORIZATION

1-1-19

Attendant care, personal care and prevocational services provided under an authorized PCSP require prior authorization. Other services provided under the ARChoices Program under an authorized PCSP do not require prior authorization.

#### 251.010 Fee Schedules

1-1-19

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.



Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

**262.100 HCPCS Procedure Codes****1-1-19**

The following procedure codes must be billed for ARChoices Services.

Electronic and paper claims now require the same National Place of Service code.

<b>Procedure Code</b>	<b>Modifiers</b>	<b>Description</b>	<b>Unit of Service</b>	<b>National POS for Claims</b>
S5125		Attendant Care Services	15 minutes	12
S5125	U2	Agency Attendant Care Traditional	15 minutes	12, 99
S5170	U2	Home-Delivered Meals	1 meal	12
S5170		Frozen Home-Delivered Meal	1 meal	12
S5170	U1	Emergency Home Delivered Meals	1 meal	12
S5161	UA	Personal Emergency Response System	1 day	12
S5160		Personal Emergency Response System – Installation	One install	12
S5100	U1	Adult Day Services, 8 to 20 units per date of service	15 minutes	99
S5100		Adult Day Services, 21 to 40 units per date of service	15 minutes	99
S5100	TD, U1	Adult Day Health Services, 8 to 20 units per date of service	15 minutes	99
S5100	TD	Adult Day Health Services, 21 to 40 units per date of service	15 minutes	99
S5150		Respite Care – In-Home	15 minutes	12
S5135		Respite Care – Short-Term Facility-Based	15 minutes	99, 21, 32
T1005		Respite Care – Long-Term Facility-Based	15 minutes	21, 32, 99
T2015		Prevocational Services Skills Development	15 minutes	11, 12, 99
T2015	U3	Prevocational Services Career Exploration	15 minutes	11, 12, 99

**262.210 Place of Service Codes**

1-1-19

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

<b>Place of Service</b>	<b>POS Codes</b>
Inpatient Hospital	21
Beneficiary's Home	12
Day Care Facility	99
Nursing Facility	32
Provider's Office	11
Other Locations	99

**262.400 Special Billing Procedures – Environmental Modifications/Adaptive Equipment**

1-1-19

Prior to payment for this service, the ARChoices beneficiary is required to secure three separate itemized bids for the same service. The bids are reviewed by the Department of Human Services Registered Nurse (DHS RN) or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided.

Each claim must be signed by the provider, the ARChoices beneficiary, and DHS RN, or designee. A statement of satisfaction form must be signed by the ARChoices beneficiary prior to any claim being submitted. Please refer to 213.290 for additional information.

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Request Information

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

**B. Program Title:**

**Living Choices Assisted Living Waiver**

**C. Waiver Number: AR.0400**

**Original Base Waiver Number: AR.0400.**

**D. Amendment Number: AR.0400.R03.01**

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

01/01/19

**Approved Effective Date of Waiver being Amended: 02/01/16**

### 2. Purpose(s) of Amendment

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

The Living Choices Assisted Living waiver is being amended as follows:

1. Section 1.F is amended to clarify that the State does not enroll individuals who need a skilled level of nursing care. Conforms to current State administrative rules.
2. For assessments and re-assessments, transition from (a) independent assessments performed by DHS registered nurses (DHS RNs) using the ArPath assessment instrument to (b) independent assessments performed by RNs of the DHS Independent Assessment Contractor using the Arkansas Independent Assessment (ARIA) instrument.
3. Increases the maximum number of unduplicated participants who are served in Waiver Years 4 and 5 to 1,725 each year.
4. Provides for a new reimbursement rate determination methodology for Assisted Living Facility services and a one-year phase-in of the new rate, beginning January 1, 2019, and culminating on January 1, 2020.
4. Various technical revisions are being made to reflect responsibilities of the new DHS Division of Provider Services and Quality Assurance (DPSQA) (a new operating agency), a new name of the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (formerly Division of Aging and Adult Services, an operating agency), and the location of Office of Long-Term Care (OLTC) in DPSQA.

### 3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	1.F; 2
Appendix A Waiver Administration and Operation	A-1; A-2-b; A-3; A-5; A-6; A-7; Quality Improvement
Appendix B Participant Access and Eligibility	B-3-a; B-6-c, d, e, f, i, and j; Quality Improvement; B-7-a; B-8
Appendix C Participant Services	C-1/C-3; C-1: 2 of 2; C-2: 1 of 3-a, b; C-2: 3 of 3-f; Quality Improvement
Appendix D Participant Centered Service Planning and Delivery	D-1-c (3 of 8), -d (4 of 8), -e (5 of 8), -f (6 of 8), -g (7 of 8), -i (8 of 8); D-2-a;
Appendix E	

Component of the Approved Waiver	Subsection(s)
Participant Direction of Services	
Appendix F Participant Rights	F- 1; F-3-b, c
Appendix G Participant Safeguards	G-1-b, c, d, e; G-2-a; Quality Improvement
Appendix H	H-1-a, b
Appendix I Financial Accountability	I-1; Quality Improvement; I-2-a; I-2-d
Appendix J Cost-Neutrality Demonstration	J-1; J-2: 1 of 9, 4 of 9, 5 of 9 (d.i.), 6 of 9 (d.i.), 7 of 9 (d.i.), 8 of 9 (d.i.), 9 of 9 (d.i.)

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

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

**Other**

Specify:

Other (specify):

1. Transition independent assessment process from (a) DHS RNs using the ArPath instrument to (b) RNs of independent assessment contractor using the Arkansas Independent Assessment (ARIA) instrument. DHS RNs will gather additional information from individuals in connection with developing the person-centered service plan (PCSP).
2. Provide for a new reimbursement rate determination methodology for Assisted Living Facility services.
3. Technical edits to reflect changes in operating divisions (names, responsibilities).

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

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

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

Living Choices Assisted Living Waiver

**C. Type of Request:** amendment

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

3 years    5 years

**Original Base Waiver Number:** AR.0400

**Waiver Number:**AR.0400.R03.01

**Draft ID:**            AR.016.03.02

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

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended:** 02/01/16

**Approved Effective Date of Waiver being Amended:** 02/01/16

## 1. Request Information (2 of 3)

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

### Hospital

Select applicable level of care

#### **Hospital as defined in 42 CFR §440.10**

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

#### **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

### Nursing Facility

Select applicable level of care

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

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

Individuals requiring a skilled level of care are not eligible for the Living Choices program. The State's definition of "skilled level of care" is set forth below at b-6-d.

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

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

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

## 1. Request Information (3 of 3)

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

**Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates (check each that applies):**

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

**§1915(b)(2) (central broker)**

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

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

**A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

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

Specify the program:

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

## 2. Brief Waiver Description

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

The Living Choices Assisted Living waiver program allows individuals to live in apartment-style living units in licensed level II assisted living facilities and receive individualized personal, health and social services that enable optimal maintenance of their individuality, privacy, dignity, and independence. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation. The environment promotes participants' personal decision-making while protecting their health and safety. The major goal of this program is to delay or prevent institutionalization of these individuals. However, assisted living services are not intended as a substitute for nursing facility or hospital care for individuals needing skilled care, as defined by State administrative rule which is set forth in B-6-d. Room and board services are not covered per federal law.

Living Choices includes 24-hour on-site response staff to assist with participants' known physical dependency needs or other conditions, as well as to manage unanticipated situations and emergencies. Assisted living facility staff will perform their duties and conduct themselves in a manner that fosters and promotes participants' dignity and independence. Supervision, safety and security are required components of the assisted living environment. Living Choices includes therapeutic, social and recreational activities suitable to the participants' abilities, interests, and needs. Assisted living participants' living units are separate and distinct from all others. Laundry and meal preparation and service are in a congregate setting for participants who choose not to perform those activities themselves. The principles of negotiated service plans and managed risk are applied.

Extended Prescription Drug Coverage is available for Living Choices participants who are eligible for regular Medicaid drug benefits, plus three additional prescriptions. Participants dually eligible for Medicare and Medicaid must obtain prescribed medications through the Medicare Part D Prescription Drug Plan, or for certain prescribed medications excluded from the Medicare Part D Prescription Drug Plan, through the Arkansas Medicaid State Plan Pharmacy Program.

The Living Choices waiver is administered by two state operating agencies, the Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of Provider Services and Quality Assurance (DPSQA). DAABHS and DPSQA operate under the authority of the Division of Medical Services (DMS), the Medicaid Agency. DAABHS, DPSQA, and DMS are all under the umbrella of the Arkansas Department of Human Services (DHS). DMS is responsible for all policy decisions concerning the waiver, promulgation of provider manuals and regulations governing the waiver, reimbursement of certified waiver providers, and oversight of all waiver-related functions delegated to DAABHS and DPSQA. DAABHS is responsible for the day-to-day administration of the waiver, establishing waiver program policies and procedures, and overseeing the development and management of person-centered service plans, among other functions. DPSQA, through its Office of Long Term Care (OLTC), is responsible for determination of level of care. DPSQA is also responsible for provider certification, compliance, and provider quality assurance. DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the Arkansas Independent Assessment (ARIA) system.

Functional eligibility for the waiver is determined using assessments and reassessments performed by the State's Independent Assessment Contractor using a new electronic instrument, the Arkansas Independent Assessment (ARIA) system and the contractor's team of registered nurses. The assessment is sent to the Office of Long-Term Care (OLTC) in the Division of Provider Services and Quality Assurance (DPSQA) to determine if the applicant's functional need is at the nursing home level of care. If an applicant is determined both financially and functionally eligible, the DHS county office approves the application.

### 3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through



the waiver, including applicable limitations on such services.

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

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

**Yes. This waiver provides participant direction opportunities.** Appendix E is required.

**No. This waiver does not provide participant direction opportunities.** Appendix E is not required.

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

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

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

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

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

#### 4. Waiver(s) Requested

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

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

**Not Applicable**

**No**

**Yes**

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

**No**

**Yes**

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

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

**Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make participant-direction of services as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect

to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would

receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

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

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

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

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

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

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

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

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

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

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

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

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

**I. Public Input.** Describe how the State secures public input into the development of the waiver:

Policy and form revisions, procedural changes and clarifications have been made through the years based on input from participants, family and providers. Comments have been reviewed and appropriate action taken to incorporate changes to benefit the participant, service delivery and quality of care. Comments and public input have been gathered through routine monitoring of program requirements, provider workshops/trainings, program integrity audits, monitoring of participants and contact with stakeholders. All of these experiences and lessons learned from the public and the resulting improvements are applied to the operations of Living Choices.

Updates and revisions to the waiver are posted on the DMS website to allow for a general public comment period of at least 30 days. Notices of updates or revisions are also published in a statewide newspaper to allow for public review and comment. Regulations, policies, rules and procedures are promulgated in accordance with the Arkansas Administrative Procedure Act. Promulgation includes review by two Arkansas legislative committees, which are open to the public and may include testimony by the public. After review by the committees, the regulations, policies, rules and procedures are adopted and incorporated into the appropriate document. All provider manuals containing program rules are available to all providers and the general public via the DMS website.

The agency first conducted five public meetings in the summer to outline the reforms being considered for the waiver amendments: Jonesboro, AR (6/4/18); Fort Smith, AR (6/6/18); Monticello, AR (6/8/18); Hope, AR (6/11/18); and Little Rock, AR (6/14/18). The public notice was published in the statewide newspaper Arkansas Democrat Gazette on October 14-16, 2018. The comment period ended November 12, 2018. The entire waiver application was published for comment. Physical copies of the proposed waiver amendments were mailed to constituents upon request. A copy was also published on the state's Medicaid website at the following link: <https://www.medicaid.state.ar.us/general/comment/comment.aspx>

The agency conducted five public hearings during the public comment period in different parts of the state: Fort Smith, AR (10/15/18); Monticello, AR (10/18/18); Hope, AR (10/22/18); Little Rock, AR (10/29/18); and Jonesboro, AR (11/7/18). At each public comment hearing, members of the public were invited to provide oral and/or written comments regarding the proposed waiver amendments. A court reporter was provided at each location to transcribe the entire hearing and all comments received. In addition, the agency provided sign-in sheets for attendees who chose to register their attendance.

During the public comment period for the Living Choices Assisted Living waiver renewal, Arkansas DHS received comments from consumer groups, providers, advocacy groups, and other stakeholders. Comments were provided through physical letters mailed/delivered to the agency; e-mails; telephone voicemails; and oral statements at public hearings. Comments included:

Comment: The most common comment was a form e-mail publicized by an advocacy group expressing opposition to Medicaid "cuts" generally, and concern for a lack of transparency in the development of the proposed amendment, and for "inadequate data" and "incorrect assumptions" in the actuarial studies supporting proposed rate changes.

Response: DHS believes the proposed changes would improve efficiency and fiscal sustainability of these programs while still protecting the health and safety of clients and ensuring that clients have access to the medically necessary services they require. DHS has conducted a total of 10 regional public meetings concerning these changes and two publicly-available webinars, in addition to meeting with both provider and consumer stakeholder groups to explain the changes and gather input. The comments fail to specify what data or assumptions are supposedly inaccurate, and rate studies were prepared by nationally-recognized actuaries.

Comment: Other commenters focused on the proposed rate change for assisted living services. Commenters expressed concern that the rate reduction would cause significant disruption to providers and could force some facilities to close. They criticized the actuarial study on which the rate is based for the small number of respondents to the provider survey referred to by the actuary. They expressed concern that the proposed rate does not take into account facility costs such as building/construction, laundry, dietary, and other costs of building and running an assisted living facility.

Response: DHS recognizes that it must move to a fully-justifiable payment methodology for assisted living. DHS retained an actuary to review the costs of providing assisted living services, and that actuary developed a recommended rate. Although the actuary did survey providers, the survey results were only a portion of the overall data reviewed by the actuary. The actuary reviewed the costs of providing assisted living services, but the rate does not include any component of room and board costs, as those are not permitted by federal rules (although a number of commenters asked that they be included). The rate recommended by the actuary as reasonable and appropriate is the rate recommended in the proposed rule. DHS recognizes that moving to a supported rate on January 1, 2019, will create significant difficulties for providers, and the proposed rule is being modified to phase-in the rate over a period of one year, giving providers time to adapt.

Comment: Commenters also objected to the current caps on participation as too small, since there is currently an active waiting list for participation.

Response: DHS modified the waiver amendment to increase the cap on the unduplicated count of participants from the existing 1,300 to 1,725.

**J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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

Last Name:

Mills

First Name:

Dave

Title:

Business Operations Manager, Office of Policy Coordination & Promulgation

Agency:

Arkansas Department of Human Services

Address:

PO Box 1437, Slot S-295

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 320-6306

Ext:

TTY

Fax:

(501) 404-4619

E-mail:

dave.mills@dhs.arkansas.gov

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

Last Name:

White

First Name:

Mark

Title:

Deputy Director

Agency:

Arkansas Dept. of Human Services, Division of Aging, Adult, and Behavioral Health Services

Address:

P. O. Box 1437, Slot S-530

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 320-6009

Ext:

TTY

Fax:

(501) 682-8155

E-mail:

mark.white@dhs.arkansas.gov

## 8. Authorizing Signature

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

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Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Arkansas**

Zip:

Phone:  Ext:  TTY

Fax:

E-mail:

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**Attachments**

**Attachment #1: Transition Plan**

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

**Replacing an approved waiver with this waiver.**

**Combining waivers.**

**Splitting one waiver into two waivers.**

**Eliminating a service.**

**Adding or decreasing an individual cost limit pertaining to eligibility.**

**Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

**Reducing the unduplicated count of participants (Factor C).**

**Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

**Making any changes that could result in some participants losing eligibility or being transferred to another waiver**



**under 1915(c) or another Medicaid authority.**

**Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Similarities and differences between the services covered in the approved waiver and those covered in the amended waiver:

All types of services covered in the approved waiver continue to be covered in the amended waiver.

When services in the approved waiver will not be offered in the new or renewed/amended waiver or will be offered in lesser amount, how the health and welfare of persons who receive services through the approved waiver will be assured:

No service covered by the approved waiver and received by any participant is discontinued under the amended waiver.

How persons served in the existing waiver are eligible to participate in the amended waiver:

Individuals served in the existing waiver may continue to participate in this HCBS program under the amended waiver, provided they (1) continue to meet financial eligibility and (2) meet the functional level of care criteria for the program as defined in the state rule and determined following their reassessment under the new Arkansas Independent Assessment (ARIA) process.

The level of care criteria for waiver and nursing facility services are established by state rule and are unchanged. The amended waiver includes a clarification that under the existing functional level of care criteria that persons requiring skilled care (as defined in the state rule) are not eligible for the waiver. This re-states existing policy and is incorporated in the assessment and eligibility determination processes.

The approved waiver provides for assessments using the ArPath system, which is based primarily on the interRAI instrument. The ArPath system includes two algorithms that gather necessary information to ascertain whether an applicant or participant needs the state's level of care criteria related to Alzheimer's or related dementia (Cognitive Performance Scale) and daily skilled monitoring of a life-threatening medical condition (Changes in Health, End-Stage Disease and Symptoms and Signs [CHESS]). Under the new Arkansas Independent Assessment (ARIA) system, the necessary information for these criteria are built into the ARIA instrument. Assessment instruments involve a complex array of questions asked by registered nurses during the face-to-face evaluation meetings with applicants and participants. As with the implementation of any new assessment instrument and routinely in the course of each assessment or re-assessment, new or additional information directly relevant to level of care criteria, and therefore a person's functional / non-financial eligibility, may be received.

How new limitations on the amount of waiver services in amended waivers will be implemented:

Before implementation of the amended waiver, the state will promulgate the new/revised provider manual. In Arkansas, manual promulgation includes a public comment period and legislative committee review. Also, the state will provide for a series of regional training sessions and webinars for providers and other stakeholders.

Re-assessments of existing participants will be performed through the new ARIA independent assessment process on a revolving basis as previously approved person-centered service plans near expiration or earlier if appropriate (such as in the event of care transitions).

If persons served in approved waiver will not be eligible to participate in the new or renewed/amended waiver, the plan describes the steps that the state will take to facilitate the transition of affected individuals to alternate services and supports that will enable the individual to remain in the community:

The amended waiver makes no changes to waiver eligibility policy, other than a technical change to Section 1.F, Levels of Care, to clarify that individuals requiring a skilled level of care are not eligible for the Living Choices program. This change aligns Section 1.F with the current Brief Waiver Description, which states that the waiver eligibility is limited to "persons aged 21 to 64 years of age with a physical disability, or 65 and older who require an intermediate level of care in a nursing facility. The new assessment process and instrument and eligibility determination process are based on the existing level of care.

In the event that a person in the approved waiver is, for whatever reason, not eligible for the amended waiver, they will be referred to other, alternative services, including, as appropriate, other waivers, Medicaid State Plan services, Medicare services, and community services.

Includes the timetable for transitioning individuals to the new waiver (i.e., will participants in the existing waiver transition to the new waiver all at the same time or will the transition be phased in?).

As described above, existing participants will be transitioned to the amended waiver on a revolving basis according to the expiration date of their current person-centered service plan and the timing of their next re-assessment. Existing participants requiring earlier-than-planned re-assessments as a result of care transitions or other life changes will be phased into the amended waiver during that re-assessment and new service plan.

How participants are notified of the changes and informed of the opportunity to request a Fair Hearing:

Participants may request a Fair Hearing concerning eligibility determinations and person-centered service plans.

Current notification processes, including letters with information on how to request a Fair Hearing, will continue, with information updated as necessary.

Relevant beneficiary materials will be updated to describe policy changes.

Additional public and stakeholder notification are achieved through the state's formal public comment and promulgation process for the waiver program manual.

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

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

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

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

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

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

## **Additional Needed Information (Optional)**

Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

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

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

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

**The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Department of Human Services, Division of Aging, Adult, and Behavioral Health Services (DAABHS) and Division of Provider Services and Quality Assurance (DPSQA)

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

## Appendix A: Waiver Administration and Operation

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**2. Oversight of Performance.**

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

**b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the

methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Arkansas Department of Human Services (DHS) uses an Interagency Agreement to define the responsibilities of the three DHS divisions – the Division of Medical Services (DMS, the Medicaid agency), DAABHS, and DPSQA – charged with responsibility for administering both the ARChoices in Homecare (ARChoices) and Living Choices Assisted Living (Living Choices) HCBS waiver programs. This agreement is reviewed annually and updated as needed. DMS, as the Medicaid agency, monitors this agreement on a continuous basis to assure that the provisions specified are executed.

DMS is responsible for all policy decisions concerning the waiver, promulgation of provider manuals and regulations governing the waiver, reimbursement of certified waiver providers, and oversight of all waiver-related functions delegated to DAABHS and DPSQA, including monitoring compliance with the Interagency Agreement.

DAABHS is responsible for the day-to-day administration of the waiver, establishing waiver program policies and procedures, overseeing the development and management of person-centered service plans, and overseeing the Independent Assessment Contractor.

DPSQA is responsible for provider certification, compliance, and provider quality assurance. Through its Office of Long Term Care (OLTC), DPSQA is responsible for level of care determinations.

DMS and DAABHS share the responsibility for monitoring and overseeing the performance of the Independent Assessment Contractor and the Arkansas Independent Assessment (ARIA) system.

To oversee and monitor the functions performed by DAABHS and DPSQA in the administration and operation of the waiver, DMS will conduct team meetings as needed with DAABHS and DPSQA staff to discuss compliance with the performance measures in the programs, results of chart reviews performed by DMS and DAABHS, corrective action plans, remediation, and systems improvements to maintain effective administration of the programs.

## Appendix A: Waiver Administration and Operation

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

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

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

A contractor (“Independent Assessment Contractor”) will perform independent assessments that gather functional need information about each Living Choices waiver applicant and participant using the Arkansas Independent Assessment (ARIA) instrument. The information gathered is used to determine the individual’s level of care and the tier level (which is intended to help inform waiver program oversight and administration and person-centered service planning).

**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

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**4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

**Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

## Appendix A: Waiver Administration and Operation

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

As described in the Interagency Agreement between the Division of Medical Services (DMS, the Medicaid agency), the Division of Aging, Adult, and Behavioral Health Services (DAABHS), and the Division of Provider Services and Quality Assurance (DPSQA), DAABHS and DMS will jointly share responsibility for oversight of the performance of the Independent Assessment Contractor, with DMS being ultimately accountable. The contract provides for performance measures the Independent Assessment Contractor is required to meet.

## Appendix A: Waiver Administration and Operation

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

The state assesses the performance of the Independent Assessment Contractor on a monthly and annual basis through review and assessment of the monthly and annual Program Performance Reports submitted by the Independent Assessment Contractor to the Contract Monitor. The state's contract with the Independent Assessment Contractor includes performance standards and requirements for a quality monitoring and assurance program.

The Independent Assessment Contractor's quality monitoring and assurance process must include (1) the staff necessary to perform quality monitoring and assurance reviews for accuracy, data consistency, integrity, and completeness of assessments and (2) procedures for assessing the performance of the staff conducting the assessments, include a desk review of assessments, tier determinations, and recommended attendant care services hours according to the Task and Hour Standards for a statistically significant number of cases. The Independent Assessment Contractor is required to include the results of the quality monitoring and assurance process in the monthly reports submitted to the Contract Monitor in the format required by DHS.

The monthly reports include the following:

1. Demographics about the beneficiaries who were assessed;
2. An activities summary, including the volume, timeliness and outcomes of all Assessments and Reassessments; and
3. A running total of the activities completed.

The annual report includes the following:

1. A summary of the activities over the prior year;
2. A summary of the Independent Assessment Contractor's timeliness in scheduling and performing assessments and reassessments;
3. A summary of findings from Beneficiary feedback research conducted by the Independent Assessment Contractor;
4. A summary of any challenges and risks perceived by the Independent Assessment Contractor in the year ahead and how the Independent Assessment Contractor proposes to manage or mitigate those; and
5. Recommendations for improving the efficiency and quality of the services performed.

The Contract Monitor and senior staff from DAABHS and DMS review the monthly and annual reports submitted by the Independent Assessment Contractor within 15 days after they have been submitted, and determine whether the Independent Assessment Contractor has submitted the required information, following its quality monitoring and assurance process, and meeting the performance standards in the contract. If not, the state will initiate appropriate corrective and preventive actions, which may include, for example, further analysis and problem solving with the contractor, root cause analysis to identify the cause of a discrepancy or deviation, enhanced reporting and monitoring, improved performance measures, requiring development and execution of corrective action plans, reallocation of staff resources, data and systems improvements, consultation with stakeholders, and/or sanctions under the contract.

## Appendix A: Waiver Administration and Operation

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**7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

#### a. Methods for Discovery: Administrative Authority

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

#### i. Performance Measures

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

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

*Where possible, include numerator/denominator.*

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

**Performance Measure:**



**Number and percent of participants with delivery of at least one waiver service per month as specified in the service plan in accordance with the agreement with the Medicaid Agency. Numerator: Number of participants with at least one service per month; Denominator: Number of participants served.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**No Waiver Service Report**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of unduplicated participants served within approved limits specified in the approved waiver. Numerator: Number of unduplicated participants served within approved limits; Denominator: Number of unduplicated participants.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MMIS**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b>	<b>Annually</b>	<b>Stratified</b>

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of policies and/or procedures developed by DAABHS, in consultation with DPSQA, that are reviewed and approved by the Medicaid Agency prior to implementation. Numerator: Number of policies and procedures by DAABHS Medicaid before implementation; Denominator: Number of policies and procedures developed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**PDQA Request Forms**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of waiver claims on the Overlapping Services Report having the same date of service as a claim for institutional services, which correctly paid only for the date of discharge. Numerator: Number of waiver claims on the Overlapping Services Report which correctly paid only for the date of discharge; Denominator: Number of waiver claims reviewed from the Overlapping Services Report.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Overlapping Services Report**

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

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of active participants served within approved limits specified in the approved waiver. Numerator: Number of active participants served within approved limits; Denominator: Number of active participants.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**ACES Report of Active Cases (Point in Time)**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:  <input type="text" value="Division of County Operations"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

N/A

**b. Methods for Remediation/Fixing Individual Problems**

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency), and the Division of Medical Services (DMS) (Medicaid agency) participate in team meetings to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement for measures related to administrative authority of the waiver.

In cases where the numbers of active participants and unduplicated participants served in the waiver are not within approved limits, remediation includes waiver amendments and possibly implementing a waiting list. DMS reviews and approves all policy and procedures (including waiver amendments) developed by DAABHS or DPSQA prior to implementation, as part of the Interagency Agreement. In cases where policy or procedures were not reviewed and approved by DMS, remediation includes DMS reviewing the policy upon discovery, and approving or removing the policy.

In cases where there are problems with level of care determinations completed within specified time frames and by a qualified evaluator, additional staff training, staff counseling or disciplinary action may be part of remediation. In addition, if these problems arise, the LOC determination is completed upon discovery, the LOC determination may be redone and payments for services may be recouped. Similarly, remediation for service plans not completed in specified time frames includes completing the service plan upon discovery, additional training for staff and staff counseling or disciplinary action. DAABHS conducts all remediation efforts in these areas.

Remediation to address participants not receiving at least one waiver service a month in accordance with the service plan and the agreement with DMS includes closing a case, conducting monitoring visits, revising a service plan to add a service, checking on provider billing and providing training. DAABHS conducts remediation efforts in these areas, and the tool used for case record review documents and tracks remediation.

**ii. Remediation Data Aggregation**



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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

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

**No**

**Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix B: Participant Access and Eligibility**

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<b>Aged or Disabled, or Both - General</b>					
		Aged	65		
		Disabled (Physical)	21	64	

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Disabled (Other)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
		Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	
		HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
		Medically Fragile	<input type="checkbox"/>	<input type="checkbox"/>	
		Technology Dependent	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Intellectual Disability or Developmental Disability, or Both</b>					
		Autism	<input type="checkbox"/>	<input type="checkbox"/>	
		Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	
		Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Mental Illness</b>					
		Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	
		Serious Emotional Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	

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

N/A

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

**Not applicable. There is no maximum age limit**

**The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

The participant remains in the waiver under the Aged group.

## Appendix B: Participant Access and Eligibility

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

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

**No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the

State. Complete Items B-2-b and B-2-c.

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

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

Specify the percentage:

**Other**

Specify:

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

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

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

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

**The following dollar amount:**

Specify dollar amount:

**The dollar amount (select one)**

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

Specify the formula:

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

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

Specify percent:

**Other:**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

**Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

**Table: B-3-a**

Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	1300
Year 2	1300
Year 3	1300
Year 4	1725
Year 5	1725

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

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

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

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

**Table: B-3-b**

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	1200
Year 2	1200
Year 3	1200
Year 4	1200
Year 5	1200

## Appendix B: Participant Access and Eligibility

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

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

**Not applicable. The state does not reserve capacity.**

**The State reserves capacity for the following purpose(s).**

## Appendix B: Participant Access and Eligibility

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

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

**The waiver is not subject to a phase-in or a phase-out schedule.**

**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

**Waiver capacity is allocated/managed on a statewide basis.**

**Waiver capacity is allocated to local/regional non-state entities.**

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

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

Entrance onto the Living Choices waiver program is on a first come, first-served basis, once individuals meet all medical and financial eligibility requirements.

However, once the unduplicated number of participants is reached, a waiting list will be implemented for this program and the following process will apply. Each Living Choices application will be accepted and eligibility will be determined. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services; that all waiver slots are filled; and that the applicant is number \_\_ in line for an available slot. It is not permissible to deny any eligible person based on the unavailability of a slot in the Living Choices program.

Entry to the waiver will then be prioritized based on the following criteria:

- a) Waiver application determination date for persons inadvertently omitted from the waiver waiting list (administrative error);
- b) Waiver application determination date for persons residing in a nursing facility and being discharged after a 90 day stay; waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;
- c) Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);
- d) Waiver application determination date for all other persons.

---

## **Appendix B: Participant Access and Eligibility**

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

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

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## **Appendix B: Participant Access and Eligibility**

### **B-4: Eligibility Groups Served in the Waiver**

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

**§1634 State**

**SSI Criteria State**

**209(b) State**

**2. Miller Trust State.**

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

**No**

**Yes**

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

---

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

---

**Low income families with children as provided in §1931 of the Act**

**SSI recipients**

**Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

**Optional State supplement recipients**

**Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one:*

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

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

Specify percentage:

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

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

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

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

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

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

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

*Specify:*

---

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

---

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

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

*Select one and complete Appendix B-5.*

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

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

*Check each that applies:*

**A special income level equal to:**

*Select one:*

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

*Select one:*

**100% of FPL**

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

Specify percentage amount:

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

*Specify:*

## **Appendix B: Participant Access and Eligibility**

### **B-5: Post-Eligibility Treatment of Income (1 of 7)**

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



applies only to the 42 CFR §435.217 group.

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

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

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

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

**Use spousal post-eligibility rules under §1924 of the Act.**

*(Complete Item B-5-b (SSI State) and Item B-5-d)*

**Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

**Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (2 of 7)

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

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

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

---

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

---

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

*Select one:*

**SSI standard**

**Optional State supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

*(select one):*

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

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

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

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the State Plan**

*Specify:*

**The following dollar amount**

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

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

*Specify:*

**Other**

*Specify:*

Up to 200% of the Individual SSI Federal Benefit Rate (FBR) which includes:

- 90.8 % of the Individual SSI FBR, rounded up to the nearest dollar, to cover room and board; refer to appendix I-5 for the explanation of the method used by the state to exclude Medicaid payment for room and board.
- 9% of the SSI FBR, rounded up to the nearest dollar, for personal needs
- Up to 100% of the Individual SSI FBR of earned income to cover work-related expenses for participants whose physician's service plan prescribes an employment activity as a therapeutic or rehabilitative measure

---

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

---

**Not Applicable**

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

*Specify:*

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

**SSI standard**

**Optional State supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

---

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

---

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

**Other**

*Specify:*

---

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

---

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

**The State does not establish reasonable limits.**

**The State establishes the following reasonable limits**

*Specify:*

## **Appendix B: Participant Access and Eligibility**

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### **B-5: Post-Eligibility Treatment of Income (3 of 7)**

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

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

---

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

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## **Appendix B: Participant Access and Eligibility**

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### **B-5: Post-Eligibility Treatment of Income (4 of 7)**

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

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

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

##### **i. Allowance for the personal needs of the waiver participant**

*(select one):*

**SSI standard**

**Optional State supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

**A percentage of the Federal poverty level**

Specify percentage:

**The following dollar amount:**

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

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

*Specify formula:*

**Other**

*Specify:*

Up to 200% of the Individual SSI Federal Benefit Rate (FBR) which includes:

- 90.8 % of the Individual SSI FBR, rounded up to the nearest dollar, to cover room and board; refer to appendix I-5 for the explanation of the method used by the state to exclude Medicaid payment for room and board.
- 9% of the SSI FBR, rounded up to the nearest dollar, for personal needs
- Up to 100% of the Individual SSI FBR of earned income to cover work-related expenses for participants whose physician's service plan prescribes an employment activity as a therapeutic or rehabilitative measure

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

Select one:

**Allowance is the same**

**Allowance is different.**

*Explanation of difference:*

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

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

Select one:

**Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

**The State does not establish reasonable limits.**

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

## **Appendix B: Participant Access and Eligibility**

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

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

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

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**Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.**

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (6 of 7)

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

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

---

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

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## Appendix B: Participant Access and Eligibility

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

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

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

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

---

**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

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## Appendix B: Participant Access and Eligibility

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### B-6: Evaluation/Reevaluation of Level of Care

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

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

#### i. Minimum number of services.

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

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

**The provision of waiver services at least monthly**

**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

**Directly by the Medicaid agency**

**By the operating agency specified in Appendix A**

**By an entity under contract with the Medicaid agency.**

*Specify the entity:*

**Other**

*Specify:*

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

These activities are performed by registered nurses (RNs) licensed by the State of Arkansas under the rules and standards of the State Board of Nursing. Arkansas is a participant in the multi-state Nurse Licensure Compact.

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

Level of Care Criteria:

The functional level of care criteria for Living Choices Assisted Living waiver eligibility are established in administrative rules and the Living Choices Assisted Living manual, as promulgated by the Arkansas Department of Human Services (DHS). Please see DHS rule 016.06 CARR 057 (2017) (Procedures for Determination of Medical Need for Nursing Home Services).

As specified in the rule, to meet functional (non-financial) eligibility for the waiver program an individual must:

1. Fully meet at least one of the following three level of care criteria:

a. The individual is unable to perform either of the following:

A. At least one (1) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or,

B. At least two (2) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without limited assistance from another person; or,

b. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,

c. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening; and

2. Not require a skilled level of care, as defined in the State rule. The State rule defines "Skilled Level of Care" to mean the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount:

a. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure;

b. Intravenous injections and hypodermoclysis or intravenous feedings;

c. Levin tubes and nasogastric tubes;

d. Nasopharyngeal and tracheostomy aspiration;

e. Application of dressings involving prescription medication and aseptic techniques;

f. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV;

g. Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress;

h. Initial phases of a regimen involving administration of medical gases;



- i. Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies that are part of active treatment, to obtain a specific goal and not as maintenance of existing function;
- j. Ventilator care and maintenance; and
- k. The insertion, removal and maintenance of gastrostomy feeding tubes;

No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition that is temporary and expected to last no more than 21 days.

For administration of this waiver, the term ‘life-threatening’ means the probability of death from the diagnosed medical condition is likely unless the course of the condition is interrupted by medical treatment.

Instrument/Tool Used:

Currently, ArPath is the instrument approved for used by registered nurses (RNs) from DHS to collect information used to determine (or re-determine) each applicant’s or participant’s level of care. The ArPath instrument, which is based primarily on the interRAI toolset, was federally approved for use in the current waiver.

Beginning on the effective date of this amended waiver, Arkansas will instead use a new instrument – the Arkansas Independent Assessment (ARIA) – to collect information to evaluate level of care. Registered nurses from the Independent Assessment Contractor will use the ARIA instrument to conduct face-to-face, in-home assessments and reassessments. Using the information collected during the assessment, the Office of Long Term Care in DPSQA will evaluate whether an individual meets the State’s level of care criteria.

All State laws, regulations, and policies concerning level of care criteria and the assessment instrument/tool (including the current ArPath instrument, the new ARIA instrument, the Living Choices waiver program manual, and the ARIA manual) are available to CMS upon request through DAABHS.

Note that the Arkansas Independent Assessment (ARIA) system is also being used to help determine medical necessity and help adjudicate prior authorization requests for State Plan personal care services and IndependentChoices self-directed personal assistance.

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

**The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

**A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

Level of Care Instrument for Institutional Care:

The instrument used to evaluate institutional level of care is form DHS-703 (Evaluation of Medical Need Criteria). The DHS-703 is completed by a registered nurse (RN) and includes information obtained from the participant, family members, caregivers, and others. The DHS-703 was designed based on the minimum data set (MDS) and the State's nursing home admission criteria. It includes the nurse's professional assessment of the participant and observations and evaluation of the participant's ability to perform activities of daily living, along with other relevant information regarding the individual's medical history.

Level of Care Instrument for Waiver Program:

The level of care instrument for the Living Choices waiver program will be the Arkansas Independent Assessment (ARIA) system will be used to support the level of care determination process.

Data needed for determining whether the State's level of care criteria are met are gathered by both instruments. The State's level of care criteria are the same for the waiver and institutional care, with the exception that individuals needing skilled nursing care are excluded from the waiver.

Both the ARIA instrument (as with the current ArPath instrument) and the DHS-703 assess needs, are used by registered nurses and are person-centered, focusing on the participant's functioning and quality of life. Both are used through independent, conflict-free assessment processes staffed by registered nurses.

The state ensures that ARIA is valid and reliable through multiple stages of testing. The Independent Assessment Contractor conducts its own system testing via automated test scripts as well as business testing to validate outcomes. In addition, the state provides mock assessments for a blinded validation analysis. The mock assessments are designed to test the validity of ARIA-assigned tiers (0, 1, 2, 3) compared to the nursing home level of care criteria for waiver functional eligibility. The mock assessments are uploaded to ARIA and tracked, and the ARIA results are compared to the expected tier levels identified by the state. This testing is single-side blinded so that the Independent Assessment Contractor is not aware of the expected tiers before the tests are run.

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

The new process for evaluating waiver applicants and re-evaluation of waiver program participants for their respective needs for the level of care under the waiver is described below.

Under the new process, each waiver applicant needing an evaluation and each waiver participant needing a re-evaluation will receive an individual assessment performed by the Independent Assessment Contractor. Each assessment or re-assessment is performed by a licensed registered nurse (RN) using the Arkansas Independent Assessment (ARIA) instrument. The Office of Long Term Care (OLTC) in DPSQA will use the assessment results to evaluate level of care. Functional need eligibility is valid for one year, unless a shorter period is specified by OLTC.

As described in B-6-e, the Independent Assessment Contractor's RNs will complete the ARIA instrument for each initial evaluation and subsequent re-evaluation, drawing upon information from a face-to-face meeting with the applicant/participant and, if necessary, information from other parties familiar with the individual's conditions, functional limitations, and circumstances.

Re-evaluations will continue to be performed on at least an annual basis, with the level of care re-affirmed or revised and a written determination issued by the Office of Long Term Care. A re-evaluation may also be performed anytime upon request the participant (or their legal representative or physician), if requested by the DHS RN responsible for the participant's person-centered service plan, or in cases a participant has experienced a significant change in circumstances, such as a inpatient hospital or skilled nursing facility admission or the loss of a primary caregiver.

The ARIA instrument is a comprehensive tool to collect detailed information to determine an individual's functional eligibility; identify needs, current supports, some of the individual's preferences, and some of the risks associated with home and community-based care for the individual; and inform the development of the person-centered service plan. The ARIA instrument is used to gather information on the applicant's (or participant's in the case of a re-evaluation) demographics; health care providers; current services and supports received (including skilled nursing, therapies, medications, durable medical equipment, and human assistance services), housing and living environment; decision-making and designated representatives; emergency contacts; Activities of Daily Living (ADLs) needs; Instrumental Activities of Daily Living (IADLs) needs; health status (including symptoms, conditions, and diagnoses); psychosocial status (including assessment of behavioral health impairments and risk factors); memory and cognition; mental status; sensory and functional communication skills; self-preservation capabilities and supports; family and other caregiver supports; participation in work, volunteering, or educational activities; and quality of life (including routines, preferences, strengths and accomplishments, and goals for future).

Once ARIA is operational, using assessment results and a DAABHS-approved tiering methodology, the ARIA system will assign tiers designed to help further differentiate individuals by need. Each waiver applicant or participant will be assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment. The tiers are intended to help inform waiver program oversight and administration and person-centered service planning. The tiers do not replace the Level of Care criteria described in B-6-d, waiver eligibility determinations, or the person-centered service plan process.

In summary:

1. Tier 0 (zero) and Tier 1 (one) indicate the individual's assessed needs, if any, do not support the need for either Living Choices waiver services or nursing facility services.
2. Tier 2 (two) indicates the individual's assessed needs are consistent with services available through either the Living Choices waiver program or a licensed nursing facility.
3. Tier 3 (three) indicates the individual needs skilled care available through a licensed nursing facility and not through the waiver program.

These indications notwithstanding, the final determination of Level of Care and waiver eligibility is made by the Office

of Long-Term Care (OLTC).

(Note that ARIA-based assessments are also used to help determine whether Medicaid enrollees meet the minimum ADL needs-based criteria for State Plan coverage of Medicaid personal care services or self-directed personal assistance services. Tier 1 (one) and Tier 2 (two) each indicate that the Medicaid enrollee meets the minimum criteria for personal care or self-directed personal assistance service coverage. Coverage of these State Plan services for Medicaid enrollees is further subject to medical necessity and prior authorization.)

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

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule**

*Specify the other schedule:*

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

**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

**The qualifications are different.**

*Specify the qualifications:*

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

DAABHS has established and maintains procedures for tracking review dates and initiating timely re-evaluations prior to each participant's respective level of care review date and prior to the expiration of the participant's current person-centered service plan. This process ensures timely reevaluations prior to the level of care review date and the expiration of the service plan (of care) so that no lapse in service occurs.

Specifically, DAABHS uses a "tickler" file system approach that DAABHS registered nurses (DHS RNs) and RN supervisors use to monitor upcoming review data and service plan expirations. The process of reassessment begins two months prior to the expiration date of the current person-centered service plan or two months prior to the annual anniversary date of the last independent assessment, whichever is earlier.

On at least a monthly basis, the DHS RN will identify participants who are due for re-assessment. The DHS RN will add the cases to the assessment schedule of the Independent Assessment Contractor by submitting the participants' information through an online web portal maintained by the Independent Assessment Contractor. The DHS RN will use the "tickler" file system to monitor for both the need for reassessment, and for timely completion of the reassessment by the Independent Assessment Contractor. Once the re-assessment is completed and the level of care is revised as appropriate, the DHS RN begins development of the new person-centered service plan.

Reassessments are ordinarily submitted to the Independent Assessment Contractor with a contractually-required 30-day time limit for completion of the reassessment. However, the contract also allows DHS, at its discretion, to submit assessments/reassessments with a 10-day time limit or a 7-day time limit when DHS deems it necessary.

The DHS RN supervisory staff, through the record review process and through routine monitoring and auditing procedures, notifies the appropriate DHS RN, RN supervisor, and Independent Assessment Contractor if a re-assessment has not been completed within the specified DAABHS policy timeframes.

The ACES report produced by the Division of County Operations is used as a tool by the DHS RN and RN supervisor to determine if the assessment is current or has expired. Patterns of noncompliance are documented and disciplinary action is taken if necessary.

Each Targeted Case Manager is also required to maintain a "Tickler" system to track the Medicaid eligibility reevaluation date and the service plan expiration date. If the reassessment process has not been completed timely, the Targeted Case Manager notifies the DHS RN prior to the expiration date of the current service plan.

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

Records of evaluations and reevaluations of level of care are maintained by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS), the primary authority for the daily operation of the waiver program, and the Office of Long Term Care (OLTC) in the Division of Provider Services and Quality Assurance (DPSQA), which is responsible for the final level of care evaluations and reevaluations. DAABHS maintains records for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations, or court cases are resolved for a participant, whichever is longer.

## **Appendix B: Evaluation/Reevaluation of Level of Care**

### **Quality Improvement: Level of Care**

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percentage of applicants who had a LOC indicating need for nursing facility LOC prior to receipt of services. Numerator: Number of applicants who received level of care prior to service; Denominator: Total number of applicants.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

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

		DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percentage of waiver participants who received an annual redetermination of LOC eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC re-evaluation. Numerator: Number of participants receiving annual redeterminations within 12 months; Denominator: number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>



<p><b>Sub-State Entity</b></p>	<p><b>Quarterly</b></p>	<p><b>Representative Sample</b> Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.</p> </div>
<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<p><b>Annually</b></p>	<p><b>Stratified</b> Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<p><b>Responsible Party for data aggregation and analysis</b> (<i>check each that applies</i>):</p>	<p><b>Frequency of data aggregation and analysis</b>(<i>check each that applies</i>):</p>
<p><b>State Medicaid Agency</b></p>	<p><b>Weekly</b></p>
<p><b>Operating Agency</b></p>	<p><b>Monthly</b></p>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percentage of participants LOC determinations made by a qualified evaluator. Numerator: Number of participants with LOC made by a qualified evaluator; Denominator: Number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Agency</b>		
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;"> DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percentage of participants LOC determinations made where the LOC criteria were accurately applied. Numerator: Number of participants LOCs with correct criteria; Denominator: Number of participants.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Monthly Level of Care Report**

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

		<input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percentage of participants annual re-evaluation LOC determinations that were completed as required by the state. Numerator: Number of participants with LOC determinations completed correctly; Denominator: Number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;">             DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.           </div>
<b>Other</b> Specify:  <input style="width: 100px; height: 20px;" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input style="width: 100px; height: 20px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

The state currently implements a system of monitoring that assures timeliness, accuracy, appropriateness and quality. Data is collected from individual participant records, aggregated to produce summation reports, and compared with periodic randomly sampled record reviews and sampled Program Integrity reviews.

Participant records undergo record reviews performed by DHS RN supervisors. Monthly activity reports track assessments and reassessments performed by the Independent Assessment Contractor. DHS RN reports are submitted to program RN supervisors and the Nurse Manager, who then review for timeliness and accuracy. The 45 Day Report tracks all waiver applications and identifies applications pending for more than 45 days. In addition, the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) maintains a daily log of assessments and reassessments sent to the Division of Provider Services and Quality Assurance (DPSQA) (operating agency) Office of Long Term Care for medical determination. Data from all assessment and review activity is aggregated to produce an annual Record Review Summary, and Level of Care Monthly Report.

Level of Care is provided to all applicants for whom there is reasonable indication that services may be needed. DHS RN supervisors perform record reviews of individual participants and results are aggregated for the Record Review Summary Report. Enrolled participants are re-evaluated at least annually. The same record review process, described above, is utilized for the re-evaluation process. Cases are identified for re-evaluation through alerts in the ARIA assessment tool.

The assessment process and instruments described in the waiver are applied appropriately and according to the approved description to determine participant level of care. Record reviews include a review of assessment and reassessment functions, and their alignment with waiver guidelines and timeframes. Findings are aggregated and included in the annual Record Review Summary.

The DHS RN supervisory staff conducts random record reviews, in which all aspects of Living Choices policy are reviewed. The Annual Report is a compilation of the results of the review of the random record selection. The record review allows reviewers to evaluate trends and identify where additional training for DHS RNs is needed. Some measures have multiple factors that are reviewed to determine if the area is in compliance. These measures are directly related to the CMS waiver assurance areas, including level of care determinations. DHS RN supervisory staff use the Raosoft calculation system to determine appropriate sample size for Record Review. This system provides a statistical valid sample based on a 95% confidence level with a margin of error of +/- 5%. A systematic random sampling of the active cases includes every "nth" name in the population.

The Division of Medical Services (DMS) QA review process includes review of the billing process by Living Choices Medicaid providers. The DMS QA review process reviews 20% of the records reviewed by DAABHS.

In addition to the record review process, an office review is completed by the DHS RN supervisor, at a minimum, annually for each DHS RN. Office reviews include, but are not limited to: Documentation maintained appropriately; Processing system clearly defined and office organized; Forms completed properly; and Required follow-up for any problems or concerns documented.

## **b. Methods for Remediation/Fixing Individual Problems**

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



The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency, with primary responsibility for waiver program operations and day-to-day oversight of the independent assessment process), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency with responsibility for level of care determinations), and the Division of Medical Services (Medicaid agency) – all three of which are part of the Arkansas Department of Human Services (DHS) – participate in team meetings as needed to discuss and address individual problems associated with level of care determinations, assessments, and system improvements, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures related to level of care determinations for the waiver.

The system currently in place for new applicants to enter the waiver program does not allow for services to be delivered prior to an initial level of care assessment. Also, DAABHS requires that all initial assessments and reassessments of level of care are completed by a registered nurse.

Level of Care assessments are required annually using the approved assessment instrument (currently, ArPath instrument, and upon the effective date of this Amendment, the Arkansas Independent Assessment (ARIA) instrument) and applying the level of care criteria. The DHS RN supervisors complete a regional monthly activity report, which lists the number of level of care evaluations and re-evaluations conducted. Remediation efforts are included on the DHS RN supervisors' monthly report.

The DHS RN supervisors complete a review to evaluate trends and identify where additional training is needed for the RNs and the OLTC staff performing level of care determinations. Remediation in these areas includes ongoing training by DAABHS for the Independent Assessment Contractor's RNs who perform these assessments conducted correctly, consistent with the assessment instrument and level of care criteria, and that initial and annual re-evaluation of level of care are completed within the required timeframes. DHS RN supervisors develop a corrective plan when remediation in this area is needed.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

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### B-7: Freedom of Choice

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

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

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

At the time of assessment and re-assessment of the waiver participant, the DHS RN explains the services available through the Living Choices waiver, discusses the qualified assisted living providers in the state and develops an appropriate person-centered service plan. As part of the service plan development process, the participant (or representative) documents their choice to have services provided in the community setting through the HCBS waiver as opposed to receiving services in an institutional setting. In addition, freedom of choice is explained through a Freedom of Choice form and the applicable qualified provider listing; both are signed by the waiver participant or their representative. This is documented on the service plan, which includes the signature of the waiver participant (or representative) and the DHS RN, and included in the participant's electronic record. NOTE: For reassessments, the Freedom of Choice form is utilized showing if changes are requested by the participant. If no changes are requested, no signatures are required on the provider listing; however, the Freedom of Choice form is signed and dated by the participant or representative. The participant's signature on the service plan, as entered by the participant or representative, documents that the participant (or representative) has made an informed decision to receive HCBS rather than services in an institutional setting and that HCBS are based on the participant's assessment of needs. Freedom of Choice documentation is tracked through the record review process, all staff performance evaluations and monthly reporting.

If necessary, the DHS RN will read all relevant information to the participant. If this is done, it will be documented in the participant's record. All forms and information will be provided in alternate formats upon request. If an alternate format is requested and/or provided, the DHS RN will document the format requested and/or provided in the participant's record.

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

Copies of the waiver participant's service plan are maintained with the Division of Aging, Adult, and Behavioral Health Services (operating agency) and with the providers chosen by the participant and included on the service plan. Freedom of Choice forms and person-centered service plans are maintained for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations or court cases are resolved for a participant, whichever is longer.

## Appendix B: Participant Access and Eligibility

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

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

All Department of Human Services (DHS) forms are available in English and Spanish. The forms can be translated into other languages when the need arises. DHS maintains an ongoing contract with a Spanish interpreter and translator agency for translation services.

All accommodations are provided on an individualized basis according to the participant's needs. DHS has a contract with an interpreter to accommodate applicants/participants who are hearing impaired. DHS RNs provide written materials to participants and will read any information to participants if needed. DHS RNs may utilize assistance from other divisions within the Arkansas Department of Human Services, such as the Division of Services for the Blind, in these instances. When this occurs, it is documented in the participant record.

## Appendix C: Participant Services

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

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

Service Type	Service		
Extended State Plan Service	Extended Medicaid State Plan Prescription Drugs		
Other Service	Living Choices Assisted Living Services		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Extended Medicaid State Plan Prescription Drugs

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17990 other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Living Choices waiver participants are eligible for the same prescription drug benefits of regular Medicaid, plus three additional prescriptions beyond the Arkansas Medicaid State Plan Pharmacy Programs benefit limit. An extension of the monthly benefit limit is provided to waiver clients unless a client is eligible for both Medicaid and Medicare (dually eligible). No prior authorization is required for the three additional prescriptions for Living Choices clients.

A waiver client who is dually eligible must obtain prescribed medications through the Medicare Part D Prescription Drug Plan or, for certain prescribed medications excluded from the Medicare Part D plan, through the Arkansas Medicaid State Plan Pharmacy Plan. Medicare has no restrictions on the number of prescription drugs that can be received during a month.

Duplication of services or potential overlap of the scope of services is managed and monitored through the MMIS.

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

N/A

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

**Participant-directed as specified in Appendix E**

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Licensed Pharmacist

## Appendix C: Participant Services

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

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**Service Type:** Extended State Plan Service

**Service Name:** Extended Medicaid State Plan Prescription Drugs

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**Provider Category:**

Individual

**Provider Type:**

Licensed Pharmacist

**Provider Qualifications**

**License** (*specify*):

Licensed as a pharmacist in the state of Arkansas, a pharmacist holding a current Pharmacy Permit issued by the Arkansas State Board of Pharmacy and issued a DEA number by the Drug Enforcement Agency.

The Division of Medical Services, Office of Long-Term Cares rules and regulations include specific experience, education and qualifications for Level II Assisted Living Facilities and their staff. Facilities must fulfill these regulations prior to licensure.

**Certificate** (*specify*):

Providers must also be enrolled with the Arkansas Division of Medical Services as a Medicaid State Plan Prescription Drug Program provider.

**Other Standard** (*specify*):

N/A

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The Medicaid program's fiscal agent

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

specified in statute.

**Service Title:**

Living Choices Assisted Living Services

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02013 group living, other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Basic Living Choices Assisted Living direct care services are:

1. Attendant care services
2. Therapeutic social and recreational activities
3. Periodic nursing evaluations
4. Limited nursing services
5. Assistance with medication to the extent that such assistance is in accordance with the Arkansas Nurse Practice Act and interpretations thereto by the Arkansas Board of Nursing
6. Medication oversight to the extent permitted under Arkansas law
7. Assistance obtaining non-medical transportation specified in the plan of care

Assisted Living services are provided in a home-like environment in a licensed Level II Assisted Living Facility and include activities such as physical exercise, reminiscence therapy and sensorineural activities, such as cooking and gardening. These services are provided on a regular basis according to the clients plan of care and are not diversionary in nature.

Personalized care is furnished to persons who reside in their own living units/apartments at the facility that may include dually occupied units/apartments when both occupants consent to the arrangement that may or may not include kitchenette and/or living rooms and that contain bedrooms and toilet facilities. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence and provides supervision, safety and security. Other persons or agencies may also furnish care directly or under arrangement with the assisted living facility, but the care provided by these other entities supplements that provided by the assisted living facility and does not supplant it.

Care must be furnished in a way that fosters the independence of each client to facilitate aging in place. Routines of care provision and service delivery must be consumer driven to the maximum extent possible and treat each person with dignity and respect.

Assisted living services may also include medication administration consistent with the Arkansas Nurse Practice Act and interpretation thereto by the Arkansas Board of Nursing; limited nursing services; periodic nursing evaluations and non-medical transportation specified in the plan of care. Nursing and skilled therapy services (except periodic nursing evaluation) are incidental rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision.

Living Choices waiver clients may receive services through the Medicaid State Plan that are not duplicative of assisted living waiver services. State plan services must be provided by qualified providers enrolled with the Medicaid agency as a provider of the specific service, (i.e. home health services, DME equipment, therapy services, prescription drugs), and who would have to meet the provider standards for the Medicaid State Plan service that is provided. The Medicaid State Plan services are not paid for through the waiver.

Attendant care services through Living Choices is the provision of assistance to a person who is medically stable and/or has a physical disability to accomplish tasks of daily living that the person is unable to complete independently, such as eating, dressing, bathing and personal hygiene, mobility and ambulation, and bowel and bladder requirements. Waiver attendant care services assist persons to remain independent as much as possible and to that extent are most often not provided as direct care to the total degree of doing the task or activity for the person. However, the required assistance may vary from actually doing a task for the person, assisting the person in performing the task himself or herself or providing safety support while the person performs the task. Attendant care services include oversight, supervision and cueing persons while performing a task. Incidental housekeeping and shopping for personal care items or food may be included in attendant care. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Preparation and serving of meals and laundry are in a congregate setting.

Pursuant to Act 1230 of 2001, the Arkansas Legislature defines limited nursing services as acts that may be

performed by licensed personnel while carrying out their professional duties, but limited to those acts that the department (DHS) specifies by rule. Acts which may be specified by rule as allowable limited nursing services shall be for persons who meet the admission criteria established by the department (DHS) for facilities offering assisted living services, shall not be complex enough to require twenty-four (24) hour nursing supervision and may include such services as the application and care of routine dressings, and care of casts, braces and splints (Ark. Code Ann. §20-10-1703).

Limited nursing services provided through the Living Choices waiver are not services requiring substantial and specialized nursing skills that are provided by home health agencies or other licensed health care agencies. Living Choices limited nursing services will be provided by registered nurses (RN), licensed practical nurses (LPN) and certified nursing assistants (CNA) who are employed or contracted with the assisted living facility. Limited nursing services include the assessment and monitoring of the waiver clients health care needs, including the preparation, coordination and implementation of services, in conjunction with the physician/primary care physician or community agencies as appropriate. LPN limited nursing services are provided under the supervision of the RN and include monitoring of the waiver clients health condition and notification of the RN if there are significant changes in the waiver clients health condition. Both the RN and LPN may administer medication and deliver medical services as provided by Arkansas law or applicable regulation. CNAs, under the supervision of an RN and LPN, may perform basic medical duties as set forth in Part II, Unit VII of the Rules and Regulations governing Long Term Care Facility Nursing Assistant Curriculum. These basic medical duties include taking vital signs (temperature, pulse, respiration, blood pressure, height/weight), and recognizing and reporting abnormal changes.

Therapeutic, social and recreational activities are activities that can improve a residents eating or sleeping patterns; lessen wandering, restlessness, or anxiety; improve socialization or cooperation; delay deterioration of skills; and improve behavior management. Therapeutic activities include gross motor activities (e.g., exercise, dancing, gardening, cooking, etc.); self-care activities (e.g., dressing, personal hygiene, or grooming); social activities (e.g., games, music, socialization); and, sensory enhancement activities (e.g., reminiscing, scent and tactile stimulation).

A periodic nursing evaluation by the ALF RN is required quarterly, and revisions made as needed. If required by licensing regulations, and an occupancy admission agreement is in place, the health care services plan portion of the occupancy admission agreement shall be revised within fourteen (14) days upon any significant enduring change to the resident and monitoring of the conditions of the residents on a periodic basis.

As described in B-6, each waiver applicant needing an evaluation and each waiver participant needing a re-evaluation will receive an individual assessment performed by the Independent Assessment Contractor. Each assessment or re-assessment is performed by a licensed registered nurse (RN) using the Arkansas Independent Assessment (ARIA) instrument. The Independent Assessment Contractor's RNs will complete the ARIA instrument for each initial evaluation and subsequent re-evaluation, drawing upon information from a face-to-face meeting with the applicant/participant and, if necessary, information from other parties familiar with the individual's conditions, functional limitations, and circumstances. The Office of Long Term Care (OLTC) will use the assessment results to evaluate level of care for the waiver and medical eligibility for the waiver.

The daily rate pays for all direct care services in the participants plan of care. These rates are exclusive of room and board.

Potential overlap of the scope of services is managed and monitored through MMIS.

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

N/A

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



**Participant-directed as specified in Appendix E**

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Level II Assisted Living Facility
Agency	Licensed Class A Home Health Agency

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Living Choices Assisted Living Services**

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**Provider Category:**

Agency

**Provider Type:**

Licensed Level II Assisted Living Facility

**Provider Qualifications**

**License** (*specify*):

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Level II Assisted Living Facility.

**Certificate** (*specify*):

**Other Standard** (*specify*):

Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual as well as be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA) as an Assisted Living Level II facility to be eligible to participate in the Arkansas Medicaid Program. A copy of the ALF's current license must accompany the provider application and Medicaid contract.

Providers must also be enrolled in the Arkansas Medicaid program as an Assisted Living Waiver Services Provider before reimbursement may be made for services provided to Living Choices clients. Provider participation requirements included training for provider staff. Training provisions include purpose and philosophy of the program; agency's written code of ethics; activities which shall or shall not be performed by the provider; record keeping; plan of care; procedure for reporting changes in a client's condition; and, a client's right to confidentiality. This training must be provided prior to the delivery of waiver services.

The facility must be located within the state of Arkansas.

Consistent with the authority and requirements of 42 CFR 455.470 (b) and (c) and with the concurrence of the federal Centers for Medicare and Medicaid Services (CMS), DPSQA may temporarily impose a moratoria, numerical caps, or other limits on the certification and enrollment of new assisted living facility providers in the Living Choices HCBS waiver program. If DPSQA determines temporary caps, limits, or moratoria are appropriate and would not adversely impact beneficiaries' access to assisted living facility services, it will initiate the process through filing a Request for State Implemented Moratorium (CMS-10628 Form) with CMS.

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

Division of Provider Services and Quality Assurance

##### **Frequency of Verification:**

Annual

## **Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Living Choices Assisted Living Services**

#### **Provider Category:**

Agency

#### **Provider Type:**

Licensed Class A Home Health Agency

#### **Provider Qualifications**

##### **License (specify):**

Licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, as a Class A Home Health Agency.

##### **Certificate (specify):**

**Other Standard** (*specify*):

Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual as well as be licensed by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance as a Class A Home Health Agency to be eligible to participate in the Arkansas Medicaid Program. A copy of the Class A Home Health Agency's current license must accompany the provider application and Medicaid contract. Providers must also be enrolled in the Arkansas Medicaid program as an Assisted Living Waiver Services Provider before reimbursement may be made for services provided to Living Choices clients. Provider participation requirements included training for provider staff. Training provisions include purpose and philosophy of the program; agency's written code of ethics; activities which shall or shall not be performed by the provider; record keeping; plan of care; procedure for reporting changes in a client's condition; and, a client's right to confidentiality. This training must be provided prior to the delivery of waiver services.

The facility must be located within the state of Arkansas.

Provider qualifications, licenses, training, education and experience for the staff of Home Health Agencies are the same as Medicaid enrolled Home Health Agencies.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Division of Provider Services and Quality Assurance

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

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

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

**As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

**As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

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

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## Appendix C: Participant Services

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

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

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

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

A criminal history record check is required for employees of long-term care facilities, according to Ark. Code Ann. §20-33-213. The Division of Provider Services and Quality Assurance (DPSQA), Office of Long-Term Care, requires state and national criminal history record checks on employees of long-term care facilities, including assisted living facilities. Employees include any person who has unsupervised access to participants; provides care to participants on behalf of a service provider, under supervision of, or by arrangement with the assisted living facility; is employed by the facility to provide care to participants; or, is a temporary employee placed by an employment agency with the facility to provide care to participants. Before making an offer of employment, the assisted living facility shall inform an applicant that employment is contingent on the satisfactory results of criminal history record checks.

When a facility operator applies for licensure to operate a long-term care facility, the operator shall complete a criminal record check form (DMS-736) and FBI fingerprint card obtained from the Office of Long Term Care. The forms and appropriate fees shall be submitted to the Office of Long Term Care attached to the application for licensure of the facility. Upon the determination that an applicant has submitted all necessary information for licensure, the Office of Long Term Care shall forward the criminal record check request form to the Arkansas State Police/Identification Bureau. Upon completion of the state and national record checks, the Bureau shall issue a report to the Office of Long Term Care for a determination whether the operator is disqualified from licensure. The determination results shall be forwarded to the facility seeking licensure.

Facilities are required to conduct initial criminal history record checks at the time of the first application and undergo periodic criminal record checks at least once every five years. Periodic criminal record checks shall be performed on all applicable employees on an ongoing basis. Each long-term care facility shall implement a schedule to conduct criminal record checks on applicable employees so that no applicable employee exceeds five years without a new criminal record check.

Facilities are required to comply with AR DHS Policy 1088.2.3, DHS Participant Exclusion Rule.

In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's claims processing contractor.

Home Health Agencies that contract with the ALF's must meet the same requirements for initial criminal history record checks.

Criminal history/background investigations in LTC/NF facilities are monitored through the Office of Long Term Care Licensing and Surveying Unit.

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

**No. The State does not conduct abuse registry screening.**

**Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

The Division of Provider Services and Quality Assurance (DPSQA), Office of Long-Term Care, requires that assisted living facilities conduct adult abuse registry checks on employees prior to licensure. The facility must provide documentation that employees have not been convicted or do not have a substantiated report of abusing or neglecting residents or misappropriating resident property. The facility shall, at a minimum, prior to employing any individual or for any individuals working in the facility through contract with a third party, make inquiry to the Employment Clearance Registry of the Office of Long Term Care and the Adult Abuse Register maintained by the Adult Protective Services Unit within the Division of Aging, Adult, and Behavioral Health Services. Employees must be re-checked every five years. The Office of Long Term Care requires that each facility have written employment and personnel policies and procedures, which include verification that an adult abuse registry check has been completed.

Employees include any person who has unsupervised access to participants; provides care to participants on behalf of a service provider, under supervision of, or by arrangement with the assisted living facility; is employed by the facility to provide care to participants; or, is a temporary employee placed by an employment agency with the facility to provide care to participants.

The OLTC Licensing and Surveying Unit ensures that mandatory screenings have been conducted.

When a facility operator applies for licensure to operate a long-term care facility, the operator shall complete a criminal record check form (DMS-736) and FBI fingerprint card obtained from the Office of Long Term Care. The forms and appropriate fees shall be submitted to the Office of Long Term Care attached to the application for licensure of the facility. Upon the determination that an applicant has submitted all necessary information for licensure, the Office of Long Term Care shall forward the criminal record check request form to the Arkansas State Police/Identification Bureau. Upon completion of the state and national record checks, the Bureau shall issue a report to the Office of Long Term Care for a determination whether the operator is disqualified from licensure. The determination results shall be forwarded to the facility seeking licensure.

Facilities are required to conduct initial criminal history record checks at the time of the first application and undergo periodic criminal record checks at least once every five years. Periodic criminal record checks shall be performed on all applicable employees on an ongoing basis. Each long-term care facility shall implement a schedule to conduct criminal record checks on applicable employees so that no applicable employee exceeds five years without a new criminal record check.

Facilities are required to comply with AR DHS Policy 1088.2.3, DHS Participant Exclusion Rule.

In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's claims processing contractor.

Home Health Agencies that contract with the ALF's must meet the same requirements for initial criminal history record checks.

Criminal history/background investigations in LTC/NF facilities are monitored through the Office of Long Term Care Licensing and Surveying Unit.

## **Appendix C: Participant Services**

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

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

**No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

**Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

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

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

**No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

**Self-directed**

**Agency-operated**

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

**The State does not make payment to relatives/legal guardians for furnishing waiver services.**

**The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

All Living Choices waiver services may be provided by a family member of the participant when the family member is employed by the assisted living facility. Legally responsible family members or caregivers (spouse or legal guardian of the person) are prohibited from receiving reimbursement for direct provision of covered services for the Living Choices participant.

Living Choices waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual and be licensed as an Assisted Living Level II facility or Class A Home Health Agency.

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

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

**Other policy.**

Specify:

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

Living Choices provider enrollment is open and continuous. Prospective Living Choices Assisted Living Providers may contact the Medicaid program's Provider Enrollment Unit for information about becoming a provider. There are no restrictions applicable to requesting this information. This process is open and available to any interested party.

The website of the Division of Provider Services and Quality Assurance (DPSQA) lists information for potential Living Choices providers. In addition, the Office of Long Term Care within DPSQA provides information about becoming a waiver provider during the process of licensing facilities, upon request.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

#### **a. Methods for Discovery: Qualified Providers**

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

##### **i. Sub-Assurances:**

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



**Performance Measures**

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

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

**Performance Measure:**

**Number and percentage of providers, by provider type, which maintained its license to participate in the waiver program in accordance with State law and waiver provider qualifications. Numerator: Number of providers with maintained license; Denominator: Total number of providers.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MMIS Provider Report**

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

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percentage of providers, by provider type, which obtained the appropriate license in accordance with State law and waiver provider qualifications prior to delivering services. Numerator: Number of new providers with appropriate license prior to delivery of services; Denominator: Number of new providers.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MMIS Provider Report**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

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

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

**Performance Measure:**

**Number and percent of qualified providers will be licensed by the Division of Provider Services and Quality Assurance. Qualified providers will be offered using the freedom of choice list. Numerator: Number of providers with maintained license; Denominator: Total number of providers.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<input type="text"/>

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

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

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

**Performance Measure:**

**Number and percent of providers meeting waiver provider training requirement as evidenced by the in-service attendance documentation. Numerator: Number of providers indicating training by in-service attendance documentation; Denominator: Total number of providers.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider In-Service Attendance Documentation**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b>	<b>Annually</b>	<b>Stratified</b>

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

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

The state identifies and rectifies situations where providers do not meet requirements.

This is accomplished by monitoring certification/license expiration dates within MMIS and continuing communication with the Medicaid fiscal agent responsible for provider enrollment functions, and reviewing monthly reports that identify providers whose participation is terminated for inactivity or violations. Participation in provider training is documented and monitored through monthly activity reports.

The state verifies that providers meet required licensing or certification standards and adhere to other state standards. License expiration dates are maintained in the MMIS and tracked for all participating and active providers.

Each month the DHS RN receives a provider list for each county included in their geographical area. This provider list may be used at each assessment and reassessment to give the participant a choice of providers for each service included on the service plan. In addition, this list is used to identify the providers who are new or who have been reinstated in the program.

Providers are required to follow all guidelines in the Medicaid Provider Manual related to provider training of employees and staff orientation, including documentation requirements, provider participation requirements, and any penalties or sanctions applicable for noncompliance.

DPSQA and DAABHS work collaboratively to train providers on program policy, including documentation requirements, reporting, claims processing and billing, the Medicaid Provider Manual and other areas. This training is scheduled, at a minimum, two times per year based on training needs.

Training requirements are explained in the provider manual. In addition, DPSQA is responsible for contacting new providers according to program policy. These contacts provide information regarding proper referrals, eligibility criteria, documentation requirements, forms, reporting, general information about the program, Section II of the Medicaid provider manual, and claims processing problems, etc. Within three months of appearing on the provider list, each new provider must meet with the DHS RN face-to-face to discuss all of the above, plus any problems noted in the first three months of participation.

Evaluations from in-services are used to address strengths and weaknesses in the training process, topics for future in-services and policy enhancements. As a result of in-services, policy clarifications have been issued; forms have been revised; training topics have been chosen; documentation requirements have been revised; training sessions have been redesigned.

The Medicaid fiscal agent provides DPSQA access to Provider License/Certification Status. If needed, this provides a second monitoring tool for monitoring licensure compliance.

The mandatory Medicaid contract, signed by each waiver provider, includes compliance with required enrollment criteria. Failure to maintain required licensure results in loss of their Medicaid provider enrollment. Each provider is notified in writing at least two months prior to the licensure expiration date that renewal is due and failure to maintain proper licensure will result in loss of Medicaid enrollment.

In accordance with the Medicaid provider manual, the provider must require staff to attend orientation training prior to allowing the employee to deliver any waiver services. This orientation shall include, but not be limited to, descriptions of the purpose and philosophy of the Living Choices program; discussion and distribution of the provider agency's written code of ethics; activities which shall and shall not be performed by the employee; instructions regarding Living Choices record keeping requirements; the importance of the service plan; procedures for reporting changes in the participant's condition; discussion, including potential legal ramifications, of the participant's right to confidentiality.



All waiver providers are responsible for all provider requirements, penalties and sanctions as detailed in the Medicaid provider manual.

Non-licensed/non-certified providers are not allowed to provide services under this waiver.

**b. Methods for Remediation/Fixing Individual Problems**

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

To continue Medicaid enrollment, a waiver provider must maintain certification by DPSQA. In cases where providers do not maintain certification, DPSQA’s remediation may include requesting termination of the provider’s Arkansas Medicaid enrollment, recouping payment for services provided after certification/licensure has expired, and allowing the participant to choose another provider.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

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

**No**

**Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

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### C-4: Additional Limits on Amount of Waiver Services

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

**Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable** - The State imposes additional limits on the amount of waiver services.

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

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

*Furnish the information specified above.*

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

*Furnish the information specified above.*

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

*Furnish the information specified above.*

**Other Type of Limit.** The State employs another type of limit.

*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

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### C-5: Home and Community-Based Settings

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

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

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

Please see Module 1, Attachment #2 for the states HCB Settings Waiver Transition Plan.

Arkansas is still assessing settings compliance in accordance with the statewide transition plan.

## Appendix D: Participant-Centered Planning and Service Delivery

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

**State Participant-Centered Service Plan Title:**

Plan of Care

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

**Registered nurse, licensed to practice in the State**

**Licensed practical or vocational nurse, acting within the scope of practice under State law**

**Licensed physician (M.D. or D.O)**

**Case Manager** (qualifications specified in Appendix C-1/C-3)

**Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

**Social Worker**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

When scheduling the person-centered service plan development visit, the DHS Division of Aging, Adult, and Behavioral Health Services (DAABHS) registered nurse (DHS RN) explains to the participant or authorized representative the process and informs the participant that they may invite anyone they choose to participate in the service plan development process. Involved in this assessment visit is the participant and anyone they choose to have attend, such as their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment process or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting.

During the service plan development, the DHS RN explains to the participant the services available through the Living Choices waiver.

When developing the person-centered service plan, all services and any applicable benefit limits are reviewed, as well as the comprehensive goals, objectives and appropriateness of the services. The participant and their representatives participate in all decisions regarding the type of services, amount and frequency of the services included on the service plan. All services must be justified, based on need and available support services. This information is recorded on the service plan, which is signed by the participant.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

a) DHS RNs will develop initial person-centered service plans for Living Choices participants based on the Independent Assessment Contractor's assessment of the participant's needs and information gathered during the service plan development meeting with the participant. The DHS RN will inform participants that they may invite anyone that they choose to participate in the service plan development process. Involved in this service plan development visit is the participant, their family, their representative, caregivers, and any other persons identified by the participant or family as having information pertinent to the assessment or service plan development process. It is the participant or family member's responsibility to notify interested parties to attend the service plan development meeting. The DHS RN will assist in notifying interested parties if requested by the participant or the representative.

The development of the person-centered service plan will begin with an in-person independent assessment conducted by the DHS Independent Assessment Contractor. The Independent Assessment Contractor will contact the waiver participant to schedule a convenient time and location for the assessment. The assessment will be scheduled and completed by the Independent Assessment Contractor within 10 working days of the Independent Assessment Contractor receiving a referral from DHS. Following the assessment and assignment of a tier level by the Independent Assessment Contractor, a DHS RN will schedule a meeting with the participant to develop the service plan. Reassessments, which will be conducted by the Independent Assessment Contractor, will be completed annually or more often, if deemed appropriate by the DHS RN. Following the reassessment by the Independent Assessment Contractor, the DHS RN will develop a person-centered service plan. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Service plans are developed and sent to all providers before services may begin.

(b) The Independent Assessment Contractor will assess the participant's needs. The DHS RN will assess the participant's comprehensive goals and objectives related to the participant's care and reviews the appropriateness of Living Choices services. If necessary, the DHS RN will read any of the information provided during the assessment to the participant. If this is done, it is documented in the participant's record. All forms and information will be provided in an alternate format upon request. If an alternate format is requested and/or provided, the DHS RN will document in the participant's record the format requested and/or provided.

All accommodations are provided on an individualized basis according to the participant's needs. DHS has a contract with an interpreter to accommodate applicants/participants who are hearing impaired. The Independent Assessment Contractor and the DHS RNs will provide written materials to participants and will read any information to participants if needed. DHS RNs may utilize assistance from other divisions within the Arkansas Department of Human Services, such as the Division of Services for the Blind, in these instances. When this occurs, it is documented in the participant's record.

The results of the Independent Assessment Contractor's functional assessment using the ARIA assessment tool will be used by the Office of Long Term Care to evaluate the level of care and by the DHS RN to develop the person-centered service plan. Information collected for the Independent Assessment Contractor's functional assessment using the ARIA tool will include demographic information and information on the waiver participant's ability to perform the activities of daily living; transferring and ambulation; continence status; nutritional status; hearing, vision, speech and language; skin condition; behavior and attitude; orientation level; other medical conditions; psychosocial and cognitive status; and, medications/treatments.

The assessment is a complete functional assessment and includes a medical history. The Independent Assessment Contractor will evaluate the participant's physical, functional, mental, emotional and social status, and will obtain a medical history to ensure that the service plan addresses the participant's strengths, capacities, health care, and other needs. The DHS RN will assess the participant's preferences, goals, desired outcomes, and risk factors. Support systems available to the participant are identified and documented, along with services currently in place. Based on this assessment information, the DHS RN will discuss the service delivery plan with the participant.

When the service plan development process results in an individual being denied the services or the providers of their

choice, the state must afford the individual the opportunity to request a Fair Hearing.

**Provisional (Temporary Interim) Service Plan Policy:** A provisional person-centered service plan may be developed by the DHS RN prior to determination of Medicaid eligibility, based on information obtained during the in-home functional assessment if the applicant is functionally eligible based on the Independent Assessment Contractor's assessment AND if the DHS RN believes, in his or her professional judgment, the individual meets the level of care criteria. The DHS RN must discuss the

Provisional Service Plan Policy and have approval from the applicant prior to completing and processing a provisional service plan, which will then be signed by the applicant or the applicant's representative and the DHS RN. The provisional service plan will be provided to the waiver applicant and each provider included on the service plan. The provider will notify the DHS RN via form AAS-9510 (Start of Care Form), indicating the date services begin. No provisional service plans will be developed if the waiting list process has been implemented.

Provisional person-centered service plans expire 60 days from the date signed by the DHS RN and the participant. A comprehensive service plan that has been approved with a Medicaid number and waiver eligibility date must be in place no later than the expiration date of the provisional service plan. Prior to its expiration date, the DHS RN will provide a signed, comprehensive service plan to the Living Choices provider.

The Independent Assessment Contractor will complete a face-to-face functional assessment within 10 working days of receiving a referral from DHS. The DHS RN meets with the participant and develops a Living Choices person-centered service plan. Once the service plan is signed by the DHS RN and the applicant, it is considered a provisional service plan.

If services are started based on the provisional service plan, providers will send the Start of Care (AAS-9510) form to the DHS RN indicating the date services started. No additional notification to the DHS RN is required when the comprehensive service plan is received.

(c) During the person-centered service plan development process, the DHS RN explains the services available through the Living Choices waiver to the participant, including any applicable benefit limits. All services the participant is currently receiving are discussed and documented on the person-centered service plan. This includes all medical and non-medical services, such as diapers, under pads, nonemergency medical transportation, family support or other services that are routinely provided.

(d) The DHS RN develops the person-centered service plan based on the information gathered through the assessment process and the discussion of available services with the participant. The service plan addresses the participant's needs, goals and preferences. The participant may invite anyone they choose to participate in the assessment and service plan development process, including family members and caregivers. Also, the DHS RN may contact anyone who may be able to provide accurate and pertinent information regarding the participant's condition and functional ability.

If there is any indication prior to or during the assessment or person-centered service plan development process that the participant is confused or incapable of answering the questions required for a proper assessment and service plan development, the assessment or service plan development will not be conducted without another person present who is familiar with the participant and his or her condition. This may be a family member, friend, neighbor, caregiver, etc. If unavailable for the interview, this person may be contacted by phone. These individuals' participation in the service plan development process also helps to ensure that the participant's goals, preferences and needs are met.

When developing or updating the person-centered service plan, the participant and their representatives participate in all decisions regarding the types, amount and frequency of the services included on the service plan. All services must be justified, based on need and available support services.

(e)- The participant must choose a provider for each waiver service selected. During the service plan development

process, the DHS RN informs the participant or their legal guardian or family member of the available services. The participant or guardian/family member may choose the providers from which to receive services. Documentation verifying freedom of choice was assured is included in the participant's record on the person-centered service plan, and on the provider list. Both documents reflect freedom of choice was given to the participant. The freedom of choice form and all related documents are included in the participant's record and reviewed during the DHS RN supervisory review process. Each service included on the service plan is explained by the DHS RN. The amount, frequency, scope and provider of each service is also discussed and entered on the service plan. The DHS RN sends a copy of the service plan to the waiver provider, as well as the participant. The DHS RN tracks the implementation of each service through the Start of Care form, which includes the date services begin.

(f)- Implementation, compliance, and monitoring of the person-centered service plan is the responsibility of DAABHS (Operating Agency), DMS (Medicaid Agency), and providers of Living Choices Assisted Living waiver services.

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the participant's condition to the DHS RN, who is the only authorized individual who may adjust a participant's service plan. Providers agree to render all services in accordance with the Arkansas Medicaid Living Choices Assisted Living Home & Community Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAABHS; to notify the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or necessitate a change in the participant's person-centered service plan; to continually monitor participant satisfaction and quality of service delivery; and, to notify the DHS RN in writing within one week of services being terminated, documenting the termination effective date and the reason for the termination.

Providers assure DPSQA that adequate staffing levels are maintained to ensure timely and consistent delivery of services to all participants for whom they have accepted a Living Choices Assisted Living service plan. Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the service plan developed by the DHS RN. Providers acknowledge that the DHS RN is the only authorized individual who may adjust a Living Choices Assisted Living waiver participant's service plan. Providers will implement the service plan with the flexibility to schedule hours to best meet the needs of the participant and will be monitored by DAABHS for compliance.

Service plans are revised by DHS RNs as needed between assessments, based on reports secured through providers, waiver participants and their support systems.

(g)- Each reassessment and person-centered service plan development is completed annually or more often, if deemed appropriate by the DHS RN. The service plan may be revised at any time, based on information relevant to the participant's condition or circumstances. Changes are reported to the DHS RN by the participant, the participant's family or representatives and service providers. The DHS RN has sole authority for all development and revisions to the waiver service plan. Service plan updates must be based on a change in the participant's status or needs.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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



The Independent Assessment Contractor will assess a participant's needs, functional abilities, and performance of activities of daily living during the assessment. The DHS RN assesses a participant's preferences, risks, dangers, and supports during the meeting with the participant to develop a person-centered service plan. In addition, the service plan development process includes assessment of risk factors and strategies to mitigate risk conducted in a manner that is sensitive to the waiver participant's preferences and the responsibilities required to reduce risk. The risk mitigation includes factors regarding the participant's functioning ability, ADL performance, support systems in place, risk of falls, environmental factors, and other dangers. This information is included on the person-centered service plan and in the participant's record. Services are started as soon as possible in order to mitigate risk.

The person-centered service plan also includes contact information for emergency care and backup plans. The name of a backup caregiver, or the person responsible for the participant, must be included on the person-centered service plan. Backup caregivers are often family members, neighbors or others familiar with the participant.

Routine monitoring of Living Choices Assisted Living participants also helps to assess and mitigate risk. DHS RNs make at least annual contact with participants and take action to mitigate risks if an issue arises.

Also, providers, family members and others who have regular contact with participants are required to report any change in participant condition, or perceived risk or other problem concerning the participant. The DHS RNs also re-evaluate potential participant risks during each reassessment and during monitoring visits. DHS RNs refer any high-risk participants to Adult Protective Services immediately if it is felt that the participant is in danger. DHS RNs also provide patient education on safety issues during the assessment and annual reassessment. The annual contact by the DHS RN is a minimum contact standard. Visits are made as needed during the interim.

Service providers are required to follow all guidelines in the Medicaid Provider manual related to emergencies, including the emergency backup plan process and contact information for emergencies. The provider assures DAABHS all necessary safeguards and precautions have been taken to protect the health and welfare of the participants they serve. Providers agree to operate and provide services in full compliance with all applicable federal, state and local standards including, but not limited to, fire, health, safety and sanitation standards prescribed by law or regulations. Providers assure DAABHS that conditions or circumstances which place a person, or the household of a person, in imminent danger will be brought to the attention of appropriate officials for follow-up. Providers agree to inform the DHS RN immediately of any change in the participant's physical, mental or environmental needs the provider observes or is made aware of that may affect the participant's eligibility or would necessitate a change in the participant's service plan.

Also, participants, family members or the participant's representative may also contact the DHS RN any time a change is needed or a safety issue arises. Additional monitoring is performed by DMS as part of the validation review, by Office of Medicaid Inspector General audits, and in response to any complaints received.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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

The participant must choose a provider for each waiver service selected. When a person-centered service plan is developed, the DHS RN must inform the individual, their representative, or family member of all qualified Living Choices Assisted Living qualified providers in the individual's service delivery area. The participant, representative, or guardian/family member may choose the providers from which to receive services. The name of the providers chosen by the participant, representative, or family member/representative must be included on the person-centered service plan prior to securing the individual's signature. Along with signing the service plan, and the Freedom of Choice form, an up-to-date provider listing from DPSQA must be signed and initialed. If a family member/representative chooses a provider for the participant, the DHS RN must identify the individual who chose the providers on the service plan and on the Freedom of Choice form. Documentation is also included in the participant's record and reviewed during the DHS RN supervisory review process.

For reassessments, the participant or representative must sign the Freedom of Choice form to show that no change in providers was made. The provider listing does not need to be initialed if there are no changes in providers. However, if a participant wishes to change providers at reassessment, both the Freedom of Choice form and provider listing must be signed and initialed indicating this change. Participants may request a change of providers at any time during a waiver year.

The participant chooses the provider. However, the participant may invite his or her family members or representative to participate in the decision-making process. Any decision made by a family member or representative is done at the participant's request and is documented.

DHS RNs leave contact information with participants at each visit. The participant may contact the DHS RN at any time to find out more information about providers.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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

All waiver service plans are subject to the review and approval by both the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) and the Division of Medical Services (DMS) (Medicaid agency).

DMS does not review and approve all service plans prior to implementation; however, all are subject to the Medicaid Agency's approval. DAABHS reviews a statistically valid random sampling of participant records which includes the service plan, and DMS reviews 20% of the records reviewed by DAABHS. Reviewed service plans are compared to policy guidelines, the functional assessment, and the narrative detailing the participant's living environment, physical and mental limitations, and overall needs. All service plans are subject to the approval of the Medicaid Agency and are made available by the operating agency upon request. DMS randomly reviews service plans through several authorities within the Medicaid Agency, such as Program Integrity and the Quality Assurance unit.

A statistically valid random sample of service plans is determined, using the Raosoft software calculations program, for review monthly by the DHS RN supervisory staff to assess the appropriateness of the service plan, to validate service provision, to ensure that services are meeting the waiver participant's needs and that necessary safeguards have been taken to protect the health and welfare of the participant and to profile provider billing practices. In the event the service plan is deemed inappropriate or service provision is lacking, the DHS RN addresses any needed corrective action. In the event provider billing practices are suspect, all pertinent information is forwarded to the DPSQA Program Integrity Unit or DPSQA QA Unit.

Each year, DAABHS reports to the DPSQA Waiver Quality Management Administrator the findings of the service plan review process.

Information reviewed by both DAABHS and DMS during the record review process includes without limitation: development of an appropriate individualized service plan, completion of updates and revisions to the service plan and coordination with other agencies as necessary to ensure that services are provided according to the service plan.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

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

**Medicaid agency**

**Operating agency**

**Case manager**

**Other**

*Specify:*

The service plan is maintained by the DHS RN in the participant's record and by the Living Choices waiver provider.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

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

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) employs Registered Nurses (DHS RNs) who are responsible for monitoring the implementation of the person-centered service plans (PCSP). When the DHS RN sends the person-centered service plan to the provider for implementation, he/she also sends a start of care form along with the PCSP. The provider is required to document the date the service began and return the form to the DHS RN. If the start of care form is not returned to the DHS RN within 10 business days, the DHS RN contacts the provider about the status of implementation. If the provider is unable to provide the service, the DHS RN contacts the participant and offers other qualified providers for the service. The DHS RN is only required to have one start of care form per service in the participant record if services remain at the same level by the same provider when reassessed. If the amount of service changes or the provider of the service changes a new start of care form is required.

DHS RNs monitor each waiver participant's status on an as-needed basis for changes in service need, reassessment, if necessary, and reporting any participant complaints of violations of rules and regulations to appropriate authorities for investigation. If participants are unable to participate in a monitoring contact, the participant may invite anyone they choose to participate in the visit. Most often this is the participant's legal representative, guardian or family member.

At each assessment and reassessment, the DHS RN provides the participant with their business card with contact information, an Adult Protective Services (APS) brochure to provide information and the toll-free APS hotline for reporting abuse, maltreatment or exploitation. This information may be utilized by the participant or guardians/family members to report any issues they deem necessary, so that DAABHS can ensure prompt follow-up to problems.

#### INFORMATION EXCHANGE:

Both DMS and DAABHS perform regular reviews to support proper implementation and monitoring of the service plan. Record reviews are thorough and include a review of all required documentation regarding compliance with the service plan development assurance. Reviews include, but are not limited to, completeness of the service plan; timeliness of the service plan development process; appropriateness of all medical and non-medical services; consideration of participants in the service plan development process; clarity and consistency; and, compliance with program policy regarding all aspects of the service plan development, changes and renewal.

The Division of Medical Services QA review reflects internal review of the billing process by Living Choices Medicaid providers. DAABHS conducts a record review on a monthly basis to monitor accuracy and completeness of the record, service plan implementation, service delivery, and the health and welfare of the participant, and DMS reviews 20% of the records reviewed by DAABHS. The DAABHS review completes a systematic random sampling of the active case population whereby every "nth" name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate sample size for this waiver population. To determine the "nth" integer, the sample is divided by the population. Those names are drawn until the sample size is reached.

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

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

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

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

## Appendix D: Participant-Centered Planning and Service Delivery

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### Quality Improvement: Service Plan

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

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

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

**i. Sub-Assurances:**

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of participants reviewed who had service plans that were adequate and appropriate to their needs as indicated by the assessment(s).**

**Numerator: Number of participants with service plans that address needs;**

**Denominator: Number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

Responsible Party for	Frequency of data	Sampling Approach
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<b>data collection/generation</b> <i>(check each that applies):</i>	<b>collection/generation</b> <i>(check each that applies):</i>	<i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;">             DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.           </div>
<b>Other</b> Specify:  <input data-bbox="408 1438 647 1527" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input data-bbox="1078 1438 1264 1527" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input data-bbox="1078 1675 1264 1765" type="text"/>
	<b>Other</b> Specify:  <input data-bbox="718 1912 954 2002" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**Performance Measure:**

**Number and percent of participants reviewed who had service plans that addressed personal goals. Numerator: Number of participants service plans that address personal goals; Denominator: Number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>



<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of participants reviewed who had service plans that addressed risk factors. Numerator: Number of participants service plans that address risk factors; Denominator: Number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of service plan development procedures that are completed as described in the waiver application. Numerator: Number of participants service plans completed according to waiver procedures; Denominator: Number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>

<p><b>Sub-State Entity</b></p>	<p><b>Quarterly</b></p>	<p><b>Representative Sample</b> Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px;"> <p>DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.</p> </div>
<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p><b>Annually</b></p>	<p><b>Stratified</b> Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<p><b>Responsible Party for data aggregation and analysis</b> (<i>check each that applies</i>):</p>	<p><b>Frequency of data aggregation and analysis</b>(<i>check each that applies</i>):</p>
<p><b>State Medicaid Agency</b></p>	<p><b>Weekly</b></p>
<p><b>Operating Agency</b></p>	<p><b>Monthly</b></p>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of service plans that were reviewed and updated by the DHS RN according to changes in participants' needs before the waiver participants' annual review date. Numerator: Number of participants service plans that were reviewed and revised by the DHS RN before annual review date; Denominator: Number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
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<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;"> DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other Specify:</b>  <input type="text"/>
	<b>Other Specify:</b>  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of participants reviewed who received services in the type, scope, amount, frequency and duration specified in the service plan. Numerator: Number of participants service plans who received services specified in the service plan; Denominator: Number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data</b>	<b>Frequency of data collection/generation</b>	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
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<b>collection/generation</b> (check each that applies):	(check each that applies):	
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;"> DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other Specify:</b>  <input type="text"/>
	<b>Other Specify:</b>  <input type="text"/>	



**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of waiver participant records reviewed with appropriately completed and signed freedom of choice forms that specified choice of providers was offered. Numerator: Number of participants with freedom of choice forms with choice of providers; Denominator: Number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data</b>	<b>Frequency of data collection/generation</b>	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
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<b>collection/generation</b> (check each that applies):	(check each that applies):	
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;"> DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other Specify:</b>  <input type="text"/>
	<b>Other Specify:</b>  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**Performance Measure:**

**Number and percent of waiver participant records reviewed with an appropriately completed service plan that specified choice was offered between institutional care and waiver services and among waiver services. Numerator: Number of participants' service plans with a choice between institutional care and waiver services and among waiver services; Denominator: Number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample Confidence</b>

		Interval =  DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
Specify: <input data-bbox="405 360 799 450" type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input data-bbox="868 663 1262 752" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The state currently operates a system of review that assures completeness, appropriateness, accuracy and freedom of choice. This system focuses on participant-centered service planning and delivery, participant rights and responsibilities, and participant outcomes and satisfaction.

Individual records are reviewed monthly by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) for completeness and accuracy and resulting data is made available for the production of the Record Review Summary Report. A Division of Medical Services (DMS) (Medicaid agency) QA audit is also conducted from a review of 20% of the records reviewed by DAABHS, to confirm that service plans are updated and revised as warranted by changes in participants' needs.

Start of Care forms are reviewed to confirm the appropriateness of service delivery.

Finally, records are reviewed to assure that a Freedom of Choice form was presented to the participant and that a complete, up-to-date list of providers has been made available to the participant.

The state monitors service plan development in accordance with its policies and procedures, and takes appropriate action when it identifies inadequacies in the development process. Revisions and updates to records are made as changes in participant needs necessitate. Monthly chart reviews check for the presence of justification for requested changes and proper documentation and data is summarized for the Chart Review Summary.

Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers.

Remediation is performed on service plans that require correction or revision. This is accomplished as discrepancies or inadequacies are identified. Confirmation of remediation is verified by the RN supervisor and is a part of the chart review process.

The Division of Medical Services (DMS) QA review reflects internal review of the billing process by Medicaid providers of ALF. DMS conducts a record review on a monthly basis of 20% of the records reviewed by DAABHS to monitor accuracy and completeness of the record, service plan implementation, service delivery, and the health and welfare of the participant.

DAABHS supervisory staff uses the Raosoft calculation system to determine appropriate sample size for Chart Review and selects every "nth" name on the list to be included in the sample.

Record reviews of the overall program files are thorough and include a review of all required documentation regarding compliance with the service plan development assurance and service plan delivery. Reviews include, but are not limited to completeness of the service plan; timeliness of the service plan development process; appropriateness of all medical and non-medical services; consideration of participants in the service plan development process; clarity and consistency; and, compliance with program policy regarding all aspects of service plan development, changes and renewal.

Some measures have multiple factors that are reviewed to determine if the area is in compliance. These measures are directly related to the CMS waiver assurance areas, including service plan development and delivery of services. Initial verification of service delivery is verified via the Start of Care form. This documentation is a part of every record review.

The State Medicaid Agency assures compliance with the service plan subassurances through the review of 20% of the records reviewed by DAABHS. DAABHS provides DMS with copies of any data analysis of the findings and plans for remediation of data analysis, including trend identification. DMS and DAABHS participate in team

meetings to review findings and discuss resolution.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency), the Division of Provider Services and Quality Assurance (DPSQA) (operating agency), and the Division of Medical Services (DMS) (Medicaid agency) participate in team meetings to discuss and address individual problems related to service plans, as well as problem correction and remediation. DAABHS, DPSQA, and DMS have an Interagency Agreement that includes measures related to the service plans as part of the waiver.

If a participant record lacks required documentation regarding this assurance, DAABHS's remediation includes completing the required documentation according to policy and additional staff training in this area.

The tool used to review waiver participants' records captures and tracks remediation in these areas.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

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**Applicability** (from Application Section 3, Components of the Waiver Request):

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (select one):

**Yes. The State requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-1: Overview (2 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-1: Overview (3 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-1: Overview (5 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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### E-1: Overview (6 of 13)



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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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E-1: Overview (7 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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E-1: Overview (8 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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E-1: Overview (9 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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E-1: Overview (10 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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E-1: Overview (11 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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E-1: Overview (12 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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E-1: Overview (13 of 13)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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E-2: Opportunities for Participant Direction (1 of 6)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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E-2: Opportunities for Participant-Direction (2 of 6)

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

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## **E-2: Opportunities for Participant-Direction (3 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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### **Appendix E: Participant Direction of Services**

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#### **E-2: Opportunities for Participant-Direction (4 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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### **Appendix E: Participant Direction of Services**

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#### **E-2: Opportunities for Participant-Direction (5 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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### **Appendix E: Participant Direction of Services**

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#### **E-2: Opportunities for Participant-Direction (6 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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### **Appendix F: Participant Rights**

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#### **Appendix F-1: Opportunity to Request a Fair Hearing**

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appeals are the responsibility of the Department of Human Services Appeals and Hearings section. Waiver applicants are advised on the DCO-707 (Notice of Action) or the system-generated Notice of Action by the County Office of their right to request a fair hearing when adverse action is taken to deny, suspend or terminate eligibility for Living Choices. The notice is issued by the LTSS caseworker, and explains the participant's right to a fair hearing, how to file for a hearing and the participant's right to representation. Notices of adverse actions and the opportunity to request a fair hearing are kept in the participant's case record. Applicants must make their request for an appeal no later than 30 days from the date on the DCO-707.

The DCO-707 Notice of Action is kept in the participant's county office case record. If the DCO-707 is a request for information only, the form may be discarded when all the needed information is received. If the information requested is not received, the form may be discarded five years from the month of origin. Otherwise, the DCO-700 will be retained for five years from the date of last approval, closure or denial.

Participants also have the right to appeal if they disagree with a revision to their service plan, which reduces or terminates services, while their eligibility remains active. Information regarding hearings and appeals is included with the participant's service plan. The DHS Appeals and Hearings section is also responsible for these types of appeals. Requests for appeals must be received by the DHS Appeals and Hearings section no later than 30 days from the business day following the postmark on the envelope with the service plan that contains a revision which the participant wishes to appeal.

Living Choices participants have the option of continuing Medicaid eligibility and services during the appeal process. They are informed of their options when notified by the DHS county office of the pending adverse action. If the findings of the appeal are not in the participant's favor, and the participant has elected the continuation of benefits, the participant is liable for payment to the provider. If Medicaid has paid the provider, DHS will consider the services that were provided during the period of ineligibility a Medicaid overpayment and will seek reimbursement from the participant.

Participants have the right to appeal if they were not provided a choice in institutional care or waiver services, or a choice of providers.

The assisted living facility and the Department of Human Services county office inform the participant of their potential payment liability if a participant has been denied eligibility for the program and if an appeal of a denial is not in the participant's favor.

During the assessment and service plan development process, the DHS RN explains these rights to the participant, family member or representative. Signatures on the service plan verify that the choice between waiver services or institutional care was exercised. Also, during this process, participants choose a provider from a list provided by the DHS RN. Choices of provider are documented on the Freedom of Choice form, and the participant signs the list of providers showing that the choice was made. At reassessments, if no change in provider is requested, the provider list is not signed by the participant.

## Appendix F: Participant-Rights

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### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

**No. This Appendix does not apply**

**Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

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### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

**No. This Appendix does not apply**

**Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Division of Aging, Adult, and Behavioral Health Services

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any dissatisfaction written or verbalized regarding a HCBS program or service is to be considered a complaint. Participants wishing to file a complaint or report any type of dissatisfaction should contact the DAABHS Central Office or their DHS RN. When a DHS RN is contacted regarding a complaint or dissatisfaction, the DHS RN explains the complaint process to the participant, and completes the HCBS Complaint Intake Report (AAS-9505). Any DAABHS staff receiving a complaint must complete the HCBS Complaint Intake Report.

The HCBS Complaint Intake Report (AAS-9505), along with the complaint database, is used to track any dissatisfaction or complaint, including complaints against DAABHS staff and DPSQA providers. The record of complaint includes the date the complaint was filed.

The complaint database was designed to register different types of complaints. Based on the data entered, the complaint can be tracked by type of complaint (service, provider, DAABHS, etc.) and complaint source (participant, county office, family, etc.), and monitored for trends, action taken to address the complaint, access, quality of care, health and welfare. The complaint database provides a means to address any type complaint filed by any source. The complaint database also tracks resolution.

Information entered into the database includes the complaint source and contact information, participant information, person or provider for whom the complaint is being made against, the person who received the complaint, the person to whom the complaint is assigned for investigation, the complaint being made, and the action taken relative to investigation findings.

Complaints concerning abuse and neglect are routed to Adult Protective Services immediately for appropriate action.

The HCBS Complaint Intake Report (AAS-9505) must be completed within five working days of receiving the complaint. Complaints must be resolved within 30 days from the date the complaint was received. If a complaint cannot be resolved by an RN supervisor, the information is forwarded to the DAABHS central office administrative staff to resolve.

DHS RNs and RN supervisors work to resolve any complaints. This involves contacting all parties involved to obtain all sides of the issue, a participant home visit and a review of the participant's service plan, if necessary. The Nurse Manager at the DAABHS central office may also be asked to assist. Based on the nature of the complaint, the Nurse Manager will use their professional judgment on issues that must be resolved more quickly, such as instances where the participant's health and safety are at risk. Compliance with this policy is tracked and reported through the database. This issue continues to be tracked and reviewed by the RN Supervisors and the Medicaid Quality Assurance staff during the chart review process.

A follow-up call or correspondence is made to the reporter, if appropriate, to discuss how the issue was resolved without violating confidentiality rules. The participant or representative is informed of the right to appeal any decision and that filing a complaint is not a prerequisite or substitute for a fair hearing.

If a participant is dissatisfied with the resolution of a complaint, a fair hearing request may be made at the local DHS county office. The DHS RN explains the hearings and appeals process to the participant at this time.

DHS RNs follow-up with participants after a complaint has been made at each reassessment or monitoring contact. DHS RN supervisors may also participate in follow up. Depending on the type of complaint, the DHS RN may take action to assure continued resolution by revising the participant's service plan or assisting the participant in changing providers.

A complaint received on a DHS RN is reported to his or her supervisor, who investigates the complaint.

The Complaint Intake Report must be completed within five working days from when DAABHS staff receives the complaint. Complaints must be resolved within 30 days. To ensure that participants are safe during these time frames, the DHS RN may put in place the backup plan on the participant's service plan or report the situation to Adult Protective

Services, if needed.

## Appendix G: Participant Safeguards

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### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Arkansas state law requires that suspected abuse, neglect, and exploitation of endangered and impaired adults be reported to the Adult Maltreatment Hotline for investigation. The method of reporting is primarily by phone to the Hotline; written reports of allegations will be entered into the Adult Protective Services system or routed to the appropriate investigative department.

Ark. Code Ann. § 12-12-1708(a) specifies mandatory reporters who are required to report suspected adult maltreatment, including abuse, exploitation, neglect, or self-neglect of endangered or impaired adults. Mandated reporters include all physicians, nurses, social workers, case managers, home health workers, DHS employees, facility administrators or owners, employees of facilities, and any employee or volunteer of a program or organization funded partially or wholly by DHS who enters the home of, or has contact with an elderly person. Living Choices waiver staff, providers, and DAABHS contractors are mandatory reporters. The statute requires immediate reporting to Adult Protective Services when any mandated reporter has observed or has reasonable cause to suspect adult maltreatment.

According to the statute, adult abuse includes intentional acts to an endangered or impaired adult which result in physical harm or psychological injury; or credible threats to inflict pain or injury which provoke fear or alarm; or unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. Exploitation includes illegal or unauthorized use of the person's funds or property; or use of the person's power of attorney or guardianship for the profit of one's own self; or improper acts or process that deprive the person of rightful access to benefits, resources, belongings and assets. Neglect is an act or omission by the endangered or impaired person (self-neglect), or an act or omission by the person's caregiver (caregiver neglect) constituting failure to provide necessary treatment, care, food, clothing, shelter, supervision or medical services; failure to report health problems and changes in health condition to appropriate medical personnel; or failure to carry out a prescribed treatment plan.

Reporting requirements for providers:

In addition to statutory requirements, the Division of Provider Services and Quality Assurance, the licensing and certification agency, requires home and community-based services (HCBS)/non-institutional providers to report the following incident types:

- (a) Abuse
- (b) Neglect
- (c) Exploitation or Misappropriation of Property
- (d) Unnatural Death
- (e) Unauthorized use of restrictive interventions
- (f) Significant Medication Error
- (g) Elopement/Missing Person
- (h) Other: Includes without limitation abandonment, serious bodily injury, incidents that require notification to police or fire department.

In accordance with DPSQA Policy 1001, the above events must be reported to the Division of Provider Services and Quality Assurance by facsimile transmission to telephone number 501-682-8551 of the completed Incident & Accident Intake Form (Form DPSQA-731) no later than 11:00 a.m. on the next business day following discovery by the provider. In addition to the requirement of a facsimile report by the next business day, the provider must conduct a thorough investigation of the alleged or suspected incident and complete an investigation report and submit it to DPSQA on Form DPSQA-742 within five working days.

Reporting requirements for DHS employees and contractors:

DHS employees and contractors are required to report incidents in accordance with DHS Policy 1090 (Incident Reporting). Under this policy, any incident requiring a report to the DHS Communications Director must be reported by telephone within one hour of the incident. All other reports must be filed with the Division Director or Designee and the DHS Client Advocate no later than the end of the second business day following the incident. Any employee not filing reports within the specified time is subject to disciplinary action unless the employee can show that it was not physically

possible to make the report within the required time.

Telephone notifications and informational e-mails to Division Directors or Designees, the DHS Client Advocate and other parties as appropriate for early reporting of unusual or sensitive information are welcomed. All such reports must be followed with completion and submission of Form DHS-1910.

If the incident alleges maltreatment by a hospital, a copy of the report will be sent to the Arkansas Department of Health by the Division Director or Designee, who should note the notification in the appropriate space on the Form DHS-1910, and forward the information to the DHS Client Advocate as a follow up Incident Report.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The DHS RN provides waiver applicants and their families with an Adult Protective Services (APS) brochure when initial contact is made. The brochure includes information on what constitutes abuse, neglect or exploitation, as well as the signs and symptoms, the persons required to report abuse and how to report suspected abuse, including to the Adult Maltreatment Hotline number. The Adult Maltreatment Hotline is accessible 24 hours a day, seven days a week. DHS RNs review this information with participants and family members at the initial assessment and at each annual reassessment. In addition, providers are required to post information about how to report a complaint to APS and the Adult Maltreatment Hotline in a visible area on their premises.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.



For incidents involving alleged abuse, neglect, and exploitation regarding adult clients, Adult Protective Services (APS) receives, investigates, evaluates, and resolves reports. Additionally, all incidents defined in DPSQA Policy 1001 must be reported to Division of Provider Services and Quality Assurance (DPSQA). These include alleged abuse, neglect, and exploitation, unnatural death, unauthorized use of restrictive interventions, significant medication error, elopement/missing person, abandonment, serious bodily injury, and incidents requiring notification to the police or fire department.

#### Adult Protective Services (APS) Responsibilities

APS visits clients within 24 hours for emergency cases or within five working days for non-emergency cases. Emergency cases are instances when immediate medical attention is necessary or when there is imminent danger to health or safety which means a situation in which death or serious bodily harm could reasonably be expected to occur without intervention, according to Ark. Code Ann. § 12-12-1703(8). Non-emergency cases refer to situations when allegations do not meet the definition of imminent danger to health or safety.

As required by law, investigations are completed and an investigative determination entered within 60 days. APS notifies the client and other relevant parties, including the offender, of the determination.

APS communicates with the waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. Operating agency and waiver staff are also interviewed by APS and asked to provide any necessary documentation for the investigation. Reports to APS are logged into a database, and DPSQA uses this resource to monitor participants of the waiver for critical incidents.

APS communicates with the Living Choices waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the client, offender, reporter, doctors, family, police and other collateral witnesses that can be found. DPSQA and Living Choices staff are also interviewed by APS and asked to provide any necessary documentation for the investigation.

#### Division of Provider Services and Quality Assurance (DPSQA) Responsibilities

DPSQA receives and triages incidents to appropriate divisions for investigation. DPSQA will investigate those incidents that relate to providers licensed and/or certified by DPSQA and forwards incidents regarding clients to the Division of Aging, Adult, and Behavioral Health Services.

Reports to DPSQA are entered into a tracking system which DPSQA uses to determine if further investigation is needed in the event of multiple complaints at one provider locations or facility. DPSQA uses this resource to monitor active participants of the waiver for critical incidents.

As required by statute, investigations are completed and an investigative determination entered within 60 days.

Unexpected client deaths must be reported immediately to the DPSQA contact using the DHS Client Unexpected Death Report. The DPSQA contact investigates the report within two days of receiving the notice of the occurrence and prepares a report of the investigation within 30 days of receiving the notice of the occurrence. The investigation includes reviewing a written report of the facts and circumstances of the unexpected death and documentation listing the client's condition, including diagnoses, prescriptions and service plan.

The DPSQA contact will determine the facts and circumstances of the occurrence. DPSQA's role includes performing a thorough investigation, reviewing current policy, making corrections if necessary and identifying patterns during the process. Final results of investigations are electronically made available to the Division of Medical Services (DMS).

All reports to the Adult Maltreatment Hotline and instances of unexpected client deaths are investigated and addressed by DPSQA. Incidents reported to the DHS Incident Reporting Information System (IRIS), a system which enables online submission and transmittal of incident reports, are investigated depending on the type of incident reported.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Division of Provider Services and Quality Assurance assumes responsibility for compiling all incident reports from providers for review and action. Incidents are reported to DPSQA staff through submission of Form DPSQA-731.

DPSQA staff review the reports as incidents occur and identify patterns and make systematic corrections when necessary. Current policy is reviewed at each occurrence and revisions may be made if necessary.

The Adult Protective Services unit tracks APS incidents. Operating agencies and the Medicaid agency, Division of Medical Services (DMS) are informed of the outcomes of incidents reported to APS applicable to waiver participants. There is a Memorandum of Understanding between the operating agency waiver units and the APS unit detailing the relationship and activities of each unit, as they relate to the waiver program.

Final results of APS investigations, final results of unexpected death findings, and results of incident reports are electronically made available to the Medicaid agency, Division of Medical Services (DMS).

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

**The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restraints or seclusion. This oversight is conducted through incident reports received and monitoring of the participant by the DHS RN, if needed.

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

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### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one):*

**The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of restrictive interventions. This oversight is conducted through incident reports received and monitoring of the participant by the DHS RN, if needed.

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

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### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

**The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) is responsible for detecting unauthorized use of seclusion. This oversight is conducted through incident reports received and monitoring of the participant by the DHS RN, if needed.

**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

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### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

**No. This Appendix is not applicable** (*do not complete the remaining items*)

**Yes. This Appendix applies** (*complete the remaining items*)

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices

(e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

## Appendix G: Participant Safeguards

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### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

**Answers provided in G-3-a indicate you do not need to complete this section**

**i. Provider Administration of Medications.** *Select one:*

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**iii. Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

*Complete the following three items:*

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## Appendix G: Participant Safeguards

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### Quality Improvement: Health and Welfare

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Health and Welfare**

*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

**a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of unpreventable and preventable causes. Numerator: Number of deaths with unpreventable causes; Denominator:**

**Number of deaths.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Unexpected Death Report**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input data-bbox="1078 981 1264 1070" type="text"/>
<b>Other</b> Specify: <input data-bbox="408 1218 647 1308" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input data-bbox="1078 1218 1264 1308" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input data-bbox="1078 1456 1264 1545" type="text"/>
	<b>Other</b> Specify: <input data-bbox="718 1695 957 1785" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**Performance Measure:**

**Number and percent of participant records reviewed where the participant and/or family or legal guardian received information about how to report abuse, neglect, exploitation and other critical incidents as specified in the waiver application.**  
**Numerator: Number of participants receiving information on abuse, neglect, exploitation and critical incidents; Denominator: Number of records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =



		<div style="border: 1px solid black; padding: 5px;"> <p>DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.</p> </div>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number of substantiated complaints. Numerator: Number of substantiated complaints; Denominator: Number of complaints.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Complaint Database**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**Performance Measure:**

**Number and percent of critical incidents that were reported within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Number of critical incidents reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;"> DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<b>Other</b> Specify:  <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input style="width: 100%; height: 30px;" type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input style="width: 100%; height: 30px;" type="text"/>
	<b>Other</b> Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>

**Performance Measure:**

**Number and percent of complaints addressed within required time frame.**

**Numerator: Number of complaints addressed in time frame; Denominator: Number of complaints.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Complaint Database**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>

<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<div style="border: 1px solid black; width: 100%; height: 20px;"></div>

**b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of critical incidents reviews/investigations that were initiated and completed according to program policy and state law. Numerator: Number of critical incident investigations initiated/completed according to policy/law; Denominator: Number of critical incidents reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>



<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of critical incidents requiring review/investigation where the state adhered to the follow-up methods as specified. Numerator: Number of critical incident reviews/investigations that had appropriate follow-up; Denominator: Number of critical incidents reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Case Record Review**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		DAABHS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**d. Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Arkansas addresses this assurance with a three-step process that involves record review, ongoing communication with Adult Protective Services (APS) and Division of Medical Services (DMS) audits of waiver participants' records. Monthly record reviews are performed by DHS RN supervisors to assure that DHS RNs report incidences of abuse or neglect, and that safety and protection are addressed at each assessment and reassessment and reported in the Record Review Summary Report. APS reports specific cases of abuse and neglect affecting waiver participants to DAABHS waiver staff. Findings are reported to the DPSQA QA Unit.

DAABHS staff are required to review the APS information with participants and other interested parties at each assessment and reassessment. This must include providing APS brochures, as well as information on how to identify possible abuse and neglect and a toll-free number for reporting abuse. Compliance with this requirement is documented in the participant record and reviewed by RN supervisors during each record review. Compliance is a part of the record review and annual reporting process.

Policy requires compliance and mandates the DHS RN to report alleged abuse to APS and/or the Office of Long Term Care (OLTC). All reports of alleged abuse, follow-ups and actions taken to investigate the alleged abuse, along with all reports to APS or OLTC must be documented in the nurse narrative. Record reviews include verification of this requirement and are included on the annual report.

The process for reporting abuse as established in Ark. Code Ann. § 12-12-1701 et seq (the Adult and Long-Term Care Facility Resident Maltreatment Act) is as follows: The Department of Human Services (DHS) maintains a single statewide telephone number that all persons may use to report suspected adult maltreatment and long-term care facility resident maltreatment. Upon registration of a report, the Adult Maltreatment Hotline refers the matter immediately to the appropriate investigating agency. Under this statute, a resident of an assisted living facility is identified as a long-term care facility resident, and for the purposes of the statute is presumed to be an impaired person. A report for a long-term care facility resident is to be made immediately to the local law enforcement agency for the jurisdiction in which the long-term care facility is located, and to OLTC under the regulations of that office. DHS has jurisdiction to investigate all cases of suspected maltreatment of an endangered person or an impaired person. The APS unit of DHS shall investigate all cases of suspected adult maltreatment if the act or omission occurs in a place other than a long-term care facility; and all cases of suspected adult maltreatment if a family member of the adult person is named as the suspected offender, regardless of whether or not the adult is a long-term care facility resident. The OLTC unit of DHS shall investigate all cases of suspected maltreatment of a long-term care facility resident.

The DPSQA QA audit reflects internal review of the billing process by Living Choices Medicaid providers. The DPSQA QA audit completes a systematic random sampling of the active case population whereby every "nth" name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate sample size for this waiver population. To determine the "nth" integer, the sample is divided by the population. Those names are drawn until the sample size is reached.

## **b. Methods for Remediation/Fixing Individual Problems**

- i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Division of Aging, Adult, and Behavioral Health Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in team meetings to discuss and address individual problems related to participant health and welfare, as well as problem correction and remediation. DAABHS and DMS have an Interagency Agreement that includes measures related to participant health and welfare for the waiver.

DAABHS's remediation efforts in cases where participants or their family members or legal guardians have not received information about how to report abuse, neglect, exploitation or critical incidents include providing the appropriate information to the participant and family member/legal guardian upon discovery that this information was not provided, providing additional training for DHS RNs and considering this remediation as part of RNs' performance evaluations.

In cases where critical incidents were not reported within required time frames, DAABHS provides remediation, including reporting the critical incident immediately upon discovery, and providing additional training and counseling to staff.

If critical incident reviews and investigations are not initiated and completed according to program policy and state law, DAABHS's remediation includes initiating and completing the investigation immediately upon discovery, and providing additional training and counseling to staff. When appropriate follow-up to critical incidents is not conducted according to methods discussed in the waiver application, DAABHS provides immediate follow-up to the incident and staff training as remediation.

DAABHS provides remediation in cases of investigation and review of unexplained, suspicious and untimely deaths that did not result in identification of preventable and unpreventable causes to include staff and provider training, implementing additional services and imposing provider sanctions. The Unexpected Death Report ensures that remediation of preventable deaths is captured and that remediation data is collected appropriately.

The DAABHS complaint database collects complaints, the outcomes and the resolution for substantiated complaints. Remediation for complaints that were not addressed during the required time frame includes DAABHS addressing the complaint immediately upon discovery, and providing additional staff training and counseling.

All substantiated incidents are investigated by the DAABHS Deputy Director or his/her designee. DAABHS plans to continue this process and reviewing remediation plans remains in development.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b>

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
	Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix H: Quality Improvement Strategy (1 of 2)**

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Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 2)

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### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DPSQA analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, DPSQA will meet with the operating agency (DAABHS) to discuss what system or program changes are necessary, if any, based on the nature of the problem (health and safety issue, etc.), complexity of the solution (does it require an amendment to the waiver application), and the financial impact. If it is determined that a system change is needed, a computer service request will be submitted to the Medicaid Management Information and Performance Unit (MMIP) within DPSQA and a priority status is assigned. MMIP prioritizes system changes to MMIS and coordinates implementation with the state fiscal agent. An action plan is developed and information is shared with the appropriate stakeholders for comment. Implementation of the plan is the final step. The MMIP Unit and the DPSQA QA Unit monitor the system changes.

As a result of the discovery processes:

The interagency agreements were revised to provide a more visible product to clarify roles and responsibilities between the Division of Medical Services (Medicaid agency) and the Division of Aging, Adult, and Behavioral Health Services (operating agency).

The agreement between the two divisions has been modified and is updated at least annually.

Medicaid related issues are documented by DAABHS waiver staff and reviewed by DPSQA QA staff, and recorded on a monthly report to identify, capture and resolve billing and claims submission problems. Error reports are worked and billing issues are resolved by the DPSQA QA staff. DPSQA QA staff reviews reports for proper resolution. These activities occur on a daily basis, and reviews occur monthly by DPSQA QA staff.

A separate Quality Assurance Unit was formed within DPSQA to monitor and advise the operating agency for Home and Community-Based Waiver Programs.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify: <input type="text"/>	<b>Other</b> Specify: <input type="text" value="Ongoing, as needed"/>

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) and the Division of Provider Services and Quality Assurance (DPSQA) both employ staff to assist in system design. When an issue arises that requires development of a Computer Service Request (CSR), meetings with the DHS information technology consultants, DPSQA Program Development and Quality Assurance staff, DPSQA Program Integrity staff, and DAABHS waiver staff are held to address needs and resolve issues, including developing new elements and testing system changes. Meetings are scheduled on an as-needed basis with the assigned DHS information technology consulting firm, the Medicaid program's fiscal agent, the DAABHS Deputy Director, DPSQA QA staff and others as may be appropriate depending on the issue for discussion.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DAABHS and DPSQA monitor the Quality Improvement Strategy on an ongoing basis and review the Quality Improvement Strategy annually. A review consists of analyzing reports and progress toward stated initiatives, resolution of individual and systematic issues found through discovery and notating desired outcomes. When change in the strategy is indicated, a collaborative effort between DPSQA and DAABHS is set in motion to complete a revision to the Quality Improvement Strategy which may include submission of a waiver amendment. DPSQA QA staff utilizes the Quality Improvement Strategy during all levels of QA reviews.

**Appendix I: Financial Accountability**

**I-1: Financial Integrity and Accountability**

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request



through the Medicaid agency or the operating agency (if applicable).

In accordance with waiver participants' service plans, sampling is pulled on a random basis as described in the waiver.

An independent audit is required annually of the provider agency when:

- State expenditures are \$100,000 or more;
- Federal expenditures are \$300,000 or more; or
- The contract the Department of Human Services (DHS) has with the provider agency requires an independent audit, regardless of funding level.

If the federal expenditures are \$300,000 or more, the audit must be performed in accordance with OMB Circular A133, which implemented the Single Audit Act as amended. A Government Auditing Standards (GAS) audit must be performed if DHS funding provided is \$100,000 or more of federal, state, or federal and state combined.

The DHS Office of Chief Counsel, Audit Section is responsible for reviewing all independent audits. The provider's audit report is reviewed by the Audit Section to determine whether requirements of applicable authorities and those contained in agency policy were met; material weaknesses in internal control exist; material noncompliance with the provision of grants, contracts, and agreements occurred; and the report included findings, recommendations, and responses thereto by management.

Material weaknesses and non-compliance, other findings, recommendations and responses are recorded and communicated to the DAABHS Deputy Director, who will take appropriate action to resolve audit findings within 90 days of the referral of the finding from the Audit Section.

If applicable, through audit requirements regarding provider organizations and thresholds of funding, the DHS Office of Quality Assurance (OQA) maintains a database of audit due dates. Each provider selects an independent auditor. The auditor completes a report and submits the report to the provider and to the DHS OQA. The DHS OQA submits a monthly report indicating findings to the DHS Executive Staff.

DPSQA Quality Assurances also reviews the services billed compared to the services listed on a participant's service plan. DPSQA record reviews include a review of the billing by LCAL providers. A systematic random sampling of the active case population is drawn whereby every nth name in the population is selected for inclusion in the sample. The sample size, based on a 95% confidence level with a margin of error of +/- 5%, is drawn. An online calculator is used to determine the appropriate sample size for this waiver population. To determine the nth integer, the sample is divided by the population. Those names are drawn until the sample size is reached.

DAABHS receives a report from DPSQA on a monthly basis with overpayments. DAABHS verifies all overbilling and sends out for recoupment. DAABHS also receives a quarterly overlapping report and no service report. DAABHS reviews and verifies the report for overlapping of services or no services being billed within 30 days.

Paid claims are compared to the person-centered service plan (PCSP) during the chart review process. Any claims paid over the authorized amount of services on the PCSP are recouped from the provider. Underutilization of services is researched to determine why the provider did not fully meet the PCSP authorized amounts and documented in the client's chart. If necessary, the PCSP is revised to reflect the actual amount of services needed to care for the beneficiary.

Desk audits are performed to review provider documentation that supports billing for the services. A random sampling approach is used in determining which provider to audit and which beneficiary files to request for review. Providers are notified of the desk audit findings by letter. Claims paid for services that are not documented according to the Medicaid policy are recouped and corrective action plans are required to be implemented.

## Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

### a. Methods for Discovery: Financial Accountability Assurance:

**The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.** (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

#### i. Sub-Assurances:

#### a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

**Number of failed MMIS edit checks which are corrected to assure appropriate for payment. Numerator: Number of corrected MMIS edit checks; Denominator: Number of edit checks.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Weekly Worksheets**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		<input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Daily Waiver Update Error Report**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Daily LTC Update Error Report**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of waiver claims reviewed that were paid using the correct rate as specified in the waiver application. Numerator: Number of claims paid at correct rate; Denominator: Number of claims.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Recipient Claims History Profile (Chart Reviews)**

<b>Responsible Party for data</b>	<b>Frequency of data collection/generation</b>	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
-----------------------------------	--	--

<b>collection/generation</b> (check each that applies):	(check each that applies):	
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px;"> DMS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
<b>Other Specify:</b>  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other Specify:</b>  <input type="text"/>
	<b>Other Specify:</b>  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of reviewed claims with services specified in the participants service plan. Numerator: Number of claims with services specified in service plan; Denominator: Number of claims.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Recipient Profiles**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		<input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>



- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

- ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

**b. Methods for Remediation/Fixing Individual Problems**

- i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Division of Aging, Adult, and Behavioral Health Services (DAABHS) (operating agency) and the Division of Medical Services (DMS) (Medicaid agency) participate in regular team meetings to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DAABHS and DPSQA have a Memorandum of Understanding (MOU) that includes measures related to financial accountability for the waiver.

The performance measure for number and percent of waiver claims paid using the correct rate specified in the waiver application will always result in 100% compliance because the rates for services are already set in MMIS; therefore, claims will not be paid at any other rate.

DAABHS’s remediation for failed MMIS checks not corrected to assure appropriate payment includes correcting the issue upon discovery, making system changes and training staff.

DAABHS’s remediation for claims for services not specified in the participant's service plan includes revising the participant's plan of care if necessary, recouping payment to the provider, imposing provider sanctions, training providers and conducting a participant monitoring visit to possibly reconsider consumer direction.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (1 of 3)**

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

**Assisted Living Facility Rate Determination Methods:** This amended waiver reforms the payment rate determination method for assisted living facilities (ALFs) serving waiver participants. For purposes of this waiver, “assisted living facility” means a Medicaid-certified and enrolled assisted living facility with a Level II license.

**Methods Employed to Determine Rates:** To establish the new assisted living facility payment methodology, the State employed two methods:

1. An actuarial analysis by the Arkansas Medicaid program’s contracted actuaries. This included a cost survey of assisted living facilities and consideration of other states’ federally-approved rate methods and rate levels; direct care cost factors (e.g., direct care work wages and benefits, direct care-related supervision and overhead); Arkansas labor market wage levels; rate scenarios; and Arkansas’ minimum and prevailing assisted living facility staffing levels. The actuary’s report is available to CMS upon request through the Division of Aging, Adult, and Behavioral Health Services (DAABHS).
2. Negotiations with representatives of the State’s participating assisted living facilities.

The rate methodology excludes reimbursement of room and board costs.

The new methodology and resulting new per diem rates provide for payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough assisted living facility providers, as required under 42 U.S.C. 1396a(a)30(A) and 42 CFR §447.200-205.

**Uniform, Statewide Rate Methodology:** The rate methodology is uniform and applies statewide to all Level II licensed assisted living facilities serving waiver participants.

**Opportunities for Public Comment:** Before submitting this amended waiver to CMS for federal review and approval, DHS engaged in various opportunities for public comment and consultations with assisted living facility providers and other interested stakeholders. This includes webinars and regional public meetings. These are in addition to the public comment process for this amended waiver and the revised provider manual. Further, both the amended waiver and the revised provider manual undergo prior review by Arkansas legislative committees.

**Entities Responsible for Rate Determination and Oversight of Rate Determination Process:** The assisted living facility rate methodology is determined by the Division of Aging, Adult, and Behavioral Health Services (DAABHS), in consultation with the Division of Provider Services and Quality Assurance (DPSQA) and the contracted actuaries, and with oversight by the Division of Medical Services (DMS). As the Medicaid agency, DMS is responsible for oversight of all Medicaid rate determinations and for ensuring that provider payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers. DAABHS (as the operating agency responsible for day-to-day waiver administration, service planning, and access and care delivery in the waiver) and DPSQA (as the operating agency responsible for ALF licensure, ALF Medicaid certification, provider accountability, quality of care, inspections, and auditing) jointly monitor to ensure that assisted living facility payments are consistent with the requirements of 42 U.S.C. § 1396a(a)30(A) and 42 CFR § 447.200-205.

**Implementation of New Assisted Living Facility Rates:**

Effective after January 1, 2019, assisted living facilities are reimbursed on a fee-for-service basis according to a new single statewide per diem rate, determined by DAABHS according to the rate determination methods (actuarial analysis and negotiations) described in this Appendix.

On the effective date of this amended waiver, the four-tier payment model provided for under the current waiver is discontinued. Thereafter, assisted living facilities will be reimbursed according to the new single, statewide per diem rate method. For purposes of assisted living facility payments, waiver participants will no longer be assigned a rate tier level.

The discontinued four-tier payment model was initially developed in 2002 prior to the use of comprehensive assessment instruments, is inconsistent with the new assessment system, is administratively cumbersome and unnecessary, and may foster unintentional incentives misaligned with the objectives of appropriate access and service use, facility efficiency, active and independent living, and optimal medication therapy management.

This rate may be interim, in that DAABHS intends to review the rate methodology in the first half of WY4. The purpose of this review is to gain a greater percentage of provider response to the provider surveys distributed by the Arkansas Medicaid program's contracted actuaries. The contracted actuaries will review the new round of provider survey results and then make recommendations for changes as appropriate. If the review results in revision to the rate, DAABHS will submit a waiver amendment to effectuate the revised rate.

Beyond the review in the first half of WY4, DAABHS will review the rate methodology no later than CY 2021. During the last two years of the current 5-year waiver term (CY 2019-2020), as data from the new Arkansas Independent Assessment (ARIA) system and use of the Task and Hour Standards for personal care-type services are accumulated and assessed, DAABHS will consider whether an acuity-adjusted methodology is appropriate. If a methodology change is determined appropriate, it will be addressed in a subsequent waiver amendment or the waiver renewal application.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Living Choices providers bill for services and are reimbursed directly through MMIS.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

**No. State or local government agencies do not certify expenditures for waiver services.**

**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

#### **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

#### **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. DPSQA staff verifies services were provided according to the person-centered service plan through an internal monthly monitoring system. Adjustments are made or cases referred to the Office of Medicaid Inspector General when claims are paid incorrectly.

All waiver claims are processed through the MMIS, using all applicable edits and audits, to assure claims are processed appropriately, timely, and compared to the Medicaid maximum allowable.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

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### I-3: Payment (1 of 7)

**a. Method of payments -- MMIS** (*select one*):

**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

**Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

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### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

**Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

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### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

**No. The State does not make supplemental or enhanced payments for waiver services.**

**Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

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### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

**No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

**Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

## Appendix I: Financial Accountability

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### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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**Answers provided in Appendix I-3-d indicate that you do not need to complete this section.**

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**The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

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### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

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### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

**No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

**No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured



that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:***

**The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

**The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

**This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

**Appropriation of State Tax Revenues to the State Medicaid agency**

**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

**Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

*Check each that applies:*

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

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### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

**No services under this waiver are furnished in residential settings other than the private residence of the individual.**

**As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Room and board costs are separate and excluded from payments for services provided by assisted living facilities. The waiver recipient is responsible for paying room and board costs directly to the facility from their own income. To ensure that room and board is affordable for persons on the Living Choices waiver and within the participant's income, the room and board amount is deducted from the participant's income, just as the personal needs allowance amount is deducted. To cover room and board, 90.8% of the Individual SSI Federal Benefit Rate (FBR), rounded to the nearest dollar, can be set aside from the waiver recipients income. Nine percent of the Individual SSI FBR rounded to the nearest dollar is deducted for personal needs allowance.

## Appendix I: Financial Accountability

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### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

**Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

**No. The State does not impose a co-payment or similar charge upon participants for waiver services.**

**Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

---

*Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

---

**Nominal deductible**

**Coinsurance**

**Co-Payment**

**Other charge**

*Specify:*

**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

---

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

---

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

---

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

**No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

**Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration**

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**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	20112.22	2249.00	22361.22	40826.00	2249.00	43075.00	20713.78
2	20119.88	2316.00	22435.88	42046.00	2316.00	44362.00	21926.12
3	20127.91	2385.00	22512.91	43303.00	2385.00	45688.00	23175.09
4	19722.61	2457.00	22179.61	44598.00	2457.00	47055.00	24875.39
5	17516.60	2530.00	20046.60	45931.00	2530.00	48461.00	28414.40

**Appendix J: Cost Neutrality Demonstration**

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**J-2: Derivation of Estimates (1 of 9)**

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	1300		1300
Year 2	1300		1300
Year 3	1300		1300
Year 4	1725		1725
Year 5	1725		1725

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay on the waiver is estimated to be 255 days. This average was calculated as days of eligibility from the MMIS segments, using the Medicaid DSS (BusinessObjects). These numbers were determined by reporting the total days of waiver service (based on service eligibility days within the waiver year) for all participants and dividing by the unduplicated count of participants.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D is derived from current reporting of expenditures from the Medicaid DSS (BusinessObjects) and consideration of previous waiver estimates of utilization and growth rates.

The unduplicated cap of 1300 was used as the number of users for WY1-WY3 as it is believed this cap will be reached each year. For WY4-WY5, the intent of the state is to expand the unduplicated cap to an amount sufficient to allow for full-year participation of each available slot. Given the average length of stay of 255 days, the state calculates 1,717 as the maximum number of unduplicated participants who can be served under a point-in-time (PIT) maximum of 1,200. The calculation is:

$$1,200 (\text{max PIT cap}) \times 365 \text{ days} \div 255 \text{ days (avg. length of stay)} = 1,717$$

This exact amount was used for the estimated number of users in Appendix J-2-d. The state currently has a waiting list for this waiver, and the state does not expect demand for waiver services to decrease. Therefore, the state believes that an estimate of maximum usage is appropriate.

For purposes of calculating the requested increase in the unduplicated cap in Appendix B-3-a, the state rounded this amount up to 1,725 to allow for a small margin of error.

Extended Medicaid State Plan Prescription Drug costs were estimated based on actual costs from the previous 6 years of the waiver. The following factors were considered in the estimates:

- The number of users for SFY 2015 was 96. Since the point-in-time cap is being increased by 20%, the number of users is projected to increase by 4% in each of the 5 waiver years.
- An average of the units used per user over the last 6 years was determined to be 15.
- The average cost per unit over the past 6 years was determined to be \$62. There has been an average growth rate of 5.61% over the last 6 years, which is applied to the average cost per unit in each year of the waiver to allow for inflation of Rx drug costs. Please note that the average cost of drugs is not a rate set by the state, but is based on a negotiation between Arkansas Medicaid and prescription drug companies.

The current payment rate for WY1-WY3 includes rates for four payment tiers, based on the participant's acuity. The current rates are \$70.89, \$75.48, \$81.89, and \$85.35. The state's actuary calculated a composite average of these four rates, adjusted to reflect the distribution of participants between the four tiers, of \$80.33. The payment rate recommended by the actuary is \$62.89, which is a 20.7% decrease from the \$80.33 composite average rate.

Because this is such a significant decrease, the state is proposing to phase-in the new rate over the remaining two years of the waiver, to allow providers and participants time to adjust and adapt to the new rate. The phase-in schedule that the state is currently proposing is to move to a single payment tier effective January 1, 2019, at the composite average rate of \$80.33, and then reduce the rate by \$4.36 every six months: On July 1, 2019, the rate will decrease to \$75.97; on January 1, 2020, the rate will decrease to \$71.61; on July 1, 2020, the rate will decrease to \$67.25; and on January 1, 2021, for the final month of the waiver, the rate will decrease to the actuary's recommended rate of \$62.89. This phase-in schedule is the reason that the average unit cost for the composite tier in WY5 is lower than WY4.

**ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was computed based on what was done in prior years. Using the market basket forecasts and the related Living Choices report of all waiver eligible recipients annual expenditures were extracted from the decision support system (DSS) component of the MMIS. Note: Costs indicated for State Category of Service AL (Assisted Living Facility), and AX (Extension of 3 prescriptions for Assisted Living) that are shown in the DSS Report on the average annual expenditures for nursing home recipients were backed out for the ALF waiver recipients.

Medicare Part D has been in effect for approximately 10 years. Arkansas Medicaid has not paid for prescription drugs for Medicare recipients during this time. Thus, prescription drug costs of individuals receiving Medicare Part D are not contained in our source documents. Therefore, they do not need to be removed.

For D', G, and G', The Market basket rate used the Bureau of Labor Statistics data as the source document, specifically the Medical Care segment. The growth factor shown for D', G, and G' in section J are the product of applying a geometric mean to three years of this BLS data.

**iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is computed based on the average annual expenditures for nursing home recipients that were extracted from the decision support system (DSS) component of the MMIS. Using the average annual expenditures for nursing home recipients and the market basket forecasts for the next 5 years. Factor G was computed for each of the 5 years of the waiver.

For D', G, and G', The Market basket rate used the Bureau of Labor Statistics data as the source document, specifically the Medical Care segment. The growth factor shown for D', G, and G' in section J are the product of applying a geometric mean to three years of this BLS data.

**iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was derived using the same methodology as in prior years. It was computed based on the average annual expenditures for nursing home recipients that were extracted from the decision support system (DSS) component of the MMIS. Using the average annual expenditures for nursing home recipients. Note: Costs indicated for State Category of Service 58 (Private SNF), 59 (Private SNG Crossover), 62 (Public ICF Mentally Retarded), and 63 (Public SNF) that are shown in the DSS Report on the average annual expenditures for nursing home recipients were backed out for the ALF waiver.

For D', G, and G', The Market basket rate used the Bureau of Labor Statistics data as the source document, specifically the Medical Care segment. The growth factor shown for D', G, and G' in section J are the product of applying a geometric mean to three years of this BLS data.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Extended Medicaid State Plan Prescription Drugs	
Living Choices Assisted Living Services	



## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 1

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Extended Medicaid State Plan Prescription Drugs Total:</b>						93000.00
Extended Medicaid State Plan Prescription Drugs	1 Month	100	15.00	62.00	93000.00	
<b>Living Choices Assisted Living Services Total:</b>						26052883.35
Tier Level 2	1 Day	455	255.00	75.48	8757567.00	
Tier Level 3	1 Day	481	255.00	81.89	10044217.95	
Tier Level 4	1 Day	182	255.00	85.35	3961093.50	
Tier Level 1	1 Day	182	255.00	70.89	3290004.90	
Composite Tier	1 Day	0	0.00	80.33	0.00	
<b>GRAND TOTAL:</b>						26145883.35
Total Estimated Unduplicated Participants:						1300
Factor D (Divide total by number of participants):						20112.22
Average Length of Stay on the Waiver:						255

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Extended Medicaid State Plan Prescription Drugs Total:</b>						102960.00
Extended Medicaid State Plan Prescription Drugs	1 Month	104	15.00	66.00	102960.00	
<b>Living Choices Assisted Living Services Total:</b>						26052883.35
Tier Level 2	1 Day	455	255.00	75.48	8757567.00	
Tier Level 3	1 Day	481	255.00	81.89	10044217.95	
Tier Level 4	1 Day	182	255.00	85.35	3961093.50	
Tier Level 1	1 Day	182	255.00	70.89	3290004.90	
Composite Tier	1 Day	0	0.00	80.33	0.00	
<b>GRAND TOTAL:</b>						26155843.35
Total Estimated Unduplicated Participants:						1300
Factor D (Divide total by number of participants):						20119.88
Average Length of Stay on the Waiver:						255

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Extended Medicaid State Plan Prescription Drugs Total:</b>						113400.00
Extended Medicaid State Plan Prescription Drugs	1 Month	108	15.00	70.00	113400.00	
<b>Living Choices Assisted Living Services Total:</b>						26052883.35
<b>GRAND TOTAL:</b>						26166283.35
Total Estimated Unduplicated Participants:						1300
Factor D (Divide total by number of participants):						20127.91
Average Length of Stay on the Waiver:						255

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Tier Level 2	1 Day	455	255.00	75.48	8757567.00	
Tier Level 3	1 Day	481	255.00	81.89	10044217.95	
Tier Level 4	1 Day	182	255.00	85.35	3961093.50	
Tier Level 1	1 Day	182	255.00	70.89	3290004.90	
Composite Tier	1 Day	0	0.00	80.33	0.00	
<b>GRAND TOTAL:</b>					26166283.35	
Total Estimated Unduplicated Participants:					1300	
Factor D (Divide total by number of participants):					20127.91	
Average Length of Stay on the Waiver:					255	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Extended Medicaid State Plan Prescription Drugs Total:</b>						124320.00
Extended Medicaid State Plan Prescription Drugs	1 Month	112	15.00	74.00	124320.00	
<b>Living Choices Assisted Living Services Total:</b>						33897185.70
Tier Level 2	1 Day	0	0.00	75.48	0.00	
Tier Level 3	1 Day	0	0.00	81.89	0.00	
Tier Level 4	1 Day	0	0.00	85.35	0.00	
Tier Level 1	1 Day	0	0.00	70.89	0.00	
<b>GRAND TOTAL:</b>					34021505.70	
Total Estimated Unduplicated Participants:					1725	
Factor D (Divide total by number of participants):					19722.61	
Average Length of Stay on the Waiver:					255	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Composite Tier	1 Day	1717	255.00	77.42	33897185.70	
GRAND TOTAL:					34021505.70	
Total Estimated Unduplicated Participants:					1725	
Factor D (Divide total by number of participants):					19722.61	
Average Length of Stay on the Waiver:					255	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Extended Medicaid State Plan Prescription Drugs Total:</b>						136890.00
Extended Medicaid State Plan Prescription Drugs	1 Month	117	15.00	78.00	136890.00	
<b>Living Choices Assisted Living Services Total:</b>						30079264.50
Tier Level 2	1 Day	0	0.00	75.48	0.00	
Tier Level 3	1 Day	0	0.00	81.89	0.00	
Tier Level 4	1 Day	0	0.00	85.35	0.00	
Tier Level 1	1 Day	0	0.00	70.89	0.00	
Composite Tier	1 Day	1717	255.00	68.70	30079264.50	
GRAND TOTAL:					30216154.50	
Total Estimated Unduplicated Participants:					1725	
Factor D (Divide total by number of participants):					17516.60	
Average Length of Stay on the Waiver:					255	

**TOC required****200.100 Qualifying Criteria for Living Choices Assisted Living Providers 1-1-19**

Living Choices providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the criteria below to be eligible to participate in the Arkansas Medicaid Program.

- A. Assisted living facilities (ALF) are licensed and regulated by the Office of Long Term Care in the Division of Medical Services (DMS), which is the division of the Arkansas Department of Human Services (DHS) that administers the Arkansas Medicaid Program. Licensed Level II ALF are qualified to enroll with Medicaid as Living Choices Assisted Living Facilities—Direct Services Providers, if all other requirements for enrollment are met.
- B. Home health agencies in Arkansas are licensed and regulated by the Arkansas Department of Health. Licensed Class A home health agencies may contract with Level II ALF to provide the bundled services covered in the Living Choices Program. In such an arrangement, federal regulations permit Medicaid to cover the services only if the home health agency, instead of the ALF, is the Living Choices provider.

Living Choices Assisted Living Waiver Services providers must meet the Provider Participation and enrollment requirements detailed in the Medicaid provider manual.

A licensed home health agency may qualify for Living Choices waiver services provider enrollment only by first contracting with a licensed Level II ALF to provide Living Choices bundled services to Living Choices beneficiaries who reside in the ALF.

- C. All Living Choice providers must be certified by the Division of Provider Services and Quality Assurance (DPSQA).
- D. Option to Temporarily Limit Certification and Enrollment of New Assisted Living Facilities: Consistent with the authority and requirements of 42 CFR 455.470 (b) and (c) and with the concurrence of the federal Centers for Medicare and Medicaid Services (CMS), DPSQA may temporarily impose a moratoria, numerical caps, or other limits on the certification and enrollment of new assisted living facility providers in the Living Choices HCBS waiver program. Such temporary caps, limits, or moratoria on the certification and enrollment of new assisted living facility providers shall be initially limited to no more than six months, may be extended in 6-month increments subject to DPSQA and CMS approval, and may be applied on a regional or another geographic basis. If DPSQA determines temporary caps, limits, or moratoria are appropriate and would not adversely impact beneficiaries' access to assisted living facility services, it will initiate the process through filing a Request for State Implemented Moratorium (Form CMS-10628) with CMS.

**200.105 Provider Assurances 1-1-19**

- A. Staffing

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries for whom they have accepted a Living Choices Assisted Living Waiver Plan of Care.

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS.

2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any Living Choices Assisted Living Waiver service(s). This orientation shall include, but not be limited to, a:
  - a. Description of the purpose and philosophy of the Living Choices Assisted Living Waiver Program;
  - b. Discussion and distribution of the provider agency's written code of ethics;
  - c. Discussion of activities which shall and shall not be performed by the employee;
  - d. Discussion, including instructions, regarding Living Choices Assisted Living Waiver record keeping requirements;
  - e. Discussion of the importance of the Plan of Care;
  - f. Discussion of the agency's procedure for reporting changes in the beneficiary's condition;
  - g. Discussion, including potential legal ramifications, of the beneficiary's right to confidentiality.

**B. Quality Controls**

The Provider agrees to continually monitor beneficiary satisfaction and quality of service delivery and to document his or her findings in the beneficiary's record. The Provider must immediately report changes in a beneficiary's condition to the DHS registered nurse (DHS RN) via Form AAS-9511 (Change of Status).

**C. Code of Ethics**

The Provider agrees to develop, distribute and enforce a written code of ethics with each employee providing services to a Living Choices Assisted Living Waiver beneficiary that shall include, but not be limited to, the following:

1. No consumption of the beneficiary's food or drink;
2. No use of the beneficiary's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;
4. No acceptance of gifts or tips from the beneficiary or their caregiver;
5. No friends or relatives of the employee or unauthorized individuals are to accompany the employee to the beneficiary's assisted living facility apartment unit;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery nor in the beneficiary's assisted living facility apartment unit;
7. No smoking in the beneficiary's assisted living facility apartment unit;
8. No solicitation of money or goods from the beneficiary;
9. No breach of the beneficiary's privacy or confidentiality of records.

**D. Home and Community Based Services (HCBS) Settings**

All Level II Assisted Living Facilities licensed by the OLTC and participating in the Arkansas Medicaid waiver must meet the following Home and Community Based Services (HCBS) Settings regulations as established by CMS. The federal regulations for the new rule is 42 CFR 441.301(c) (4)-(5). Facilities who enroll in the waiver on or after the date of this policy change must meet these HCBS settings requirements prior to certification. Those facilities already enrolled in the waiver before this policy change must comply with

the HCBS settings requirements under the timeframe established by the HCBS settings transition plan.

Settings that are HCBS must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

1. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
  - a. Choice must be identified/included in the person-centered service plan.
  - b. Choice must be based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
2. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
3. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
4. Facilitates individual choice regarding services and supports and who provides them.
5. In a provider-owned or controlled residential setting (e.g., Assisted Living Facilities), in addition to the qualities specified above, the following additional conditions must be met:
  - a. The unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
  - b. Each individual has privacy in their sleeping or living unit:
    - i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
    - ii. Beneficiaries sharing units have a choice of roommates in that setting.
    - iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
  - c. Beneficiaries have the freedom and support to control their own schedules and activities, and have access to food at any time.
  - d. Beneficiaries are able to have visitors of their choosing at any time.
  - e. The setting is physically accessible to the individual.
  - f. Any modification of the additional conditions specified in items a through d above must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
    - i. Identify a specific and individualized assessed need.
    - ii. Document the positive interventions and supports used prior to any

- modifications to the person-centered service plan.
- iii. Document less intrusive methods of meeting the need that have been tried but did not work.
  - iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
  - v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
  - vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
  - vii. Include the informed consent of the individual.

**200.110**      **Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Facilities**      **1-1-19**

Level II ALFs, located within the state of Arkansas, licensed and certified by the Office of Long Term Care, DPSQA, are eligible to apply for Medicaid enrollment as Living Choices providers. Qualified Level II Assisted Living Facility providers contract with Medicaid as Living Choices Assisted Living Facility providers to provide and claim reimbursement for Living Choices bundled services instead of contracting with another entity (e.g., a licensed home health agency) that is enrolled with Medicaid to provide and receive payment for those services. Living Choices includes provisions for alternative methods of delivering services because assisted living facilities have different business and staffing arrangements and the Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service. Additional details in this regard are provided in this manual.

**200.120**      **Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Agencies**      **1-1-19**

Within their licensing regulations, Level II ALFs may contract with home health agencies and other entities and individuals to provide required and optional services for residents of the ALF. In the Living Choices Program, an ALF that chooses not to be the Medicaid-enrolled provider of Living Choices services may contract only with a licensed home health agency to furnish Living Choices bundled services. The Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service.

A Licensed Class A Home Health Agency is eligible to enroll in the Arkansas Medicaid Program as an Assisted Living Agency provider only if it has a contract with a Level II Assisted Living Facility to deliver all Living Choices bundled services furnished in that facility. A home health agency must have a separate Medicaid provider number for each ALF in which it is the Living Choices provider.

To enroll as a Living Choices Assisted Living Agency, the agency must comply with certain procedures and criteria. This section describes those criteria and procedures, as well as the actions DMS takes to facilitate enrollment.

- A. The provider must be licensed by the Division of Health Facility Services, Arkansas Department of Health, as a Class A Home Health Agency.
- B. The provider must submit to the Medicaid program's Provider Enrollment Unit and to DPSQA the following items, in addition to the other documentation required in this section.
  1. A copy of its contract with the ALF (financial details may be omitted). The contract must describe in detail the agency's contractual obligations to provide Living Choices bundled services to the ALF's Living Choices beneficiaries.



2. Copies of contracts (financial details may be omitted) with any entities or individuals the agency has sub-contracted with to provide components of Living Choices bundled services.

**202.100 Records that Living Choices Assisted Living Facilities and Agencies Must Keep**

1-1-19

- A. Living Choices Assisted Living facility and agency providers must maintain required personal care aide training program documentation as specified in this manual.
- B. A provider must also maintain the following items in each Living Choices beneficiary's file.
  1. The beneficiary's attending or primary care physician's name, office address, telephone number and after-hours contact information.
  2. A copy of the beneficiary's current plan of care (form AAS-9503).
  3. Written instructions to the facility's attendant care staff.
  4. Documentation of limited nursing services performed by the provider's nursing staff in accordance with the beneficiary's plan of care. Records must include:
    - a. Nursing service or services performed,
    - b. The date and time of day that nursing services (exclusive of attendant care services) are performed,
    - c. Progress or other notes regarding the resident's health status and
    - d. The signature or initials and the title of the person performing the services.
  5. Documentation of periodic nursing evaluations performed by the ALF nursing staff in accordance with the beneficiary's plan of care.
  6. Records of attendant care services as described in this manual.
  7. Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the beneficiary's condition to the DHS RN, who is the only authorized individual who may adjust a beneficiary's plan of care. Providers agree to render all services in accordance with the Arkansas Medicaid Living Choices Assisted Living Home & Community-Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAABHS; to notify the DHS RN immediately of any change in the beneficiary's physical, mental or environmental needs the provider observes or is made aware of that may affect the beneficiary's eligibility or necessitate a change in the beneficiary's plan of care; to continually monitor beneficiary satisfaction and quality of service; and to notify the DHS RN in writing within one week of services being terminated, documenting the termination effective date and the reason for termination.

**210.000 PROGRAM COVERAGE**

1-1-19

Living Choices Assisted Living is a home and community-based services waiver program that is administered jointly by the Division of Medical Services (DMS, the state Medicaid agency) and the Division of Aging, Adult, and Behavioral Health Services (DAABHS), under the waiver authority of Section 1915(c) of the Social Security Act. Home and community-based services waiver programs cover services designed to allow specific populations of individuals to live in their own homes or in certain types of congregate settings. The Living Choices Assisted Living waiver program serves persons aged 65 and older and persons aged 21 through 64 who are determined to be individuals with physical disabilities by the Social Security Administration or the

Arkansas DHS Medical Review Team (MRT), and who are eligible for nursing home admission at the intermediate level of care.

The rules and regulations for licensure of Level II Assisted Living Facilities (ALF) are administered by the Office of Long Term Care within DMS. As agencies of the Arkansas Department of Human Services (DHS), DAABHS, DMS and the Division of County Operations (DCO) administer the policies and procedures and the rules and regulations governing provider and beneficiary participation in the Living Choices Program.

Individuals found eligible for the Living Choices Program may participate in the program when residing in a licensed Level II ALF that is enrolled as a Living Choices waiver provider in the Arkansas Medicaid Program.

## **211.000 Scope of the Program**

**1-1-19**

The *Level II Assisted Living Facilities Rules and Regulations* manual defines assisted living as: "Housing, meals, laundry, social activities, transportation (assistance with and arranging for transportation), one or more personal services, direct care services, health care services, 24-hour supervision and care, and limited nursing services." Medicaid, by federal law, may not cover beneficiaries' room and board except in nursing and intermediate care facilities. Medicaid covers some services only under certain conditions. This home and community-based services waiver program permits Medicaid coverage of assisted living services as described in this manual.

Individuals participating in the Living Choices Program reside in apartment-style living units in licensed Level II ALF and receive individualized personal, health and social services that enable optimal maintenance of their individuality, privacy, dignity and independence. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation. The environment promotes residents' self-direction and personal decision-making while protecting their health and safety.

Assisted living includes 24-hour on-site response staff to assist with residents' known physical dependency needs or other conditions, as well as to manage unanticipated situations and emergencies. Assisted living provider staff perform their duties and conduct themselves in a manner that fosters and promotes residents' dignity and independence. Supervision, safety and security are required components of the assisted living environment. Living Choices includes therapeutic social and recreational activities suitable to residents' abilities, interests and needs.

Services are provided on a regular basis in accordance with individualized plans of care that are signed by a DHS registered nurse. Assisted living beneficiaries reside in their own living units, which are separate and distinct from all others. Laundry and meal preparation and service are in a congregate setting for beneficiaries who choose not to perform those activities themselves.

## **211.100 Eligibility for the Living Choices Assisted Living Program**

**1-1-19**

- A. To qualify for the Living Choices Program, an individual must meet the targeted population as described in this manual and must be found to require a nursing facility intermediate level of care. Individuals meeting the skilled level of care, as determined by the Office of Long Term Care, are not eligible for the Living Choices Assisted Living Program.

The Living Choices Program processes for beneficiary intake, assessment, and service plan development include:

1. Determination of categorical eligibility;
2. Determination of financial eligibility;
3. Determination of nursing facility level of care;
4. Development of a person-centered service plan (PCSP); and

5. Notification to the beneficiary of his or her choice between home- and community-based services and institutional services.
- B. Candidates for participation in the program (or their representatives) must make application for services at the DHS office in the county in which the Level II ALF is located. Medicaid eligibility is determined by the DHS County Office and is based on non-medical and medical criteria. Income and resources comprise the non-medical criteria. Medically, the candidate must be an individual with a functional disability.
  - C. To be determined an individual with a functional disability, an individual must meet at least one of the following three criteria, as determined by a licensed medical professional.
    1. The individual is unable to perform either of the following:
      - a. At least 1 of the 3 activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon, another person; or
      - b. At least 2 of the 3 ADLs of transferring/locomotion, eating or toileting without limited assistance from another person; or
    2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or others; or
    3. The individual has a diagnosed medical condition that requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.
  - D. Individuals who required skilled level of care as defined in the Department of Human Services regulations are not eligible for the Living Choices Waiver.
  - E. The Arkansas Independent Assessment (ARIA) is the assessment instrument used by registered nurses of the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each waiver applicant or participant is assigned a tier level (0, 1, 2, or 3) following each assessment or reassessment. The tiers are intended to help inform waiver program oversight and administration and person-centered service planning. The tiers do not replace the Level of Care criteria described in Bullet C above, waiver eligibility determinations, or the person-centered service plan process.
    1. Tier 0 (zero) and Tier 1 (one) indicate the individual's assessed needs, if any, do not support the need for either Living Choices services or nursing facility services.
    2. Tier 2 (two) indicates the individual's assessed needs are consistent with services available through either the Living Choices Waiver program or a licensed nursing facility.
    3. Tier 3 (three) indicates the individual needs skilled care available through a licensed nursing facility and, therefore, is not eligible for the Living Choices Waiver program.

These indications notwithstanding, the final determination of Level of Care and functional eligibility is made by the Office of Long-Term Care (OLTC).

For more information on ARIA, please see the ARIA Provider Manual.

- F. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition that is temporary and expected to last no more than 21 days. However, that individual shall not receive waiver services or

benefits when subject to a condition or change of condition that would render the individual ineligible if the condition or change in condition is expected to last more than 21 days.

- G. Individuals diagnosed with a serious mental illness or mental retardation are not eligible for the Living Choices Assisted Living program unless they have medical needs unrelated to the diagnosis of mental illness or mental retardation and meet the other qualifying criteria. A diagnosis of severe mental illness or mental retardation must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation when they meet the other qualifying criteria.
- H. Eligibility for the Living Choices waiver program is determined as the latter of the date of application for the program, the date of admission to the assisted living facility or the date the plan of care is signed by the DHS RN and beneficiary. (If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process.)
- I. The Living Choices waiver provides for the entrance of all eligible persons on a first come, first-served basis, once individuals meet all medical and financial eligibility requirements. However, the waiver dictates a maximum number of unduplicated beneficiaries who can be served in any waiver year. Once the maximum number of unduplicated beneficiaries is projected to be reached considering the number of active cases and the number of pending applications, a waiting list will be implemented for this program and the following process will apply:
  - 1. Each Living Choices application will be accepted and medical and financial eligibility will be determined.
  - 2. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services, that all waiver slots are filled, and that the applicant is number X in line for an available slot.
  - 3. Entry to the waiver will then be prioritized based on the following criteria:
    - a. Waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error;
    - b. Waiver application determination date for persons being discharged from a nursing facility after a 90-day stay; waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;
    - c. Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);
    - d. Waiver application determination date for all other persons.

### 211.150 Level of Care Determination

1-1-19

A prospective Living Choices beneficiary must require a nursing facility intermediate level of care.

The intermediate level of care determination is made by medical staff with the Department of Human Services (DHS), Office of Long Term Care. The determination is based on the assessment performed by the Independent Assessment Contractor RN, using standard criteria for functional disability in evaluating an individual's need for nursing home placement in the absence of community alternatives. The level of care determination, in accordance with nursing home admission criteria, must be completed and the individual deemed eligible for an intermediate level of care by a licensed medical professional prior to receiving Living Choices services.

The Independent Assessment Contractor RN performs an assessment periodically (at least annually), and the Office of Long Term Care re-determines level of care annually. The results of

the level of care determination and the re-evaluation are documented on form DHS-704, Decision for Nursing Home Placement.

**NOTE: While federal guidelines require level of care reassessment at least annually, the Independent Assessment Contractor may reassess a beneficiary's level of care and/or need any time it is deemed appropriate by the DHS RN to ensure that a beneficiary is appropriately placed in the Living Choices Assisted Living Program and is receiving services suitable to his or her needs.**

## 211.200

## Plan of Care

1-1-19

- A. Each beneficiary in the Living Choices Assisted Living Program must have a person-centered service plan, also referred to as an individualized Living Choices Plan of Care (AAS-9503). The authority to develop a Living Choices plan of care is given to the Medicaid State agency's designee, the DHS RN. The Living Choices plan of care developed by the DHS RN includes without limitation:
1. Beneficiary identification and contact information to include full name and address, phone number, date of birth, Medicaid number and the effective date of Living Choices Assisted Living waiver eligibility;
  2. Primary and secondary diagnosis;
  3. Contact person;
  4. Physician's name and address;
  5. The amount, frequency and duration of required Living Choices services and the name of the service provider chosen by the beneficiary or representative to provide the services;
  6. Other services outside the Living Choices services, regardless of payment source identified and/or ordered to meet the beneficiary's needs. Living Choices providers are not required to provide these services, but they may not impede their delivery.
  7. The election of community services by the waiver beneficiary; and
  8. The name and title of the DHS RN responsible for the development of the plan of care.
  9. Each beneficiary, or his or her representative, has the right to choose the provider of each non-waiver service. Non-waiver services are the services listed on the plan of care that are not included in the bundled services of the Living Choices Program (e.g., medical equipment rental). The plan of care names the provider that the beneficiary (or the beneficiary's representative) has chosen to provide each service.
- B. A copy of the plan of care signed by the DHS RN and the waiver beneficiary will be forwarded to the beneficiary and the Living Choices service provider(s) chosen by the beneficiary or representative, if waiver eligibility is approved by the DHS County Office. Each provider is responsible for developing an implementation plan in accordance with the beneficiary plan of care. The original plan of care will be maintained by the DHS RN.

The implementation plan must be designed to ensure that services are:

1. Individualized to the beneficiary's unique circumstances;
2. Provided in the least restrictive environment possible;
3. Developed within a process ensuring participation of those concerned with the beneficiary's welfare;
4. Monitored and adjusted as needed, based on changes to the waiver plan of care, as reported by the DHS RN;

5. Provided within a system that safeguards the beneficiary's rights; and
6. Documented carefully, with assurance that appropriate records will be maintained.

**NOTE: Each service included on the Living Choices plan of care must be justified by the DHS RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary and other factors deemed appropriate by the DHS RN.**

Living Choices services must be provided according to the beneficiary plan of care. Providers may bill only for services in the amount and frequency that is authorized in the plan of care. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

**NOTE: Plans of care are updated annually by the DHS RN and sent to the assisted living provider prior to the expiration of the current plan of care. However, the provider has the responsibility for monitoring the plan of care expiration date and ensuring that services are delivered according to a valid plan of care. At least 30 and no more than 45 days before the expiration of each plan of care, the provider shall notify the DHS RN via email and copy the RN supervisor of the plan of care expiration date.**

**Services are not compensable unless there is a valid and current care plan in effect on the date of service.**

- C. The assisted living provider employs or contracts with a Registered Nurse (the "assisted living provider RN") who implements and coordinates plans of care, supervises nursing and direct care staff and monitors beneficiaries' status. At least once every three months, the assisted living provider RN must evaluate each Living Choices beneficiary.
- D. The DHS RN must reevaluate a beneficiary's medical condition within fourteen days of being notified of any significant change in the beneficiary's condition. The assisted living RN is responsible for immediately notifying the DHS RN regarding beneficiaries whose status or condition has changed and who need reevaluation and reassessment.

#### **REVISIONS TO A BENEFICIARY PLAN OF CARE MAY ONLY BE MADE BY THE DHS RN.**

**NOTE: All revisions to the plan of care must be authorized by the DHS RN. A revised plan of care will be sent to each appropriate provider. Regardless of when services are provided, unless the provider and the service are authorized on a Living Choices plan of care, services are considered non-covered and do not qualify for Medicaid reimbursement. Medicaid expenditures paid for services not authorized on the Living Choices plan of care are subject to recoupment.**

- E. An individual may be served in a Level II Assisted Living Facility under a provisional plan of care developed by the beneficiary and the DHS RN and signed by the beneficiary or the beneficiary's representative and the DHS RN, if the beneficiary and the provider accept the risk of possible ineligibility.
  1. A provisional plan of care may be effective for no more than 60 days.
  2. If approved by the Division of County Operations, eligibility for the program will be determined as the latter of the date of application for the program, the date of admission to the assisted living facility or the date the provisional plan of care is signed by the DHS RN and the beneficiary, and a plan of care will be sent to the provider.

**NOTE: No provisional plans of care will be developed if the waiting list process is in effect.**

**212.200      Periodic Nursing Evaluations      1-1-19**

The assisted living provider RN must evaluate each Living Choices Program beneficiary at least every three months, more often if necessary. The assisted living provider RN must alert the DHS RN to any indication that a beneficiary's direct care services needs are changing or have changed, so that the DHS RN can reassess the individual.

Each Living Choices beneficiary will be evaluated at least annually by a DHS RN. The DHS RN evaluates the resident to determine whether a nursing home intermediate level of care is still appropriate and whether the plan of care should continue unchanged or be revised. Re-evaluations and subsequent plan of care revisions must be made within fourteen days of any significant change in the beneficiary's status.

**215.000      Living Choices Forms      1-1-19**

Living Choices providers are required to utilize all program forms as appropriate and as instructed by the Division of Medical Services and the Division of Aging and Adult Services. These forms include without limitation:

- A. Plan of Care – AAS-9503
- B. Start Services – AAS-9510
- C. Beneficiary Change of Status – AAS-9511

Providers may request form AAS-9511 by writing to the Division of Aging, Adult and Behavioral Health Services. [View or print the Division of Aging, Adult and Behavioral Health Services contact information.](#)

Forms AAS-9503 and AAS-9510 will be mailed to the provider by the DHS RN.

Instructions for completion and retention are included with each form. If there are questions regarding any waiver form, providers may contact the DHS RN in your area.

**216.260      In-Service Training      1-1-19**

Medicaid requires personal care aides to participate in least twelve (12) hours of in-service training every twelve (12) months after achieving Personal Care Aide certification.

- A. Each in-service training session must be at least 1 hour in length.
  - 1. When appropriate, in-service training may occur at an assisted living facility when the aide is furnishing services.
  - 2. In-service training while serving a Living Choices beneficiary may occur only if the beneficiary or the beneficiary's representative has given prior written consent for training activities to occur concurrently with the beneficiary's care.
- B. The Living Choices provider and the personal care aide must maintain documentation that they are meeting the in-service training requirement.
- C. Providers are required to attend at least one in-service per calendar year. Required in-services are co-sponsored by DMS and DAABHS.

**250.100      Reimbursement of Living Choices Assisted Living Facilities and Agencies      1-1-19**

Medicaid reimbursement to Living Choices assisted living facility and agency providers is based on a statewide daily (per diem) rate, as determined by DMS and specified in the Fee Schedule under Section 250.210. The daily rate pays for all direct care services in the beneficiary's plan of care. Reimbursement is direct care for services only; room and board are to be paid by the beneficiary or his or her legal representative.

A day is a covered date of service when a Living Choices beneficiary receives any of the services described in Sections 212.100 through 212.500 between midnight of that day and midnight of the following day.

262.100

Living Choices Assisted Living Procedure Codes

1-1-19

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<b>Procedure Code</b>	<b>Modifier</b>	<b>Description</b>
T2031		Living Choices Assisted Living

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AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: January 1, 2019

CATEGORICALLY NEEDY

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1. Personal Care
  - A. Personal care services are provided by a personal care aide to assist with a client's physical dependency needs. The personal care aide must have at least 24 hours classroom training and a minimum of supervised practical training of 16 hours provided by or under the supervision of a registered nurse for a total of no less than 40 hours.
  - B. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease that are –
    1. Authorized for the individual in accordance with a service plan approved by the State;
    2. Provided by an individual who is qualified to provide such services; and
    3. Furnished in a home, and at the State's option, in another location, including licensed residential care facilities and licensed assisted living facilities.
  - C. The State defines "a member of the individual's family" as:
    1. A spouse,
    2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent,
    3. A minor's "guardian of the person" or anyone acting as a minor's "guardian of the person" or
    4. An adult's "guardian of the person" or anyone acting as an adult's "guardian of the person".
  - D. **Under no circumstances may Medicaid reimbursement be made for personal care services rendered by the client's:**
    1. **Legal guardian; or**
    2. **Attorney-in-fact granted authority to direct the client's care.**
  - E. Personal care services are covered for categorically needy individuals only.
  - F. Personal care services are medically necessary, prescribed services to assist clients with their physical dependency needs.
    1. Personal care services involve "hands-on" assistance, by a personal care aide, with a client's physical dependency needs (as opposed to purely housekeeping services). **Personal care services also include employment-related personal care associated with transportation.**
    2. The tasks the aide performs are similar to those that a nurse's aide would normally perform if the client were in a hospital or nursing facility.
  - G. Prior authorization is required for personal care pursuant to the Independent Assessment for all beneficiaries. **Personal care services for adults 21 years of age or older are limited to a maximum of 64 hours per calendar month.**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

iii. Payment Methodology (Continued)

- C. X The State will use a different reimbursement methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached.

iv. Use of Cash

- A. X The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.
- B.      The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

When the participant voluntarily elects to discontinue participation in IndependentChoices, **DHS professional staff** will discuss with the individual the reason for disenrollment and assist the individual in resolving any barriers or problems that may exist in preventing continuation. If the participant wishes to continue with the option to disenroll, **DHS professional staff** will assist by informing the participant of traditional agency personal care providers in the participant's area. **DHS professional staff** will assist with the coordination of agency services to the degree requested by the participant.

IndependentChoices can continue until agency services are established or the participant may elect to use informal supports until agency services are established.

The timeframes discussed under involuntary disenrollment do not apply to voluntary disenrollment. The request of the participant will be honored whether they ask to be disenrolled immediately or at anytime in the future. **DHS professional staff** will coordinate the participant's wishes to the degree requested by the participant. This may include self-advocacy by the participant and asking **DHS professional staff** to coordinate agency services with the participant's preferred provider. In some instances the participant may wish to forego agency personal assistance services and choose to rely on family or friends. If the participant requests that **DHS professional staff** coordinate the agency services, **DHS staff** will ascertain when services can be started. **DHS staff** will then close the IndependentChoices case the day before agency services begin. Regardless of the situation, the State will assure that there will not be an interruption in delivering necessary services unless it is the preference of the participant to depend on informal supports.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

vi. Involuntary Disenrollment

- A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to traditional service delivery model are noted below.

Participants may be disenrolled for the following reasons:

1. **Health and Welfare:** Any time **DPSQA** feels the health and welfare of the participant is compromised by continued participation in the IndependentChoices Program, the participant may be returned to the traditional personal care program. Prior to this point **counseling entity's support coordinator** has worked with the participant offering suggestions, identifying or changing representatives or employees to better meet the needs of the consumer, making in-home visits as needed by APS or HCBS RNs, and working to resolve these concerns. If no resolution is available, meeting the participant's health and well-being needs is of most importance; including referral back to the traditional model.
2. **Change in Condition:** Should the participant's cognitive ability to direct his/her own care diminish to a point where the participant can no longer self-direct and there is no responsible representative available to direct the care the **counseling entity's support coordinator** will seek out sources of support. If no resources are available, the IndependentChoices case will be closed. The participant will be informed of the pending closure by letter. The letter will include a list of traditional personal care agencies serving the participant's area. If the participant is also a 1915(c) waiver recipient, an e-mail will be auto generated to the HCBS RN or targeted case manager. The e-mail to the HCBS RN or targeted case manager is auto generated and populated with the appropriate names once a closure date is entered in the database. The e-mail will inform the HCBS RN or targeted case manager of the pending closure of the IndependentChoices case necessitating a change in the HCBS service plan. Within five days of sending the letter the **counseling entity's support coordinator** will follow up with the participant to determine which agency the participant may wish to choose. The **counseling entity's support coordinator** will coordinate the referral with the agency provider. However, if the participant declines agency services, the **counseling entity's support coordinator** will respect the choice made by the participant. The participant may choose to have their needs met by informal caregivers.
3. **Misuse of Allowance:** A notice will be issued should the participant or the representative who manages their cash allowance: 1) fail to pay related state and federal payroll taxes; 2) use the allowance to purchase items unrelated to personal care needs; 3) fail to pay the salary of a personal assistant; or 4) misrepresent payment of a personal assistant's salary. The **counseling entity's support coordinator** will discuss the violations with the participant and allow the participant to take corrective action including restitution if applicable. The participant will be permitted to remain in the program, but will be assigned to the fiscal intermediary, who will provide maximum bookkeeping support and services. The participant or representative will be notified that further failure to follow the expenditure plan will result in disenrollment and a report filed with Office of Medicaid Inspector General when applicable.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

## 1915(j) Self-Directed Personal Assistance Services (Continued)

## vi. Involuntary Disenrollment (Continued)

Should an unapproved expenditure or oversight occur a second time, the participant/representative will be notified that their IndependentChoices case is being closed and the participant is being returned to traditional personal care. Office of Medicaid Inspector General is informed of situations as required. The State will assure interruption of services will not occur while the participant is transitioning from IndependentChoices to traditional services.

4. Underutilization of Allowance: The fiscal intermediary is responsible for monitoring the use of Medicaid funds received on behalf of the participant. If the participant is underutilizing the allowance and not using the allowance according to their cash expenditure plan, the fiscal intermediary will inform the counseling entities through quarterly reports and monthly reports upon request. The **counseling entity's support coordinator** will discuss problems that are occurring with the participant and their support network. Together the parties will resolve the underutilization. The **counseling entity's support coordinator** will continue to monitor the participant's use of their allowance through both reviewing of reports and personal contact with the participant. If a pattern of underutilization continues to occur, future discussions will focus on what is in the best interest of the participant in meeting their ADLs even if the best solution is a return to agency services. Unused funds are returned to the Arkansas Medicaid program within 45 days upon disenrollment. Funds accrued in the absence of a savings plan will be returned to the Arkansas Medicaid program within a twelve month filing deadline. Exceptions to involuntary disenrollment may be considered if the participant has been hospitalized for an extended period of time or has had a brief visit out of state with approval by the participant's physician. Person-centered planning allows the flexibility of decision making based on individual needs that best meet the needs of the participant.
5. Failure to Assume Employer Authority: Failure to Assume Employer Authority occurs when a participant fails to fulfill the role of employer and does not respond to counseling support. Participants who fail in their employer responsibilities but do not have a representative will be given the opportunity to select a representative who can assume employer responsibilities on behalf of the participant. Disenrollment will not occur without guidance and counseling by the **counseling entity's support coordinator** or by the fiscal intermediary. When this occurs, the **counseling entity's support coordinator** will coordinate agency personal care services to the degree requested by the participant. The participant may wish to self-advocate from a list provided by the **counseling entity's support coordinator**, ask the **counseling entity's support coordinator** to coordinate, or may simply wish to receive personal assistance services informally. The participant's wishes will be respected.
- B. The State will provide the following safeguards to ensure continuity of services and assure participant health, safety and welfare during the period of transition between self-directed and traditional service delivery models.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

vi. Involuntary Disenrollment (Continued)

When a participant is involuntarily disenrolled, a notice of intent to close the IndependentChoices case will be mailed to the participant. The notice will allow a minimum of 10 days but no more than 30 days before IndependentChoices enrollment will be discontinued, depending on the situation. During the transition period, the **counseling entity's support coordinator** will work with the participant/representative to assure services are provided to help the individual transition to the most appropriate personal care services available.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

There are no additional restrictions on living arrangements.

viii. Geographic Limitations and Comparability

- A.  X  The State elects to provide self-directed personal assistance services on a statewide basis.
- B.      The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe: \_\_\_\_\_
- C.      The State elects to provide self-directed personal assistance services to all eligible populations.
- D.  X  The State elects to provide self-directed personal assistance services to targeted populations. Please describe: Age 18 and older.
- E.      The State elects to provide self-directed personal assistance services to an unlimited number of participants.
- F.  X  The State elects to provide self-directed personal assistance services to 7500 participants, at any given time.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Not applicable. The state will not allow entities who provide other Medicaid State Plan services to be responsible for developing the self-directed service plan.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including:

- i. How it will conduct activities of discovery, remediation and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and
- ii. The system performance measures, outcome measures and satisfaction measures that the State will monitor and evaluate.

Many activities evaluate the overall performance of the IndependentChoices program such as:

- The IndependentChoices program uses a database to track a wide array of data, and uses all of the data it stores. Data entry drives end user functionality through form and e-mail generation, field calculation, data cross-referencing, and notices and reports. The reporting capabilities can help to monitor every element of operations such as: case particulars, work reports and management and operational tools. Use of the database supports discovery, remediation, and quality improvements.
- Using a **DHS**-approved assessment tool to determine the resources in time required to provide care in the home.
- Reports received from Financial Management Services provider received on a quarterly basis used by **DHS Independent Choices QA staff** to determine why underutilization of the Cash Expenditure Plan occurs and how underutilization can be resolved.

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State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

All individual facets of the program work in a continuum to identify, remediate and improve the quality of services and the satisfaction of program participants while improving the overall performance of the program. Each phase of the program is described, detailing how assurances are met through the Arkansas Quality Assurance and Improvement Plan described below.

Monitoring and Oversight

The Division of Medical Services (DMS) retains responsibility for the administration and oversight of all Medicaid programs. The Division of **Provider Services and Quality Assurance (DPSQA)** is the operating agency for the IndependentChoices program and responsible for the day-to-day operations. Both Divisions are part of the Arkansas Department of Human Services. **DPSQA** will be responsible for executing the Quality Assurance and Improvement Plan with monitoring and oversight by DMS.

**DPSQA** will provide DMS with a monthly report comparing status of current data to previous year data. Examples included in the report may include but are not limited to the following:

- Enrollment activities
- Status of pending applications
- Status of active case load
- Participants who also receive home and community based services (HCBS)
- Medicaid Cost for IndependentChoices including participant-directed cost for HCBS services
- Detailed information for cost data for the most current month including cost of participant's budget and support services.
- Year in Progress, count of participants, contact notes, home visits, new enrollments for the current month, year to date and accumulative prior year experiences.

Lines of communication between the two Divisions are established and utilized to discuss additional needs and concerns that either Division may have.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

The IndependentChoices database is designed in such a way that discovery and remediation go hand in hand; not only for the **DHS Independent Choices QA staff**, nurses and contractors, but also for management staff. By design, the efficiency of the database enhances the **DHS Independent Choices QA staff's** ability to **monitor the program without being** overly burdened by paperwork. Examples on the following pages may include but are not limited to:

The database quantifies:

- referrals received during the month,
- persons disenrolling,

The database identifies:

- reasons for disenrolling from the program,
- IndependentChoices participants who also receive HCBS waiver services,
- the HCBS RN assigned to the participant,
- the participant's physician,
- physician's fax number,
- date of next reassessment due.

The database tracks and creates exception reports when standards are not met and quantifies results. Some examples of the reports are:

- time between the date of referral, the nurse's home visit, and receipt of the assessment from the **DHS Independent Assessment Contractor**,
- time between the referral and the actual enrollment
- number of home visits made by HCBS RN's within a timeframe.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Each active and pending record contained within the database only includes data fields that are used in reporting. Each participant record may include the following:

- representative information, if applicable,
- participant's employee,
- participant's back-up worker,
- directions to the participant's home,
- nurse tracking,
- **Independent Choices QA** tracking,
- contact notes,
- HCBS ARChoices service plan for persons receiving both ARChoices and IndependentChoices.

These data elements will assist the **DHS Independent Choices QA staff** and nurses in performing their duties by allowing timely management and monitoring of each participant's case. The database allows nurses, **DHS Independent Choices QA staff** or contractors to set health risk indicators identifying program participants who may require more frequent monitoring.

The data allows nurses and **DHS Independent Choices QA staff** to run reports from their case load. Automated highlights on specific data elements draw the nurse or **DHS Independent Choices QA staff** attention to areas that require special attention. Highlighted data fields represent the following:

- assessment performed by the **DHS Independent Assessment Contractor** but not received by **DPSQA**,
- date enrollment forms sent to a potential enrollee but not returned.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Reports are available to management to monitor quality of services provided to program participants and performance of staff. The reports identify program strengths and weaknesses or individual areas of concern. Reports compare data elements over periods of time to measure progress of corrective actions. As issues are identified they are addressed with appropriate staff to determine a new course of action through issuing new policy, enacting new procedures, clarifying an existing policy or procedure, or developing additional training. Identified issues continue to be monitored to determine if the corrective action is resolving the concern and is achieving the expected outcomes.

These reports allow flexibility to generate data based on any specified period of time, by a nurse, **DHS Independent Choices QA staff**, contractor or by management. Reporting frequencies range from daily, monthly, or annually. Policy dictates a maximum period of time for completion of specific tasks with the focus on completing necessary tasks that allow the program participant to direct and meet their own health care needs.

Reporting is used to identify and remediate problems, improve program operation and to evaluate staff performance.

The database stores contact notes documenting IndependentChoices **QA** staff and contractors' communication with program participants. Policy requires each contact note to be entered into the participant's record to enhance the ability of management to address concerns expressed by the participant, a legislator, the Governor's Office, etc., with a quick review of the contact notes.

Examples of data elements found in the nurse tracking database portion may include, but is not limited to these data elements describing some of the following characteristics:

- **Level of care tier** category
- principal diagnosis,
- secondary diagnoses,
- participant well cared for,
- strong informal supports,
- no concerns noted,
- need for frequent **counseling entity's support coordinator** contact.

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State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Contact notes may include the following:

- person initiating the call,
- person receiving the call,
- date and time of call,
- subject of contact
- description of communication,
- complaint indicator
- whom complaint is directed toward
- date of complaint resolution

Nurses are supported by the Nurse Case Load Report that quantifies the active and pending caseload for each nurse by describing the following:

- by county, the number of active and pending clients with or without home and community-based services,
- data is also displayed in the aggregate by nurse per assigned counties.

**The DHS Independent Assessment Contractor uses a DHS-approved assessment tool to define the participant's medical needs relative to the amount of resources required to care for the person in the home. The DHS-approved assessment tool is similar to the MDS assessment performed in nursing homes but is specifically designed for the community environment. The assessment results in a **level of care tier** defining the degree of functional impairment. These results help define the population served in addition to using a scientifically scaled and validated assessment instrument. The use of this assessment helps to more clearly describe the medical complexities of program participants as they strive to remain in the community and avoid institutionalization.**

Monitoring occurs in various other ways such as:

- Underutilization of the allowance could be the first indication that a participant may be experiencing difficulty directing their own care. It could indicate the beginning of a decline in cognitive function, impairing the participant's ability to direct their care, a need for a representative or decision making partner; a loss of worker; or it may be nothing more than not submitting the timesheets in a timely manner. Each **counseling entity's support coordinator** works with his or her participants to determine the cause of the underutilization. The **counseling entity's support coordinator** and participant work together to resolve the problem with the **counseling entity's support coordinator** providing further assistance, as needed, or by the participant meeting his or her responsibilities as an employer. The **counseling entity's support coordinator** follows-up with additional calls to the participant and monitors future underutilization reports for reoccurrences.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

- Site visits to the contractors are made at a minimum bi-annually and more often if needed. The purpose of the site visit may be to provide an in-service, address concerns, or to evaluate performance. If during an evaluation deficiencies are noted, **DPSQA** may provide additional in-services, require an acceptable corrective action plan, monitor the corrective action plan, withhold payment or terminate the contract.

Participant Feedback

The **DPSQA** and its counseling and fiscal contractors support and encourage participant communication by provision of a toll-free number. Participants may pose questions and voice concerns using the toll-free number. Incoming calls from participants and outgoing calls from **counseling entity's support coordinators** or contractors are entered into the participant's individual electronic record. If the communication is an expressed complaint the **counseling entity's support coordinator** follows **DPSQA** required reporting procedures for documenting and resolving the complaint. Resolutions may include policy or procedural changes. Monitoring will continue to determine if the change has any impact or if the problem needs additional review.

A DHS appeal process is available for decisions made concerning Medicaid eligibility. An internal appeal process is available for participants when they are in disagreement with the number of hours recommended by the HCBS RN, involuntary disenrollment or if they have disagreements with their **counseling entity's support coordinator** or fiscal agent. The purpose of the internal appeal is to allow the participant a voice in the decision and a way to mediate any misunderstandings between the participant and the IndependentChoices program. Additional supporting information may be shared during this time. **DPSQA** will issue a letter to the participant within five days from the date the internal appeal is conducted. Most disagreements are resolved prior to a participant initiating a request for a fair hearing and appeal. A formal Medicaid Fair Hearing is available when services are reduced, suspended, eliminated, or upon loss of Medicaid eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Information and Assistance

Brochures are available for marketing purposes and are provided to any of the 75 county offices upon request.

Each participant receives a program handbook to convey program guidelines and expectations. Examples of information provided may include any of the following and is subject to additions and deletions as needs arise:

- Overview of the IndependentChoices program
- Overview of support services
- Use of a representative (Decision-Making Partner)
- Eligibility
- Participant rights
- Participant responsibilities
- Personal assistance services
- Other Medicaid services
- Medicaid waiver services
- Expectations from **counseling entity's support coordinator**, nurse, bookkeeper
- Participant's enrollment duties
- Confidentiality
- When participant-direction begins
- Case Expenditure Plan
- Record Keeping
- Payroll
- Timesheets
- Hiring, training, conflict resolution, and termination of personal assistant
- Adult protective services
- Support services monitoring
- Reassessments
- Appeal rights

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State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Participants may also receive in-home visits, newsletters, questionnaires, and contact by phone to support participants wishing to direct their own care.

Participants can speak with their **counseling entity's support coordinator** or the fiscal intermediary from 8:00 a.m. until 4:30 p.m., Monday through Friday, except for legal holidays or during inclement weather. After hours the participant may leave a message; the **counseling entity's support coordinator** will return the call within one working day. Complaints are entered by the receiving party whether that is the **counseling entity's support coordinator** or the fiscal intermediary.

A packet of communication forms is provided to each participant to report a change, to revoke and/or change disclosure of information and to appeal adverse decisions. The **counseling entity's support coordinator** may also verbally take information related to changes in address or phone number.

Health and Welfare

Each participant must have an individual back-up plan to handle situations when the participant's primary employee is unavailable. The participant identifies a person who is willing to assume the tasks of the primary employee. The participant determines the risk involved and how the risk is mitigated based on their own individual needs. Inquiry of the use of the back-up plan occurs during phone communication with the participant. Reports from the IndependentChoices database can identify any program participant without a back-up personal attendant and if there is a conflict regarding a representative serving as a paid back-up personal attendant. The **counseling entity's support coordinator** initiates communications with the participant to begin remediation.

**The counseling entity's support coordinator** and fiscal entities will work closely together to provide information necessary for each entity to perform their duties. Frequent and thorough communication facilitates this good working relationship.

The database assists in addressing health and welfare concerns by allowing monitoring and management of each individual file by:

- identifying a participant's representative, employee, physician, back-up worker, directions to the home, results of the **Independent Assessment**, and updates by the **counseling entity's support coordinator** assisting the participant in the IndependentChoices program, and;
- documenting all communications with the program participants.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Financial Accountability

**DPSQA** assures that payments are made to Medicaid eligible participants by:

- accessing Medicaid eligibility data prior to enrolling a person into IndependentChoices to assure eligibility for Medicaid and the IndependentChoices program;
- IndependentChoices program logic implemented by the Arkansas Medicaid fiscal intermediary, interfaces with the Medicaid Management Information System (MMIS) to edit against creation of an allowance for any participant who is no longer Medicaid eligible or is institutionalized;
- **DPSQA** maintains the MMIS eligibility file for IndependentChoices. The Arkansas fiscal intermediary reads the MMIS eligibility file to create claims for the IndependentChoices program. **DPSQA** queries on a weekly basis the Medicaid data warehouse to identify persons who are deceased, entered a nursing home, or have lost Medicaid eligibility. Once identified, the IndependentChoices eligibility segment is closed by **DHS** Independent Choices **QA staff** on a weekly basis. Through contact with the participant or participant's family or representative this information is obtained prior to the update of the MMIS;
- **DPSQA** also queries the Medicaid data warehouse to identify IndependentChoices participants who have had an acute hospitalization. Once identified, **DPSQA** informs the program participant, FMS provider and the counseling entity by letter that the participant's allowance paid prospectively during the hospitalization must be returned to the Medicaid program. The day of admission and day of discharge are allowable days;
- preventing duplication of agency and consumer-directed services by informing agency provider by fax seven days in advance the date the participant will begin directing their own personal care services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Qualified Providers

IndependentChoices counseling and fiscal providers assist program participants in all phases of program participation. Some of the examples of the work by these providers may include but is not limited to any of the work activities below:

- enrollment of new participants;
- develop and implement participant-directed budget;
- coordinate with FMS provider and **DPSQA**;
- orientation to IndependentChoices and the philosophy of participant direction;
- offer skills training to the degree desired by the participant on how to recruit, interview, hire, evaluate, manage or dismiss assistants;
- participant-directed counseling support services;
- monitoring IndependentChoices participants/representatives;
- monitor over and under expenditures of Cash Expenditure Plan;
- provide quarterly reports to **DPSQA**;
- manage the individual budget on behalf of the participant;
- process payroll and support payment for other qualified services and supports;
- report and pay state and federal income taxes, FICA, Medicare, and state and federal unemployment taxes;
- verify citizenship status of workers;
- serve as the fiscal agent of the participant per IRS rules;
- issues reports to **DPSQA**;
- communicate with **counseling entity's support coordinator** on budget changes;
- inform participants of their individual budget balance.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Qualified Providers (continued)

**DPSQA** is responsible for the following activities:

- monitor the counseling and fiscal providers to ensure compliance with the spirit of participant-direction and that appropriate counseling, fiscal and programmatic procedures are maintained;
- serve as the liaison between counseling agency, fiscal provider, Medicaid Management Information System (MMIS), and the Arkansas Medicaid fiscal intermediary;
- monitor the process to reimburse the counseling agency and fiscal provider for services provided to program participants.

Quality assurance measures previously discussed, assist **DPSQA** in discovery and remediation to assure high standards in the offering and management of the participant-directed personal care program. The IndependentChoices program establishes, as its foundation, a person-centered approach that guides not only **DPSQA**, but counseling and fiscal providers as well.

xii Risk Management

- A. The risk assessment methods used to identify potential risks to participants are described below:

The HCBS RN or the **counseling entity's support coordinator** is the catalyst for identifying potential risks. In-home visits by either party help to identify risks involved in the current home environment as well as potential risks involved with self-direction. The **counseling entity's support coordinator** or the HCBS RN can identify risks that may be environmental in nature such as throw rugs, uneven floors, etc. or the **DHS**-approved assessment tool may identify potential risks such as not receiving a flu vaccine, etc. Based on the HCBS RN's observation and the **DHS**-approved assessment tool, the HCBS RN after receiving notification from the **counseling entity's support coordinator** will discuss the potential risks identified with the individual. If the HCBS RN determines that a representative is needed, the RN will inform the **counseling entity's support coordinator**.

When the HCBS RN determines that a person is in need of a representative, the nurse will inform the **counseling entity's support coordinator** and the **counseling entity's support coordinator** will work with the participant to determine if there is someone who knows the participant's likes, dislikes, and preferences and is willing to accept the responsibilities to represent the participant in the IndependentChoices program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xii. Risk Management (Continued)

The **counseling entity's support coordinator** is responsible for working with the participant to determine who can serve as the representative. The **counseling entity's support coordinator** will then work with the representative to teach, educate and work with the proposed representative so that the representative is fully aware of the responsibilities they are accepting in representing a person in a participant-directed program.

If the HCBS RN arrives and the participant is experiencing cognitive impairment and no informal supports are present, the participant will be discouraged from enrolling unless an informal support system can be identified, including someone to act as a representative decision maker. Participation in IndependentChoices requires the participant or their representative to be assertive in their role as employer and accept the risks, rights and responsibilities of directing their own care. If a representative is unavailable and the potential enrollee is incapable of performing these tasks without health and safety risks the person will not be enrolled. Blatant health and welfare concerns will not be compromised if solutions cannot be identified and enacted.

In addition to the HCBS RN's involvement there is communication with other agency providers providing home and community based services, with all parties having a vested interest in the health and welfare of the participant. This communication assists the operating agency to respond to any voiced concern with self-directed care.

The Participant Responsibilities and Agreement Form, which details all the requirements of self-direction, identifies areas where the individual may not be able to meet their responsibilities.

B. The tools or instruments used to mitigate identified risks are described below.

Every opportunity is afforded a participant to direct their own care, but the participant must accept and assume employer responsibility. Counseling support is available to help the participant, but ultimately it is the determination of the participant to succeed that determines whether participant direction will be a successful program for them. The IndependentChoices program requires a participant to make good decisions in order to assure that their personal assistance needs are met.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

## 1915(j) Self-Directed Personal Assistance Services (Continued)

## xii. Risk Management (Continued)

When a participant needs a representative, the program allows for appointment of a Decision-Making Partner (DMP) who is willing to act and assume the employer role for the participant. The **counseling entity's support coordinator** is the person responsible for working with the participant or the participant's family in the appointment of a **Representative or** decision-making partner. Each time a **Representative or** DMP is appointed the enrollment of the DMP is similar to a new participant enrollment. The **Representative or** DMP must be at least 18 years of age and able and willing to meet the following requirements:

- Possess knowledge of the participant's preferences
- Be willing to meet and uphold all program requirements
- Be willing to sign tax form and verify timesheets,
- Show a strong personal commitment to the participant
- Visit the participant at least weekly
- Uphold all duties without influence by the personal assistant or paid back-up worker
- Obtain approval from the participant and a consensus from other family members of the participant to serve as the DMP
- Be willing to submit to a criminal background check
- Be available to discuss the program hours

**Once the participant has appointed a Representative or DMP**, there are specific forms that must be completed.

If at any time **DPSQA** learns that the participant's personal attendant is not providing the care agreed upon, the counselor will contact the participant/representative to ascertain the ability of the participant/representative to fulfill the role of employer. This discussion is to seek what types of assistance or support the participant or representative may need. A review of recurring instances of noncompliance could be reason for involuntary disenrollment.

When persons affiliated with the IndependentChoices program suspect abuse or neglect causing potential for health and safety risk to the participant by the representative, family members, personal attendant, or others, the participant will be referred to Adult Protective Services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

xii. Risk Management (Continued)

- C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

The service plan is a result of the **Independent Assessment and a form designated by DHS** and will list **the** risks identified in the assessment. The service plan will **also require the nurse to list** any other risks identified through observation that **were** not identified through the **Independent Assessment or form designated by DHS**, or risks identified by the participant, representative or interested parties through a participant-centered approach. The **service plan will identify the plan** or actions needed to mitigate the risks and who is responsible for each action. The service plan requires the signature of the participant/representative, **agreeing to the service plan and what the participant/representative is willing to do to mitigate risk.**

- D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

**IndependentChoices nurses and counseling entity's support coordinator** are trained to apply a participant-centered approach in developing all plans with the participant. Participants are always encouraged to invite friends and family members who have a personal commitment to the participant to be present in all meetings between the participant and nurse or **counseling entity's support coordinator**. Identified risks will be discussed with the participant/representative and interested parties to determine a plan to mitigate the risk. The **nurse and counseling entity's support coordinator are there to facilitate and guide** the discussion and identify concerns with any discussed approaches to mitigation of risk.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

## 1915(j) Self-Directed Personal Assistance Services (Continued)

## xiii. Qualifications of Providers of Personal Assistance

- A.  The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.
- B.  The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

## xiv. Use of Representative

- A.  The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.
- v.  The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.

If the participant has been diagnosed with a mental or cognitive impairment such as mental retardation, dementia, Alzheimer's Disease, etc., the participant or family members close to the participant will be required to choose a representative in order to participate or continue to participate in Independent Choices. **If the participant has not been diagnosed with a mental condition, but the DPSQA RN and counseling staff determines through the Self-Assessment instrument, discussions with the participant, and sometimes a trial period of self-direction with enhanced counseling, that the individual's cognitive abilities are not sufficient to self-direct, the participant will be required to choose a representative. The counseling staff will work with the participant to establish a representative, using all avenues to find one if necessary. If the participant refuses to select a representative or the participant cannot find anyone who can act in that capacity after all avenues have been exhausted, the counseling entity's support coordinator will coordinate with the participant to transition the participant to the traditional personal care provider of choice.**

- B.  The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

## xv. Permissible Purchases

- a.  The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.
- b.  The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

1915(j) Self-Directed Personal Assistance Services (Continued)

iii. Financial Management Services

- C. X The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.
- v. \_\_\_\_\_ The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with Section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or
  - vi. X The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with Section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth in Federal regulations 45 CFR Section 74.40 – Section 74.48.)
  - vii. \_\_\_\_\_ The State elects to provide financial management services using “agency with choice” organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.
- D. \_\_\_\_\_ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

*TOC required*

## 200.000 INDEPENDENTCHOICES GENERAL INFORMATION

### 200.100 IndependentChoices

1-1-19

The IndependentChoices program is a state plan service under 1915(j) of the Social Security Act. IndependentChoices is operated by the Division of Provider Services and Quality Assurance (DPSQA) with support from the Division of Aging, Adult, and Behavioral Services (DAABHS). The program offers Medicaid-eligible individuals who are elderly and individuals with disabilities an opportunity to self-direct their personal assistant services.

IndependentChoices seeks to increase the opportunity for consumer direction and control for Medicaid beneficiaries receiving or needing personal assistant services. Personal Assistant services in IndependentChoices include state plan personal care for Medicaid beneficiaries and attendant care services for ARChoices in Homecare (ARChoices) beneficiaries. IndependentChoices offers an allowance and counseling services in place of traditional agency-provided personal assistance services and items related to personal assistance needs.

The participant or designee is the employer and accepts the responsibility in directing the work of their employee to the degree necessary to meet their individual needs for assistance with activities of daily living and instrumental activities of daily living.

If the participant needs someone to hire and supervise the personal assistant, make decisions about care and administer the cash expenditure plan as well as complete all forms, a Representative may be appointed.

IndependentChoices participants or their Representative must be able to assume the responsibilities of becoming an employer by hiring, training, supervising and firing if necessary their directly hired workers. In doing so the program participant accepts the risks, rights and responsibilities of directing their care and having their health care needs met.

The IndependentChoices program respects the employer authority of the participant who chooses to direct his or her care by hiring an employee who will be trained by the employer (the participant or Representative) to provide assistance how, when, and where the employer or Decision-Making Partner determines will best meet the participant's individual needs. The Medicaid beneficiary assumes the risks, rights and responsibilities of having their health care needs met in doing so.

**NOTE: The IndependentChoices Program follows the rules and regulations of the State Plan approved Personal Care Program, unless stated otherwise in this manual.**

### 200.200 Eligibility

1-1-19

To be eligible for IndependentChoices, a participant must:

- A. Be 18 years of age or older
- B. Be eligible for Medicaid, as determined by the DHS Division of County Operations, in a category that covers personal care, or be eligible for Supplemental Security Income (SSI) through the Social Security Administration, or be eligible for ARChoices and determined in need of attendant care services or personal care by the DHS Registered Nurse (RN).
- C. Be receiving personal assistance services or be medically eligible to receive personal assistance services. Personal assistance services include state plan personal care and ARChoices attendant care services.
  1. **Personal Care:** In determining eligibility and level of need for personal care, IndependentChoices follows policy found in the Arkansas Medicaid Personal Care Provider Manual.

2. **Attendant Care:** The DHS RN must determine and authorize attendant care services based on ARChoices policy.
- D. Not be living in a home or property owned, operated or controlled by a provider of services unless the provider is related by blood or marriage to the participant. This includes single family homes, group homes, adult family homes, congregate settings, a living situation sponsored or staffed by an agency provider, etc.
- E. Be willing to participate in IndependentChoices and understand the rights, risks and responsibilities of managing his or her own care with an allowance; or, if unable to make decisions independently, have a willing Representative who understands the rights, risks and responsibilities of managing the care of the participant with an allowance.

## 202.000 Participation Requirements

### 202.100 Participants

1-1-19

Individuals meeting participant eligibility requirements may enroll in the program. Personal contact will be made by telephone and in person to determine the individual's ability to understand the requirements for directing his or her own personal assistance services. Individuals who are not comfortable with this responsibility or who are determined to be unable to understand this responsibility will be asked to identify a Representative. Individuals who are unable to understand the risks, rights and responsibilities of managing personal assistance services with an allowance and who do not have anyone to serve as a Representative will be discouraged from participating in IndependentChoices.

If the individual has a mental or cognitive limitation that restricts him or her from voicing his or her preferences and self-directing his or her care, the individual will not be able to participate in IndependentChoices without a Representative. Individuals able to voice their preferences and self-direct their care, but having limitations that hinder their ability to keep up with the paperwork involved, such as signing timesheets, etc., may have their Representative assist them. If at any time the individual's health and safety is jeopardized because of the inability to self-direct his or her care and there is no Representative available, the individual will be disenrolled from IndependentChoices.

### 202.200 Representative(s)

1-1-19

A Representative will be required if the individual interested in participating has a court-appointed legal guardian, other appointed representative, i.e., power of attorney, or an established payee of income. A Representative will also be required for any potential enrollee or participant who is:

- A. Unable to understand his or her own care needs
- B. Unable to make decisions about his or her care
- C. Unable to organize his or her life style and environment by making these choices
- D. Unable to understand how to recruit, hire, train and supervise personal assistants
- E. Unable to understand the impact of his or her decisions and assume responsibility for the results
- F. Noncompliant with project objectives when circumstances indicate a change of competency or ability to self direct

The enrollee, counseling staff, or a representative of the fiscal agency may request a Representative. A Representative may be a legal guardian, other legally appointed Representative, an income payee, family member, or friend. The Representative may not be



paid for this service and may not be an employee of the participant. A Representative must be at least 18 years of age and demonstrate a strong personal commitment to the participant and be knowledgeable of the participant's preferences. The individual chosen as Representative must be willing and capable of complying with all program criteria and responsibilities.

### 202.300 Enrollment

1-1-19

The Division of Aging, Adult, Behavioral Services (DAABHS) is the point of entry for ARChoices waiver participants who choose self-direction via the IndependentChoices program. The counseling entity is the point of entry for Personal Care participants who choose self-direction. The IndependentChoices program is limited based on an approved number through the Medicaid State Plan.

The individual or their designee will first call the Counseling Entity's toll-free number at 866-710-0456. Information about the program is provided to the individual and verification made that the individual is currently enrolled in a Medicaid category that covers personal assistance services. If the individual is currently enrolled in an appropriate Medicaid category and has an assessed physical dependency need for "hands on" assistance with personal care needs, DPSQA will enter the participant's information into a DPSQA database. If the individual is not currently enrolled in an appropriate Medicaid category, the individual will be referred to the DHS County Office for eligibility determination.

The counseling entity's support coordinators and fiscal agent will then work with the individual to complete the enrollment forms either by mail and telephone contact or by a face-to-face meeting. The individual will be provided with a program manual, which explains the individual's responsibilities regarding enrollment and continuing participation. The individual must complete the forms in the Enrollment Packet, which consists of the Participant Responsibilities and Agreement, the Backup Personal Assistant (Caregiver) and the Authorization to Disclose Health Information. The individual must also complete the forms in the Employer Packet, which includes the Limited Power of Attorney, IRS and direct deposit forms related to being a household employer. Each caregiver/employee must complete the forms in the Employee Packet which include the standard tax withholding forms normally completed by an employee, the Employment Eligibility Verification Form (I-9), a Participant/Caregiver Agreement, Employment Application a Caregiver/Employee Agreement, as well as documents pertinent to a criminal background check including maltreatment registry requests and a consent form a release results of a criminal history report from the Arkansas Crime Information Center (Arkansas State Police). Each packet includes step-by-step instructions on how to complete the above forms. Assistance is available to the individual, Representative and the personal assistant to help complete the forms and answer any questions.

As part of the enrollment process, the DHS Independent Assessment contractor will complete an assessment. DHS professional staff or contractor(s) designated by DHS will use the Task and Hour Standards to determine the level of medical necessity. This determination creates the budget for self-directed services. Eligibility for personal care services is based on the same criteria as state plan personal care services. **NOTE:** For ARChoices beneficiaries, the DHS RN will determine the need for personal care and attendant care hours using the Task and Hour Standards, subject to the beneficiary's ARChoices Individual Services Budget. The ARChoices person-centered service plan will reflect that the beneficiary chooses IndependentChoices as the provider. .

After the independent assessment, the counseling entity's support coordinators and the fiscal agent will process all of the completed enrollment forms. The assessment is sent to DHS professional staff or contractor(s) designated by DHS for authorization if the beneficiary is not authorized for services through a waiver person-centered service plan for ARChoices. State and IRS tax forms will be retained by the fiscal agent. Disbursement of funds to a beneficiary or their employee will not occur until all required forms are accurately completed and in the possession of the fiscal agent.

For beneficiaries under age 21, all personal care hours must be authorized through the designated DHS contractor.

IndependentChoices follows the rules and regulations found in the Arkansas Medicaid Personal Care Provider Manual in determining and authorizing personal care hours. For beneficiaries receiving services through the ARChoices waiver program, the signature of the DHS RN is sufficient to authorize personal care services. After the service plan is authorized, the actual day services begin is dependent upon all of the following conditions:

- A. DAABHS issues a seven-day notice to discontinue service to any agency personal care, ARChoices provider currently providing services to the individual.
- B. The date the beneficiary's worker is able to begin providing the necessary care. It can be no earlier than the date DHS professional staff or contractor(s) designated by DHS authorized the service plan for the non-waiver eligible participant, if an agency provider is not providing the personal care services.
- C. The fiscal agent is in possession of all required employer and employee documents.

If the beneficiary is not also a beneficiary of ARChoices services, then continuation of personal assistance services requires reauthorization prior to the end of the current service plan end date.

The counseling entity's support coordinator will contact the participant/employer to develop the cash expenditure plan. Services may not commence prior to the date authorized by DHS professional staff or contractor(s) designated by DHS.

#### **202.600 Cash Expenditure Plan**

**1-1-19**

The amount of the Cash Expenditure Plan (CEP) is determined by DHS professional staff or contractor(s) designated by DHS using the Task and Hour Standards to determine the level of medical necessity. For ARChoices beneficiaries, the CEP is subject to the beneficiary's ARChoices Individual Services Budget. The counseling entity's support contractor and the participant/employer or Representative will work together to develop the CEP, which may be updated and revised whenever a need arises. The CEP is intended to be a blueprint of how the monthly allowance may be spent to meet the needs identified in the service plan. The CEP may include ten percent of the amount of the participant's plan as a discretionary expenditure not to exceed \$75.00. The discretionary expenditure is used to purchase personal hygiene items and does not require the participant to maintain receipts for the purchases. For reporting purposes, discretionary purchases will be self-declared by the participant and will be part of the quarterly reporting requirement performed by the fiscal agent.

#### **202.800 Participant/Caregiver Agreements**

**1-1-19**

The fiscal agent is responsible for obtaining the Worker Information and Qualification Form. The purpose of this form is to state the agreements to which both the employer and the employee(s) are in agreement. The agreement is signed by both the beneficiary or Representative and the employee.

#### **202.900 Back-up Plans**

**1-1-19**

Having a back-up worker is required for participation in IndependentChoices. The counseling entity will assist the participant/employer or Representative as the employer in developing a back-up plan to outline how the participant's needs will be met should the caregiver/employee be absent from the home for any reason. The back-up plan must identify a back-up caregiver. This

back-up caregiver will need to enroll as a caregiver for the IndependentChoices program. The back-up plan may also identify an informal back-up caregiver.

## 220.000 COVERED SERVICES

### 220.100 Cash Allowance

1-1-19

- A. Purpose of Cash Allowance: The cash allowance allows the IndependentChoices participant to directly purchase personal assistance services and certain other goods and services that lessen the need for Medicaid-funded human assistance while increasing the participant's ability to maintain independence in the community. The cash allowance is primarily used to pay the salary or wages of the participant's employee. The other goods and services for which the cash allowance may be used to purchase are not widely used but in some cases may help further support a beneficiary's independence and need for paid personal assistance.
- B. Permissible Uses of Cash Allowance: An IndependentChoices participant's cash allowance may only be used for the following expenses if consistent with the individual's approved patient-centered service plan and service budget:
1. Self-directed Personal Assistance Services: Salary or wages of self-hired personal assistant(s) to provide self-directed Personal Assistance Services, in lieu of State Plan personal care services and ARChoices attendant care services. Such Personal Assistance Services are covered for medically necessary human assistance with specific activities of daily living (ADL) tasks, instrumental activities of daily living (IADL) tasks, and health-related tasks to the extent covered under either the State Plan personal care services benefit or the ARChoices attendant care services benefit (if the individual is a ARChoices waiver participant). The ADL, IADL, and health-related tasks supported must also be consistent with the individual's assessed needs.
  2. Backup and Respite Personal Assistance: Purchasing Personal Assistance Services from a licensed home health agency or a licensed personal care agency to supplement or back up self-hired personal assistants or to provide respite care to relieve unpaid caregivers.
  3. Technology for Safety, Communication, and Independence: Purchase or rental of adaptive technology used to assist the beneficiary with completing activities of daily living, communicating with others, and residing safely and independently at home (i.e., augmentative and alternative communication devices, assistive listening or reading devices, captioned telephones, other sensory adaptive equipment, visual or audible alerting devices, and personal computer with accessibility technology and accommodations for the individual's physical or sensory limitations).
  4. Service Animal: Purchase and maintenance of a service animal. This includes necessary food, veterinarian services, dog license, handling material (collar, harness, and leash), and training of beneficiary in proper care and handling of the service animal. "Service animal" is as defined under federal Americans with Disabilities Act (ADA) regulations at 28 CFR 35.104.
  5. Cost of a complete national fingerprint-based criminal background check on a self-hired personal assistant(s).
  6. Discretionary Cash used to purchase personal hygiene items for the beneficiary.
  7. With the prior written approval by the Division of Provider Services and Quality Assurance (DPSQA) director (or his/her designee):
    - a. Environmental Accessibility Adaptations: The purchase and installation of

interior or exterior physical adaptations to the beneficiary's home necessary to ensure their health and safety, decrease the need for paid and unpaid human assistance, and enable the individual to function with greater independence in the community. Such adaptations must provide direct medical or remedial benefit to the beneficiary due to a disability(ies) and functional limitation(s). The ARChoices waiver provides similar coverage for Environmental Accessibility Adaptations. For ARChoices waiver participants, the Environmental Accessibility Adaptations available under IndependentChoices, ARChoices, or the two benefits in combination may not be used to provide Environmental Accessibility Adaptations in excess, duplication, or circumvention of what may be covered and reimbursed through IndependentChoices or ARChoices separately.

- b. **Emergency Goods and Services:** On a time-limited basis, the following goods and services in the event of a documented emergency representing a risk to the beneficiary's health and welfare: food and clothing; housing for beneficiary (and their service animal, if any); household utilities (i.e., electricity, water, heating fuel, and telephone); and pest control.
- c. **Other goods and services on a case-by-case basis provided DPSQA** determines such purchases (1) will likely increase the participant's independence and reduce the need for Medicaid-funded paid human assistance, (2) can be economically purchased and reliably provided, (3) will not result in funds in the individual's IndependentChoices budget being insufficient to meet the participant's needs, (4) are consistent with the participant's assessed needs, and (5) are consistent with the participant's person-centered service plan and self-directed services budget.

#### **220.200 Personal Assistance (Caregiver) Services**

1-1-19

Caregivers/employees will be recruited, interviewed, hired and managed by the participant as the employer or a designated Representative. Family members, other than those with legal responsibility to the beneficiary, may serve as personal assistants. A court appointed legal guardian, spouse, power of attorney or income payee may not serve as a caregiver/employee.

The participant/employer's caregiver/employee performs the services under the agreed upon terms of the Worker Information and Qualification Form and the Employee Responsibilities and Attestation Form.

#### **220.205 Personal Care**

1-1-19

The Arkansas Medicaid program covers up to 14.75 hours per week (64 hours per calendar month) of State Plan Personal Care Services for participants aged 21 and older assessed as needing personal care. The hour limit does not apply to beneficiaries under age 21. Personal care is allowed in the home and outside the home, such as in the workplace. IndependentChoices follows the policy in the Arkansas Medicaid Personal Care Provider Manual in determining eligibility and the level of assistance of personal care needed by the IndependentChoices participant. Participants needing personal care in the workplace must meet the requirements found at 213.540 of the Arkansas Medicaid Personal Care Provider Manual.

#### **220.210 Personal Care/Hospice Policy Clarification**

1-1-19

Medicaid beneficiaries are allowed to receive Medicaid personal care services, in addition to hospice aide services, if the personal care services are unrelated to the terminal condition or the hospice provider is using the personal care services to supplement the hospice aide and attendant care services.

- A. The hospice provider is responsible for assessing the patient's hospice-related needs and developing the hospice plan of care to meet those needs, implementing all interventions described in the plan of care, and developing and maintaining a system of communication and integration to provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. The hospice provider coordinates the hospice aide with the services furnished under the Medicaid personal care program to ensure that patients receive all the services that they require. Coordination occurs through contact with beneficiaries or in home providers.
- B. The hospice aide services are not meant to be a daily service, nor 24-hour daily services, and are not expected to fulfill the caregiver role for the patient. The hospice provider can use the services furnished by the Medicaid personal care program to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care. The hospice provider is only responsible for the hospice aide and attendant care services necessary for the treatment of the terminal condition.
- C. Medicaid payments for personal care services provided to an individual also receiving hospice services, regardless of the payment source for hospice services, must be supported by documentation in the individual's personal care medical chart or the IndependentChoices Cash Expenditure Plan. Documentation must support the policy described above in this section of the Personal Care provider manual.

**NOTE: Based on audit findings, it is imperative that required documentation be recorded by the hospice provider and available in the hospice record. Documentation must substantiate all services provided. It is the hospice provider's responsibility to coordinate care and assure there is no duplication of services. While hospice care and personal care services are not mutually exclusive, documentation must support the inclusion of both services and the corresponding amounts on the care plan. To avoid duplication and to support hospice care in the home that provides the amount of services required to meet the needs of the beneficiary, the amount of personal care services needed beyond the care provided by the hospice agency must meet the criteria detailed in this section. Most often, if personal care services are in place prior to hospice services starting, the amount of personal care services will be reduced to avoid any duplication. If those services are not reduced or discontinued, documentation in the hospice and personal care records must explain the need for both and be supported by the policy in this section.**

### 220.300 Attendant Care Services

1-1-19

In-home services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible participant's function in his or her own home. IndependentChoices allows ARChoices participants the choice of self-directed attendant care services rather than receiving attendant care services through a certified agency.

The DHS RN will determine the number of hours of attendant care services needed by the participant, using the Task and Hour Standards as indicated on the ARChoices person-centered service plan. If the participant chooses to self-direct attendant care services, the DHS RN will refer the participant to the IndependentChoices program by sending the person-centered service plan to IndependentChoices, noting that IndependentChoices was selected.

### 220.400 Exclusions from Coverage and Reimbursement

1-1-19

- A. Goods and services of any kind are not available (not covered and not reimbursable) under IndependentChoices, including through the use of the cash allowance, when and to the extent any of the following may apply:
1. When available to the participant from another source, including without limitation family members, a member of the participant's household, or other unpaid caregivers; a Medicaid State Plan covered service; the Medicare program (Medicare Part A, Part B, or Part D); the participant's Medicare Advantage plan (including targeted or other supplemental benefits offered by the plan); the participant's Medicare prescription drug plan; and private medical, long-term care, disability, or supplemental insurance coverage. This includes reasonably comparable or substitute goods and services;
  2. When not for the sole benefit of the participant or the maintenance of the participant's service animal;
  3. When provided contrary to any Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, pharmacists, or other licensed professionals;
  4. When goods and services of any kind are acquired or received for re-sale, or otherwise re-sold or gifted, whether for cash, barter or in-kind trade, or other compensation or consideration, and regardless who may benefit; and
  5. When goods and services of any kind are acquired or received to substitute, or otherwise replace, other goods or services sold, traded, or gifted or intended to be sold, traded, or gifted.
- B. In addition, the following types of goods and services are not available (not covered and not reimbursable) under IndependentChoices, including through the use of the cash allowance:
1. Alcoholic beverages of any kind, including distilled spirits, wine, malt beverages, and alcoholic soft drinks;
  2. Tobacco products of any kind;
  3. Medical marijuana;
  4. Any controlled substance listed under 21 CFR Part 1308 or any controlled substance analogue as defined under 21 USC § 802(32)(A);
  5. Prescription drugs, non-prescription (over-the-counter) drugs, vitamins, minerals, or other dietary supplements;
  6. Illegal goods and services of any kind;
  7. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including without limitation aseptic or sterile procedures; application of dressings; medication administration; injections; observation and assessment of health conditions; insertion, removal, or irrigation of catheters; tube or other enteral feedings; tracheostomy care; oxygen administration; ventilator care; drawing blood; and care and maintenance of any medical equipment;
  8. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
  9. Services provided for or goods used by any person other than the participant, including without limitation a provider, family member, household resident, or neighbor;



10. Companion, socialization, entertainment, or recreational services or activities of any kind, including without limitation game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship;
11. Cleaning of any spaces of a home or place of residence (including without limitation kitchen, bathroom, living room, dining room, family room, and utility or storage rooms, and the floors, furnishings, and appliances therein) shared by the participant with one or more adults who are, together or separately, physically able to perform housekeeping of these areas; and
12. Habilitation services, including without limitation assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills.

## **230.000 BENEFIT LIMITS AND DURATION OF SERVICES**

### **230.100 Benefit Limits 1-1-19**

Benefits are limited by the amount of the participant's allowance. Each individual participant has a maximum allowance based on his or her individual service plan. The Division of Provider Services and Quality Assurance will authorize the allowance. Payment is made prospectively by the Medicaid fiscal intermediary. The participant's allowance will be issued monthly directly from the Medicaid fiscal intermediary to the IndependentChoices fiscal agent as long as the individual remains Medicaid eligible and the individual is not receiving hospice or nursing facility services. The IndependentChoices fiscal agent will disburse the cash allowance in accordance with the approved cash expenditure plan and timesheets completed by the participant or Representative and signed by the personal attendant twice monthly in equal intervals.

### **231.000 Loss of Medicaid Eligibility 1-1-19**

Participants must remain Medicaid eligible to continue participation in IndependentChoices. Participants will be advised to report any changes in the amount of household income or resources to the DHS county office. The DPSQA will notify the counseling entity, fiscal agent, and DHS RNs informing them of participants who have lost Medicaid eligibility. IndependentChoices staff will then take action to close the IndependentChoices case within the MMIS. Internal edits within the MMIS system prevent the Medicaid fiscal agent from adjudicating a claim for any person not Medicaid eligible on the date(s) of service.

### **231.100 Loss of Medical Eligibility for Personal Assistant Services 1-1-19**

If at any time the IndependentChoices nurse determines that personal assistance services are not necessary for an IndependentChoices participant, the participant's IndependentChoices case will be closed after a 10-day notice and DPSQA staff will terminate the eligibility.

### **231.300 Hospitalization 1-1-19**

An IndependentChoices participant's allowance paid prospectively during hospitalization must be returned to the Medicaid Program. The day of admission and day of discharge are allowable days when the participant receives personal assistance services prior to admission or after discharge from the hospital. The participant is instructed to provide supporting hospital documentation to the counseling entity's support coordinators and the fiscal agent to support receipt of personal assistance services on the day of admission. The fiscal agent will be responsible for calculating and collecting the refund.

### **231.400 Long-Term Care Placement 1-1-19**

If at any time a participant requires placement in a long-term care facility, the DHS RN and IndependentChoices program specialist must be notified immediately by the counseling entity's support coordinators or fiscal agent. The IndependentChoices case will be closed on the date prior to entry into a facility. No monthly allowance is allowed during the time of institutionalization. The Medicaid fiscal intermediary will not disburse the cash allowance if Medicaid is currently making payment for long-term care facility services.

### 231.500 Voluntary Disenrollment

1-1-19

When the participant voluntarily elects to discontinue participation in IndependentChoices, DHS professional staff will discuss with the participant or their designated Representative the reason for disenrollment and assist the participant in resolving any barriers or problems that may exist in preventing continuation. If the participant wishes to continue with the option to disenroll, DHS staff will assist the participant by informing him or her of traditional agency personal care providers in the participant's area. The DHS staff will assist with the coordination of agency services to the degree requested by the participant. The participant or their designated Representative may also reach out to the Aging and Disability Resource Center (866-801-3435) for assistance in identifying available agency services. If the participant is an ARChoices waiver participant, the DHS RN may be contacted to assist with transitioning waiver clients to appropriate agency services.

IndependentChoices can continue until agency services are established or the participant may elect to use informal supports until agency services are established.

### 231.600 Involuntary Disenrollment

1-1-19

Participants may be disenrolled for the following reasons:

- A. **Health, Safety and Well-being:** At any time that DHS or the counseling entity determines that the health, safety and well-being of the participant is compromised by continued participation in the IndependentChoices Program, the participant may be returned to the traditional personal care program.
- B. **Change in Condition:** Should the participant's cognitive ability to direct his or her own care diminish to a point where he or she can no longer direct his or her own care and there is no Representative available to direct the care, the IndependentChoices case will be closed. DHS and the counseling entity will assist the participant with a referral to traditional services.
- C. **Misuse of Allowance:** Should a participant or the Representative who is performing all of their payroll functions (and not using the fiscal agent) use the allowance to purchase items unrelated to personal care needs, fail to pay the salary of a caregiver/employee, misrepresent payment of a caregiver/employee's salary, or fail to pay related state and federal payroll taxes, the participant or Representative will receive a warning notice that such exceptions to the conditions of participation are not allowed. The participant will be permitted to remain on the program, but will be assigned to the fiscal agent, who will provide increased oversight coordinated with the counseling entity's support coordinators. The participant or Representative will be notified that further failure to follow the expenditure plan could result in disenrollment. Should an unapproved expenditure or oversight occur a second time, the participant or Representative will be notified that the IndependentChoices case is being closed and they are being returned to traditional personal assistance services. The Office of Medicaid Inspector General is informed of situations as required. DHS and the counseling entity will assist the participant with transition to traditional services. The preceding rules are also applicable to participants using the fiscal agent.
- D. **Underutilization of Allowance:** The fiscal agent is responsible for monitoring the use of the Medicaid funds received on behalf of the participant. If the participant is underutilizing the allowance and not using it according to the cash expenditure plan, the fiscal agent will



inform the counseling entity's support coordinators and the IndependentChoices program specialists through weekly and monthly reports on request. The counseling entity's support coordinators will discuss problems that are occurring with the participant and their support network. The counseling entity's support coordinators will continue to monitor the participant's use of their allowance through both review of reports and personal contact with the participant. If underutilization continues to occur, future discussions will focus on what is in the best interest of the participant in meeting their ADL's even if the best solution is a return to agency services. Unused funds are returned to the Arkansas Medicaid program within 45 days after disenrollment. Funds accrued in the absence of a savings plan will be returned to Medicaid within a twelve-month filing deadline. Involuntary disenrollment may be considered if the participant has been hospitalized for more than 30 days and a discharge date is unknown to the participant or Representative. Participants with approval by DHS professional staff or contractor(s) designated by DHS for an out-of-state visit may be involuntarily disenrolled if their stay extends past the approval period. The participant is required to provide a copy of authorizations by DHS professional staff or contractor(s) designated by DHS to their support coordinator for monitoring purposes.

- E. **Failure to Assume Employer Authority:** Failure to Assume Employer Authority occurs when a participant fails to fulfill the role of employer and does not respond to counseling support. Disenrollment will not occur without guidance and counseling by counseling entity's support coordinator or by the fiscal agent. When this occurs, the counseling entity's support coordinator will coordinate agency personal care services to the degree requested by the participant. The participant may wish to self-advocate from a list provided by the DHS or the counseling entity, ask DHS or the counseling entity to coordinate or may simply wish to receive personal assistance services informally. The participant's wishes will be respected.

Whenever a participant is involuntarily disenrolled, the IndependentChoices program will mail a notice to close the case. The notice will provide at least 10 days but no more than 30 days before IndependentChoices will be discontinued, depending on the situation. During the transition period, DHS or the counseling entity will work with the participant or Representative to provide services to help the individual transition to the most appropriate services available.

## 250.000 COMPLAINTS/GRIEVANCES AND APPEALS

### 250.100 Complaint/Grievances 1-1-19

Grievances based on dissatisfaction with any service or level of service provided by the counseling entity's support coordinators, fiscal agent, or DHS staff may be made in writing to the Division of Provider Services and Quality Assurance (DPSQA), IndependentChoices Program, P.O. Box 1437, Slot S530, Little Rock, AR 72203-1437, or by telephone to IndependentChoices at 1-866-801-3435.

### 250.200 Appeal Rights 1-1-19

IndependentChoices participants have the right to appeal certain decisions or actions with which they disagree. The method used to make the appeal and the time frames within which an appeal is made depends on the basis of the appeal. The Division within the Department of Human Services that will hear the appeal is also based on the reason for the appeal.

Appeals for hearings will also be handled in several ways based on the reason the appeal was made.

### 250.300 Reason for Appeal 1-1-19

If the participant loses eligibility for personal assistance services, he or she may ask for an Administrative Reconsideration according to Section 161.200 of the Medicaid Provider Manual or

may appeal the decision according to Medicaid Provider Manual policy 161.300 through 169.000.

An appeal may be filed by a participant or Representative based on actions or circumstances listed below:

- A. Dissatisfaction with action taken by an IndependentChoices Counselor or Fiscal Agent
- B. Involuntary case terminations including but not limited to:
  - 1. Loss of Medicaid eligibility
  - 2. Institutionalization
  - 3. Dissatisfaction with number of personal care hours
  - 4. Health, safety or well being of participant is compromised
  - 5. Duplication of services
  - 6. IndependentChoices case closure based on noncompliance with program requirements
- C. Loss of Medicaid eligibility will result in the closure of the case. Any appeal made by the participant must be filed with the Office of Appeals and Hearings according to Medicaid Provider Manual Policy 161.300 through 169.000.

#### **250.400      Administrative Review and Appeal of Involuntary Disenrollment      1-1-19**

A participant may request administrative review of the involuntary closure of his/her case by writing to the Division of Provider Services and Quality Assurance, P.O. Box 1437, Slot S530, Little Rock, AR 72203-1437 or may be sent by fax (1-501-683-4180).

The participant has thirty (30) days from the date of notification of disenrollment to file an administrative review of this decision. Administrative Review requests may be mailed or faxed to DPSQA and must be post marked or received within 30 days of the disenrollment decision. All notifications of Involuntary Disenrollment must be made in writing and sent by Certified Mail with a receipt to assure that the date the notification was received is documented. Requests received after the 30-day limit will not be reviewed. Reviews will be completed and decisions will be available within 45 days of the request.

The Administrative Review decision, if unfavorable, may be appealed through the established DHS Hearings and Appeals policy according to Medicaid Provider Manual Policy 161.300 through 169.000.

When a participant is involuntarily disenrolled from the IndependentChoices program, the participant may be returned to the traditional personal care program. If the participant appeals this decision, the participant will continue to receive Medicaid personal care services through a personal care agency during the time of the appeal.

### **260.000      REIMBURSEMENT**

#### **260.100      Fiscal Support Services      1-1-19**

Beneficiaries in IndependentChoices will be offered a monthly allowance in lieu of traditional agency-provided personal assistance services. The intended use of the monthly allowance is to purchase items or other medically necessary personal assistance services that are allowed. All payments are by electronic funds transfer (EFT). Use of the monthly allowance is determined by the beneficiary/representative exercising budget authority outlined on the Cash Expenditure

Plan. Requests to purchase nontraditional or unusual items over \$50.00 will require the approval of the Counselor and DAAS. The fiscal agent, or bookkeeper, will receive the beneficiary's cash payment from the Arkansas Medicaid fiscal intermediary. The Medicaid fiscal intermediary will make monthly prospective payments to the fiscal agent based on active IndependentChoices participants as indicated on the MMIS.

Personal assistants will complete their timesheets and obtain the authorizing signature of the beneficiary. The timesheet will be submitted to the fiscal agent bi-weekly.

The fiscal agent will perform all payroll functions. This will include preparation and payment through EFT for assistants and compliance with applicable state and federal employer/employee laws.

## 260.400 CONTRACTED SERVICES

### 260.410 DPSQA Responsibilities

1-1-19

IndependentChoices seeks to ensure that providers contracted by DPSQA are competent and experienced and possess the technical ability to perform all required functions. To assure this goal is met DPSQA will:

- Competitively procure a counseling entity and fiscal agent that understand the concepts of independent living and consumer direction and have experience providing counseling or fiscal services to participants
- Clearly identify performance standards, corrective action plans and consequences for deviations from the standards
- Provide a training curriculum that effectively conveys the philosophy of consumer direction and completely defines the performance standards and procedures that must be followed by IndependentChoices providers
- Monitor performance standards to assure that support coordinators and fiscal agents are providing the service and quality required
- Conduct on-site survey reviews of fiscal agents as needed, but no less than annually

### 260.420 Employer Authority

1-1-19

The IndependentChoices participant is the employer of record, and as such, hires a Personal Assistant who meets these requirements:

- A. Is a US citizen or legal alien with approval to work in the US
- B. Has a valid Social Security number
- C. Signs a Work Agreement with the participant/Representative
- D. Must be able to provide references if requested
- E. Submit to central registry checks and national and state criminal background checks in compliance with Ark. Code Ann. §§ 20-33-213 and 20-38-101 et seq. Criminal background checks shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.
- F. Obtains a Health Services card from the Division of Health. if requested

- G. May not be an individual who is considered legally responsible for the client, e.g., spouse or guardian
- H. Must be 18 years of age or older
- I. Must be able to perform the essential job functions required

**260.430****Counseling**

1-1-19

Counseling is provided to beneficiaries statewide through a self-directed service budget (SDSB) contract. The counseling contractor must adhere to performance based contracting standards and the Scope of Service established by DPSQA in addition to State and Federal requirements. The counselors representing the contract must have a minimum of three years experience working with the general public with experience in teaching, mentoring or coaching with outcome based expectations. Examples of potential counselors may include but are not limited to active or retired teachers, public servants, health professionals, social workers or non-professionals who have exceptional communication skills and pass the self-directed service budget delivered training offered by the SDSB counseling contractor.

A counseling contractor may not provide SDSB enrollment or monitoring activities to a family member. A family member is defined as an individual currently related to the counselor by virtue of blood, marriage, adoption or a relative of any degree.

Other job related education and/or experience may be substituted for all or part of these basic requirements with approval of DPSQA.

The current contract requires IndependentChoices counseling providers to perform the following:

- A. Enrollment of new beneficiaries
- B. Develop and implement beneficiary directed budget
- C. Coordinate with Financial Management Services (FMS) provider and DMS
- D. Orientation to IndependentChoices and the concept of consumer direction
- E. Skills training on how to recruit, interview, hire, evaluate, manage or dismiss assistants
- F. Consumer-directed counseling support services
- G. Monitor IndependentChoices participants/Representatives
- H. Monitor over and under expenditures of the Cash Expenditure Plan
- I. Provide monthly reports to DPSQA
- J. Use RNs to assess functional need for personal care
- K. Inform DAAS of beneficiaries' readiness to begin self-direction and when disenrollment occurs

**260.440****Financial Management Services (FMS)**

1-1-19

Financial management services (FMS) will be beneficiary directed and provided by the IndependentChoices fiscal agent. The FMS contractor must adhere to performance based contracting standards and the Scope of Service established by DMS in addition to State and Federal requirements. If FMS is provided by a Certified Public Accountant (CPA), the CPA must be licensed in the State of Arkansas. Subcontracts with FMS direct-service providers must be approved by DPSQA. The entity providing the direct FMS service must have an IRS FEIN (Federal Employer Identification Number) dedicated to fiscal agency services. The entity

providing this service must have at least 3 years experience providing fiscal employer agency work to individuals with physical disabilities in Arkansas.

The FMS will provide the following supports and services:

- A. Collect and process timesheets of support workers
- B. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- C. Prepare and disburse IRS Forms W-2 and W-3 annually
- D. Receive and disburse funds for payment of beneficiary -directed services under an agreement with Medicaid and the Medicaid fiscal intermediary
- E. Assure that all expenditures match the written budget
- F. The current contract with the FMS requires the following:
  1. Creation of systematic processes, internal controls, policies and procedures to comply with FMS requirements
  2. Receiving and reviewing all necessary Federal and State forms required for enrolling the participant to be a "Household Employer," as well as New Hire Packets from the enrolling beneficiary's employee
  3. Obtaining individual FEIN number enabling FMS provider to act as a Household Employer Agent
  4. Communicating and assisting consumers in the completion of these forms if needed
  5. Resending and monitoring receipt of forms as needed
  6. Accepting the beneficiary's allowance from Medicaid's fiscal intermediary once monthly
  7. Accurately posting allowance income and expenditures and developing and submitting a monthly report on carry-over balance
  8. Disbursing the monthly allowance as directed on the Cash Expenditure Plan
  9. Withhold and pay State and Federal payroll taxes per regulations
  10. Informing the Counseling Agency and DAAS when a beneficiary has 30 days of their allowance (excluding savings directed toward a specific purchase) remaining at the end of the month on the Cash Expenditure Plan
  11. Notifying DPSQA and providing a corrective action plan in the event any beneficiary's allowance ever becomes less than zero
  12. Making refunds to Arkansas Medicaid within forty five days post disenrollment or sooner if no outstanding obligations are present upon disenrollment
  13. Providing monthly management reports to beneficiaries and DPSQA
  14. Respond to requests for income verification
  15. Providing to DPSQA, by the end of February, an annual report of the previous years' activity. The report will inform by beneficiary, by month, the amount of the allowance received, the wages paid to beneficiary's employee, taxes withheld, and, in descriptive terms, how the allowance was spent.
  16. Mail W-2s in January of each year if the employee's wages meet the earnings threshold per IRS Publication 926—Household Employer's Tax Guide

*TOC required*

## 200.000 PERSONAL CARE GENERAL INFORMATION

### 200.100 Arkansas Medicaid Participation Requirements for Personal Care Providers 1-1-19

Numerous agencies, organizations and other entities may qualify for enrollment in the Arkansas Medicaid Personal Care Program. Participation requirements vary among these different types of providers. Sections 200.110 through 200.160 outline the participation requirements specific to each type of personal care provider. Section 201.000 describes the procedures required to enroll in the Medicaid Program. Sections 201.010 through 201.050 set forth the licensing, certification and other requirements specific to each type of personal care provider.

All owners, principals, employees, and contract staff of a personal care provider must have national and state criminal background checks according to Arkansas Code Annotated §§ 20-33-213 and 20-38-101 *et seq.* Criminal background checks shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

### 200.140 Assisted Living Facilities 1-1-19

- A. Only one type of assisted living facility, a Level 1 Assisted Living Facility (ALF), may enroll as a personal care provider.
- B. The Division of Provider Services and Quality Assurance (DPSQA) certifies, licenses and regulates certain institutions, including ALFs.
- C. Each ALF has a separate license, regardless of which type it is and regardless of its location or proprietorship.
- D. Each ALF that provides personal care for Medicaid beneficiaries and that desires Medicaid reimbursement for those services must enroll separately in the Arkansas Medicaid Personal Care Program, effective for dates of service on and after March 1, 2005.
  1. Some providers operate multiple ALF facilities, sometimes on the same property or in the same complex and sometimes in multiple locations.
    - a. Effective for dates of service before March 1, 2005, Medicaid covers personal care services provided by enrolled RCFs for residents of Level I ALFs under the same proprietorship as the enrolled RCF.
    - b. Level I ALFs that are not under the same proprietorship as a Medicaid-enrolled RCF may not contract for Medicaid-covered personal care with an enrolled RCF owned by another entity.
    - c. Except under the conditions described in part a above, personal care in any assisted living facility may be provided only by the facility itself, if it is enrolled in the Arkansas Medicaid Personal Care Program, or by
      - (1). A private care agency that is enrolled as a Personal Care provider or
      - (2). A Class A or Class B home health agency that is enrolled as a Personal Care provider.
  2. Several provider files may share the same Federal Employer Identification Number (FEIN). For example: A corporate entity that has one FEIN owns an RCF and a Level I ALF and enrolls them as Personal Care Program providers.
    - a. Each facility is assigned a unique Arkansas Medicaid provider number.
    - b. Each facility's Arkansas Medicaid Personal Care provider number is linked to its unique license number.

- c. Each facility's Arkansas Medicaid Personal Care provider number is linked to the corporate entity's single FEIN.
- E. Sections 200.141 and 200.142 outline Arkansas Medicaid Personal Care Program participation requirements for RCFs, and Level I ALFs.
- F. Level II ALFs may participate in the Living Choices Assisted Living Program.
  - 1. Living Choices is a home- and community-based program established for certain nursing home-eligible individuals who, without a program like Living Choices, would not be able to live in a dwelling of their own or would be able to do so only with great difficulty and with significant risk to their health and safety.
  - 2. Providers may obtain Living Choices Program participation requirements by downloading the Living Choices Assisted Living Provider Manual from the Arkansas Medicaid website, <https://medicaid.mmis.arkansas.gov>.
  - 3. Living Choices services are not covered for beneficiaries receiving services through the Personal Care Program, and Personal Care Program services are not covered for beneficiaries in the Living Choices Program.

**200.141 Residential Care Facilities 1-1-19**

A residential care facility applying for enrollment as a personal care provider must be licensed as a residential care facility by the Division of Provider Services and Quality Assurance (DPSQA).

**200.142 Level I Assisted Living Facilities 1-1-19**

A Level I ALF applying for enrollment as a personal care provider must be licensed as a Level I ALF by the Division of Provider Services and Quality Assurance (DPSQA)..

**201.110 Class A and Class B Home Health Agencies 1-1-19**

Class A and Class B Home Health Agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current Class A or Class B license. In addition, certification by DPSQA is required for Medicaid provider enrollment.

**201.120 Private Care Agencies 1-1-19**

- A. Private care agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current license from the Arkansas Department of Health. In addition, certification by DPSQA is required for Medicaid provider enrollment.
- B. Private care agencies must ensure that there is on file with the Provider Enrollment Unit proof of liability insurance coverage of not less than one million dollars (\$1,000,000.00), covering their employees and independent contractors while those individuals and entities are engaged in providing covered Medicaid services.
- C. Annually, private care agency providers must ensure that there is on file with the Provider Enrollment Unit proof that the agency's required liability insurance remains in force and has remained in force at a level of coverage no less than the required minimum since the provider's previous report.

**201.131 Residential Care Facilities 1-1-19**

A residential care facility applying for enrollment as a personal care provider must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of its current license from the



Division of Provider Services and Quality Assurance (DPSQA). In addition, certification by DPSQA is required for Medicaid provider enrollment.

### 201.132 Level I Assisted Living Facilities

1-1-19

A Level I Assisted Living Facility (ALF) applying to enroll as a personal care provider must ensure that there is on file with the Provider Enrollment Unit a copy of its current license from the Division of Provider Services and Quality Assurance (DPSQA).. In addition, certification by DPSQA is required for Medicaid provider enrollment.

### 202.210 Out-of-State Limited Services Personal Care Providers

1-1-19

- A. Out-of-state providers may enroll in Arkansas Medicaid as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and they have a claim or claims to file with Arkansas Medicaid.
1. To enroll, providers must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. [View or print the provider enrollment and contract package \(Application Packet\).](#) [View Medicaid Provider Enrollment Unit contact information.](#)
  2. Out of state providers must also be certified by DPSQA.
  3. Enrollment as a limited services provider automatically expires after a year unless the provider provides and bills for subsequent services for Arkansas Medicaid beneficiaries during the year. See part B below.
- B. Out-of-state limited services providers remain enrolled for one year.
1. If an out-of-state limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.
  2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
  3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

### 213.000 Scope of the Program

1-1-19

- A. Personal care services are primarily based on the assessed physical dependency need for "hands-on" services with the following activities of daily living (ADL): eating, bathing, dressing, personal hygiene, toileting and ambulating. Hands-on assistance in at least one of these areas, based on the ARIA assessment results, is required. This type of assistance is provided by a personal care aide based on a beneficiary's physical dependency needs (as opposed to purely housekeeping services). An individualized plan of care is developed based on the ARIA assessment results and information in the form designated by DHS that is submitted by the provider, and is based on a beneficiary's assessed dependency in at least one of the above-listed activities of daily living. While not a part of the eligibility criteria, the need for assistance with other tasks and IADLs (Instrumental Activities of Daily Living) are considered in the assessment. Both types of assistance are considered when determining the amount of overall personal care assistance authorized. Routines or IADLs include meal preparation, incidental



housekeeping, laundry, medication assistance, etc. These tasks are also defined and described in this section of this provider manual and are defined in the Arkansas State Board of Nursing Position Statement 97-2.

- B. The tasks the aide performs are similar to those that a nurse's aide would normally perform if the beneficiary were in a hospital or nursing facility.
- C. Personal care services may be similar to or overlap some services that home health aides furnish.
  - 1. Home health aides may provide personal care services in the home under the home health benefit.
  - 2. Skilled services that only a health professional may perform are not considered personal care services.
- D. Personal care services, as described in this manual, are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, Level II assisted living facility, intermediate care facility for persons with intellectual disabilities, or institution for mental disease that are:
  - 1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State, e.g., ARChoices, IndependentChoices;
  - 2. Furnished in the beneficiary's home, and at the State's option, in another location.
  - 3. Provided by an individual qualified to provide such services and who is not a member of the beneficiary's family. See Section 222.100, part A, for the definition of "a member of the beneficiary's family".
- E. Personal care for Medicaid-eligible individuals requires prior authorization. See Sections 240.000 through 246.000.
- F. Only Class-A Home Health agencies, Class-B Home Health agencies and Private Care agencies may provide personal care in all State-approved locations. Residential care facilities, public schools, and education service cooperatives may provide personal care only within their own facilities. School districts and education service cooperatives may not provide personal care in the beneficiary's home unless the home is deemed a public school in accordance with the Arkansas Department of Education guidelines set forth in Section 213.520.

### **213.120 Non-Inpatient, Non-Institutionalized Status**

**1-1-19**

- A. Personal care services are services furnished to an individual who is not an inpatient or a resident of:
  - 1. A hospital,
  - 2. A nursing facility,
  - 3. A Level II assisted living facility,
  - 4. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) or
  - 5. An institution for mental diseases (IMD).
- B. Individuals who are inpatients or residents of the foregoing institutions or facilities are ineligible for Personal Care Program services.
  - 1. Under applicable federal statutory and regulatory provisions, the institutional status of an individual controls the individual's exclusion from service eligibility.

2. The location of the personal care service delivery site is not a determinant of the institutionalized individual's ineligibility for services.

**213.200 Physical Dependency Need Criteria for Service Eligibility**

1-1-19

- A. The terms "routines," "activities of daily living" and "service" have particular definitions that apply to the Personal Care Program. See Sections 216.100 through 216.140 for definitions of these and other terms employed in this manual.
- B. Personal care services, described in Sections 216.000 through 216.330, must be medically necessary services authorized by DHS professional staff or contractor(s) designated by DHS.
- C. Personal care services are individually designed to assist with a beneficiary's assessed physical dependency needs related to the following routine activities of daily living and instrumental activities of daily living:
  1. Bathing
  2. Bladder and bowel requirements
  3. Dressing
  4. Eating
  5. Incidental housekeeping
  6. Laundry
  7. Personal hygiene
  8. Shopping for personal maintenance items
  9. Taking medications\*
  10. Mobility and Ambulation

\* Assistance with medications is a personal care service only to the extent that it is permitted by the Arkansas Nurse Practice Act, implementing regulations permit a personal care aide to perform the service, and Arkansas State Board of Nursing Position Statement 97-2.
- D. A number of conditions may cause "physical dependency needs."
  1. Particular disabilities or conditions may or may not be pertinent to specific needs for individual assistance.
  2. In assessing an individual's need for personal care, the question to pursue is whether the individual is unable to perform tasks covered by this program without assistance from someone else.
  3. The need for individual assistance indicates whether to consider personal care.

**213.310 IndependentChoices Program, Title XIX State Plan Program**

1-1-19

IndependentChoices is operated by the Division of Provider Services and Quality Assurance (DPSQA) and operates under the authority of the Title XIX State Plan with the Division of Medical Services responsible for administrative and financial authority.

IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly (age 65 and older) to direct their personal care. The beneficiary chooses a cash allowance in lieu of agency personal care services. IndependentChoices provides qualifying beneficiaries with counseling and training to assist them with information to fulfill their role as an employer. The beneficiary as the employer will hire, train, supervise and, if

necessary, terminate the services of their employee. In addition to hiring an employee, the beneficiary may use part of their budget to purchase goods and services that lessen their physical dependency needs. In addition to counseling support services, beneficiaries may receive Financial Management Services (FMS) from a DMS contracted provider. The FMS provider will assist the participant by processing timesheets, withholding and reporting State and Federal taxes, issuing a W-2 to all employees who meet the tax threshold and refunding taxes to the participant and the employee when the threshold was not met. The FMS provider also coordinates the accuracy and coordination of the forms used to establish the Medicaid beneficiary as an employer and to employ a worker. The FMS provider representing the Medicaid beneficiary will obtain permissions and execute an IRS Form 2678 to act as the beneficiary's agent.

**NOTE: The Independent Choices Program is required to follow the rules and regulations of the State Plan approved Personal Care Program, unless stated otherwise in this manual.**

**213.500**      **Personal Care Service Locations**      **1-1-19**

- A. Arkansas Medicaid covers personal care in a beneficiary's home and, at the state's option, in another location, for beneficiaries of all ages.
1. A beneficiary's home is the beneficiary's residence, subject to the exclusions in part B, below.
  2. Service locations outside the beneficiary's home must be included in the service plan. (If shopping or assistance with shopping is included in the service plan, it is understood that the actual activity occurs at a store. The place of service—for billing purposes—remains the beneficiary's home.)
  3. The beneficiary's assessment and service plan must justify the medical necessity for personal care in a location other than the beneficiary's residence. For example: A beneficiary's service plan includes assistance with dressing. This particular beneficiary regularly (by PCP referral or a physician's order) goes to a clinic or other site for a therapy, such as aqua therapy, that involves changing clothes. If, at the therapy site, assistance with dressing and/or changing is not included with the therapy service, the personal care service plan may include an aide's assistance. However, in such a situation, only the time the aide spends performing the service is covered.
- B. Medicaid does not cover personal care services in the following locations:
1. A hospital,
  2. A nursing facility,
  3. A Level II assisted living facility,
  4. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) or
  5. An institution for mental diseases (IMD).
- C. All individuals residing in locations listed above in part B are ineligible for Medicaid-covered personal care.
- D. Individuals who are inpatients or residents of the facilities and institutions listed in part B are not eligible for Medicaid-covered personal care services in any location.

**213.540**      **Employment-related Personal Care Outside the Home**      **1-1-19**

No condition of this section alters or adversely affects the status of individuals who are furnished personal care in sheltered workshops or similarly authorized habilitative environments. There

may be a few beneficiaries working in sheltered workshops solely or primarily because they have access to personal care in that setting. This expansion of personal care outside the home may enable some of those individuals to move or attempt to move into an integrated work setting.

- A. Personal care may be provided outside the home when the requirements in subparts A1 through A5 are met and the services are necessary to assist an individual with a disability to obtain or retain employment.
  1. The beneficiary must have an authorized, individualized personal care service plan that includes the covered personal care services necessary to and appropriate for an employed individual or for an individual seeking employment.
  2. The beneficiary must be aged 16 or older.
  3. The beneficiary's disability must meet the Social Security/SSI disability definition.
    - a. A beneficiary's disability may be confirmed by verifying his or her eligibility for SSI, Social Security disability benefits or a Medicaid disability aid category, such as Working Disabled or DDS Alternative Community Services waiver.
    - b. If uncertain whether a beneficiary qualifies under this disability provision, contact the Department of Human Services local office in the county in which the beneficiary resides.
  4. One of the following two conditions must be met.
    - a. The beneficiary must work at least 40 hours per month in an integrated setting (i.e., a workplace that is not a sheltered workshop and where individuals without disabilities are employed or are eligible for employment on parity with applicants with a disability).
    - b. Alternatively, the beneficiary must be actively seeking employment that requires a minimum of 40 hours of work per month in an integrated setting.
  5. The beneficiary must earn at least minimum wage or be actively seeking employment that pays at least minimum wage.
- B. Personal care aides may assist beneficiaries with personal care needs in a beneficiary's workplace and at employment-related locations, such as human resource offices, employment agencies or job interview sites.
- C. Employment-related personal care associated with transportation is covered as follows.
  1. Aides may assist beneficiaries with transportation to and from work or job-seeking and *during* transportation to and from work or for job-seeking.
  2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; see Section 215.300, part F) in the service plan and all pertinent service documentation.
  3. Medicaid does not cover mileage associated with any personal care service.
  4. Authorized, necessary and documented assistance with transportation to and from work for job-seeking and during transportation to and from work or for job-seeking is included in the 64-hour per month personal care benefit limit for beneficiaries aged 21 and older.
- D. All personal care for beneficiaries requires prior authorization.
- E. Providers furnishing both employment-related personal care outside the home and non-employment related personal care at home or elsewhere for the same beneficiary must comply with the applicable rules at Sections 215.350, 215.351 and 262.100.

On rare occasions, a personal care beneficiary might have urgent cause to travel to a locality outside his or her personal care provider's service area. If DHS professional staff or contractor(s) designated by DHS authorizes personal care during the beneficiary's stay in that locality, the beneficiary may choose a personal care provider agency in the service area to which he or she is traveling.

A. In-State and Out-of-State Limited Services Secondary Personal Care Provider

If the selected provider is an in-state provider, the selected provider's services may be covered if all the following requirements are met:

1. The beneficiary's personal care provider (the "primary" provider) must request in writing that the selected provider (the "secondary" provider) assume the beneficiary's service for the specified duration of the beneficiary's stay.
2. The primary provider must forward to the secondary provider a copy of the beneficiary's current service plan and service documentation, including logs, for a minimum service-period of sixty days prior to the request.
3. If the secondary provider requests additional information or documentation, the primary provider must forward the requested materials immediately.
4. The secondary provider must execute a written agreement to assume the beneficiary's care on behalf of the primary provider.
5. The secondary provider must submit its service documentation to the primary provider within ten working days of the beneficiary's departure from the temporary locality.

B. Out-of-State Limited Services Secondary Personal Care Provider

If the provider is an out-of-state provider, the provider must also download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application and contract to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. [View or print the provider enrollment and contract package \(Application Packet\).](#)

The selected provider must also submit to contractor designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff a written request for prior authorization accompanied with copies of the provider's license, Medicare certification, beneficiary's identifying information and the beneficiary's service plan.

C. All documentation exchanged between the primary and secondary providers must satisfy all Medicaid requirements.

**213.610 Personal Care/Hospice Policy Clarification**

**1-1-19**

Medicaid beneficiaries are allowed to receive Medicaid personal care services, in addition to hospice aide services, if the personal care services are unrelated to the terminal condition or the hospice provider is using the personal care services to supplement the hospice and homemaker services.

- A. The hospice provider is responsible for assessing the patient's hospice-related needs and developing the hospice plan of care to meet those needs, implementing all interventions described in the plan of care, and developing and maintaining a system of communication and integration to provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. The hospice provider coordinates the hospice aide with the services furnished under the Medicaid personal care program to ensure that patients receive all the services that they require. Coordination occurs through contact with beneficiaries or in home providers.

- B. The hospice aide services are not meant to be a daily service, nor 24-hour daily services, and are not expected to fulfill the caregiver role for the patient. The hospice provider can use the services furnished by the Medicaid personal care program to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care. The hospice provider is only responsible for the hospice aid and homemaker services necessary for the treatment of the terminal condition.
- C. Medicaid payments for personal care services provided to an individual also receiving hospice services, regardless of the payment source for hospice services, must be supported by documentation in the individual's personal care medical chart or the IndependentChoices Cash Expenditure Plan. Documentation must support the policy described above in this section of the Personal Care provider manual.

**NOTE: Based on audit findings, it is imperative that required documentation be recorded by the hospice provider and available in the hospice record. Documentation must substantiate all services provided. It is the hospice provider's responsibility to coordinate care and assure there is no duplication of services. While hospice care and personal care services are not mutually exclusive, documentation must support the inclusion of both services and the corresponding amounts on the care plan. To avoid duplication and to support hospice-care in the home that provides the amount of services required to meet the needs of the beneficiary, the amount of personal care services needed beyond the care provided by the hospice agency must meet the criteria detailed in this section. Most often, if personal care services are in place prior to hospice services starting, the amount of personal care services will be reduced to avoid any duplication. If those services are not reduced or discontinued, documentation in the hospice and personal care records must explain the need for both and be supported by the policy in this section.**

#### 214.200 Service Plan Review and Renewal 1-1-19

- A. A personal care service plan terminates one (1) year after its initial or revised beginning date of service, unless described otherwise in this section.  
  
DHS professional staff or contractor(s) designated by DHS must review the service plan no less often than once per year, unless described otherwise in this section. See **NOTE** below.
- B. Personal care services may not continue past the one-year anniversary of an initial or revised beginning date of service until DHS professional staff or contractor(s) designated by DHS authorizes a revised service plan or renews the authorization of an existing service plan.

#### 214.300 Authorization of ARChoices Person Centered Service Plan and Personal Care Individual Service Plan 1-1-19

The DHS RN is responsible for developing an ARChoices Person-Centered Service Plan (PCSP) that includes both waiver and non-waiver services. Once developed, the PCSP is signed by the DHS RN authorizing the services listed.

The signed ARChoices PCSP will suffice as the "Personal Care Authorization" for services required in the Personal Care Program. The personal care individualized service plan, developed by the Personal Care provider, is still required.

As the ARChoices PCSP is effective for one year, once signed by the DHS RN; the authorization for personal care services, when included on the ARChoices PCSP, will be for one year from the



date of the DHS RN's signature, unless revised by the DHS RN or the personal care individualized service plan needs to be revised, whichever occurs first.

**NOTE: For ARChoices beneficiaries who receive personal care through traditional agency services or have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices PCSP, signed by a DHS RN, will serve as the authorization for personal care services for one year from the date of the DHS RN's signature, as described above.**

The responsibility of developing a personal care individualized service plan is not placed with the DHS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care Provider Manual.

The Arkansas Medicaid Program waives no other Personal Care Program requirements with regard to personal care individualized service plan authorizations obtained by DHS RNs.

#### 214.310 Development of ARChoices Person-Centered Service Plan

1-1-19

If personal care services are not currently being provided when the DHS RN develops the ARChoices Person-Centered Service Plan (PCSP), the DHS RN will determine if personal care services are needed. If so, the service, amount, frequency, duration and the beneficiary's provider of choice will be included on the ARChoices PCSP. A copy of the ARChoices PCSP and a Start of Care form (AAS-9510) will be forwarded to the personal care provider, as is current practice for waiver services. The Start of Care form must be returned to the DHS RN within 10 working days from mailing or action may be taken by the DHS RN to secure another personal care provider or modify the ARChoices PCSP. (The ARChoices PCSP is dated the date it is mailed.) Before taking action to secure another provider or modifying the PCSP, the applicant and/or family members will be contacted to discuss possible alternatives.

This PCSP supersedes any other care plan that may have been previously developed by another Medicaid provider for the applicant. The ARChoices PCSP must include all appropriate ARChoices services and certain non-waiver services appropriate for the applicant, such as Personal Care.

An agency providing services to an ARChoices beneficiary must report these services to the DHS RN. The services being provided to the ARChoices beneficiary must be included on the ARChoices PCSP. Prior to beginning services or revising services provided to an ARChoices beneficiary, contact the DHS RN so the PCSP is properly revised and approved. Please report all changes in services and changes in the ARChoices beneficiary's circumstances to the DHS RN immediately upon learning of the change. Certain services provided to an ARChoices beneficiary that are not included on the ARChoices PCSP may be subject to recoupment by the Medicaid Program.

**NOTE: It is the IndependentChoices employer or personal care provider's responsibility to place information regarding their presence in the home in a prominent location so that the DHS RN will be aware that they are serving the beneficiary. Preferably, the provider will place the information on the refrigerator or under the phone the applicant uses, unless the applicant objects. If so, the provider will place the information in a location satisfactory to the applicant, as long as it is readily available and easily accessible by the DHS RN.**

The personal care individualized service plan developed by the personal care provider must meet all requirements as detailed in the personal care provider manual. This includes, but is not limited to, the amount of personal care services, personal care tasks, frequency and duration. The ARChoices PCSP and the required justification for each service remains the responsibility of the DHS RN. Therefore, final decisions regarding services included on the ARChoices PCSP rest with the DHS RN.

**NOTE: For ARChoices waiver beneficiaries participating in the IndependentChoices program, services are effective on the date of the DHS RN's signature on the ARChoices waiver PCSP.**

**214.330 Medicaid Audit Requirements for the ARChoices Person-Centered Service Plan 1-1-19**

When the Medicaid Program, as authorized by the ARChoices Person-Centered Service Plan (PCSP), reimburses for Personal Care services, all Medicaid audits will be performed based on that authorization. Therefore, all documentation by the Personal Care provider must tie services rendered to services authorized as reflected on the ARChoices PCSP.

**215.000 Personal Care Assessment and Individualized Service Plan**

**215.100 IndependentChoices Assessment and Service Plan Formats 1-1-19**

A.

For IndependentChoices beneficiaries who are also active waiver beneficiaries in the ARChoices Program, the assessment tool used for waiver level of care determination and the waiver Person-Centered Service Plan (PCSP) will suffice to support authorization for personal care services, if signed by the DHS RN. Eligibility for personal care services is based on the same criteria as state plan personal care services. Services are effective on the date of the waiver PCSP. Personal care services provided prior to that date are not eligible for Medicaid reimbursement. The waiver assessment tool and the waiver PCSP must include, at least, the information designated by DHS that is utilized to support the medical necessity, eligibility and amount of personal care services provided through IndependentChoices or agency personal care services. This information is required in documentation for each beneficiary. As with all required documentation, this information must be available in the participant's chart or electronic record and available for audit and Quality Management Strategy reviews.

**215.200 Personal Care Provider's Proposed Individualized Service Plan 1-1-19**

- A. As part of each prior authorization request, each provider shall submit a complete and accurate form designated by DHS. The form must be prepared, certified, and signed by an Arkansas licensed registered nurse.
- B. The completed form designed by DHS shall include all information required on the form applicable to the individual beneficiary, including:
1. Beneficiary and provider information;
  2. Detailed information concerning physician diagnosed physical and Behavioral Health Services conditions, identified physical dependency needs, and mental/cognitive status; and
  3. For each physical dependency need identified, written descriptions including:
    - a. The extent to which the beneficiary can personally perform individual task components of routines and activities of daily living,
    - b. The type and amount of assistance the beneficiary may need with each task thus identified, including the frequency (per day, week, or month, as applicable) of each task with which the beneficiary needs assistance and for which other sources of assistance are not available; and
    - c. The extent beyond which the beneficiary cannot personally perform individual task components or routines and activities of daily living;



4. Detailed information on all personal assistance available to the beneficiary through other sources, including informal caregivers (e.g., family, friends), community organizations (e.g., Meals on Wheels), Medicare (e.g., Medicare home health aide services), or the beneficiary's Medicare Advantage health plan;
  5. A proposed service plan, with proposed hours/minutes and frequency of needed tasks consistent with the Task and Hour Standards (as described in Section 240.100); and
  6. The signed approval of the beneficiary or the beneficiary's legal representative.
- C. When a beneficiary has two or more personal care providers, the providers should cooperate in the required nursing evaluation and the preparation and submission of the prior authorization request and completed form designated by DHS on behalf of the beneficiary.
- D. When an individual will receive some or all of his or her services in a congregate setting, the assessment must reflect the RN's determination that the individual is an appropriate candidate for services delivered in that setting. See Section 216.201 and Sections 220.110 through 220.112.

**215.210****Alternative Resources for Assistance**

1-1-19

- A. The following requirements regarding alternative resources for assistance do not apply, or apply only insofar as they are legal, practical and practicable when the identifiable resources are prohibited from assisting the beneficiary by law or by a facility's or organization's rules or bylaws. For example, a relative of the beneficiary is an alternative resource in the beneficiary's home or the relative's home but not in the public school.
- B. The form designated by DHS that is submitted by the provider to DHS or the contractor designated by DHS must include written evidence that the beneficiary or the beneficiary's representative and the provider have considered alternative resources available to assist or partially assist the beneficiary with physical dependency needs identified in the assessment.
1. The provider must determine whether voluntary third-party resources are available and if so, the extent of the third party's willingness to devote time to the benefit of the beneficiary. The provider must:
    - a. Consider other members of the beneficiary's household as well as nearby relatives and friends,
    - b. Indicate the usual times of their availability to assist the beneficiary and the frequency and duration of their assistance, and
    - c. Explain the circumstances of any individual household member's inability to provide any assistance or to provide less than complete assistance with the beneficiary's physical dependency needs.
  2. The provider must also consider such alternative community resources as public and private community agencies and organizations, whether secular or religious, paid or volunteer.
    - a. Consider entities that provide not only in-home services, but also such services as adult day care or caregiver respite.
    - b. List the approximate number of hours per week the beneficiary receives (or will receive) services from each such community resource.
- C. The provider must make reasonable efforts to determine the nature, scope, frequency and duration of other services the individual receives, particularly in-home services.

- D. The provider's case record documentation must include the certification that the beneficiary's individualized service plan does not duplicate any other in-home services of which the provider is aware.

**215.300 Individualized Service Plan**

1-1-19

A beneficiary must receive services in accordance with an individualized service plan.

- A. The plan must be acceptable to the beneficiary or the beneficiary's representative.
- B. A registered nurse and other appropriate personnel of the personal care provider agency, in concert with the beneficiary or the beneficiary's representative, must design the individualized service plan to correlate with the physical dependency needs identified in the assessment.
- C. The individualized service plan must be limited to assistance with the beneficiary's individual physical dependency needs.
- D. The service plan must clearly identify which of the beneficiary's physical dependency needs will be met by each task performed by a personal care aide.
  - 1. This requirement does not necessarily mandate writing a unique statement for each task or task component. Indexing the assessment may expedite documentation by permitting one to reference the relevant section of the assessment for the explanatory detail. For example:
    - a. "Task 1 (corresponds to) Physical Dependency 2."
    - b. "Task 6 (corresponds to) Physical Dependency 3."
  - 2. In addition to establishing its correspondence to the assessment (e.g., designing individualized services for a beneficiary's physical dependency needs); the service plan must describe for each routine or activity listed:
    - a. The individual tasks the aide is to perform for the beneficiary,
    - b. The individual tasks with which the aide is to assist the beneficiary and
    - c. The frequency and duration of service of each routine and activity, including:
      - (1). The number of days per week each routine or activity will be accomplished and
      - (2). The maximum and minimum estimated aggregate minutes the aide should spend on all authorized tasks each service day.
- E. The service plan must include written instructions for the personal care aide specifying how and when to execute or assist with the beneficiary's routines or activities including:
  - 1. The number of days per week to accomplish each routine or activity (as well as which days when relevant) and
  - 2. The time of day to accomplish the routine or activity when the time is pertinent, such as when to prepare meals.
- F. The service plan must include written instructions describing whether and to what extent the aide's function in individual task components of each routine or activity is:
  - 1. To assist the beneficiary to perform the task,
  - 2. To perform the task for the beneficiary or
  - 3. To observe the beneficiary perform the task.
- G. The service plan must require the beneficiary to perform all tasks within the beneficiary's capability. Medicaid does not cover assistance with any task a beneficiary can perform

unless DHS professional staff or contractor(s) designated by DHS have authorized the assistance. For example:

1. A beneficiary can manage his own laundry but he cannot extract wet items from the washer while leaning over the machine.
    - a. The assessment notes that he needs assistance with the task of removing wet items from the washing machine.
    - b. The service plan describes the assistance designed for his individual physical dependency need with his laundry.
    - c. The registered nurse instructs the aide to perform the task(s) constituting the service.
  2. Loading the washer, emptying the dryer, folding and ironing clothing and linens are not covered tasks for this particular beneficiary.
  3. Removing laundry from the washer and loading it in the dryer are covered tasks for this beneficiary if those tasks are described in his service plan and authorized by DHS professional staff or contractor(s) designated by DHS.
- H. The form designated by DHS that is submitted by the provider must support the service plan and the provider's RN's instructions to the aide(s) regarding the delivery of services. The plan must reflect whether the individual is receiving services in more than one setting. If a beneficiary is receiving services in more than one setting, it must be clear in which setting a beneficiary receives a particular service or assistance. See part G of Section 215.200, Section 216.201 and Sections 220.110 through 220.112.

See Section 215.330 for information about service plan revision requirements.

**215.310 Identifying Individual Physical Dependency Needs 1-1-19**

- A. A personal care provider must identify and describe (*assess*) a beneficiary's need for assistance (*physical dependency need*) with individual task components of routines and activities of daily living in the form designated by DHS.
- B. The provider must describe the type, amount, frequency and duration of assistance required for each task thus identified (*individualized service plan*) in the form designated by DHS.
- C. A personal care aide furnishes assistance (*service*) with the individual task components of routines and activities of daily living, in accordance with the individualized service plan authorized by DHS professional staff or contractor(s) designated by DHS.
- D. The following examples illustrate how to facilitate service plan development and service documentation by assessing the beneficiary at the level of individual task performance:
- E. A beneficiary is unable to pick up slender items, such as spoons and toothbrushes, and sometimes loses his grip on those objects.
  1. This condition causes similar physical dependency needs in different routines.

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**Sample Assessment Entry**

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Eating:	The beneficiary needs someone to place eating utensils in his grasp and to retrieve them when he drops them.
Oral hygiene:	The beneficiary needs someone to place his toothbrush in his grasp and to retrieve it when he drops it.

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2. The service plan will contain instructions to the aide similar to this Sample Service Plan Entry.

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**Sample Service Plan Entry**


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Eating:	Place the <i>(object)</i> in <i>(beneficiary's name)</i> 's grasp.
Oral hygiene:	Retrieve the <i>(object)</i> when <i>(beneficiary's name)</i> drops it and replace the <i>(object)</i> in his grasp.

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- F. Medicaid Program staff reviewing a personal care provider's records must be able to readily observe that the service plan logically follows the assessment, which is possible only if the provider assesses the beneficiary at the individual task performance level.
1. Additionally, the aide's daily service documentation and the registered nurse's case notes must address the requirements and objectives of the service plan.
  2. There must be a clear and logical relationship of each component of this documentation to each other component and to the service continuum.

215.330

**Service Plan Revisions**

1-1-19

**NOTE: Subsections (A) (3) and (B) are not applicable to Independent Choices program.**

- A. DHS professional staff or contractor(s) designated by DHS must authorize permanent service plan changes before the provider amends service delivery.
1. For purposes of this requirement, a **permanent** service plan change is one expected to last 30 days or more.
  2. Service plan revisions must be made if a beneficiary's condition changes to the extent that the personal care provider must modify, add or delete tasks.
  3. Service plan revisions must be made if the provider identifies a need to increase or decrease the amount, frequency or duration of service.
    - a. Changes in the amount, frequency or duration of a service must be documented in the medical record,
    - b. The reasons for the service variances must be written daily in the service documentation.
  4. All Service plan revisions require the provider to submit an amended prior authorization request. DHS professional staff or the DHS contractor will review the request and determine, based on application of the Task and Hour Standards described in Section 240.100, the amount of adjustment to make in prior authorized minutes. DHS professional staff or the DHS contractor will revise the number of minutes in Interchange.
- B. Providers may not reduce a beneficiary's services without prior authorization by DHS professional staff or contractor(s) designated by DHS
- C. The personal care provider must document medical reasons for service plan revisions.
- D. The new beginning date of service is the date authorized by DHS professional staff or contractor(s) designated by DHS.
- E. Service plan revisions and updates since the previous assessment must remain with the service plan. Updates since the previous assessment must include documentation of when and why the change occurred.

## 216.000

## Coverage

1-1-19

- A. Personal care services, as described in this manual, are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, Level II assisted living facility, intermediate care facility for persons with intellectual disabilities, or institution for mental disease that are:
1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State
  2. Provided by an individual qualified to provide such services and who is not a member of the beneficiary's family. See Section 222.100, part A, for the definition of "a member of the beneficiary's family"
  3. Prior authorized by DHS professional staff or contractor(s) designated by DHS
  4. Provided by an individual who is
    - a. Qualified to provide the services,
    - b. Supervised by a registered nurse (RN) or (when applicable) a Qualified Intellectual Disabilities Professional (QIDP) and
    - c. Not a member of the beneficiary's family OR
    - d. Qualified to provide the service according to approved policy in the IndependentChoices Program.
  5. Furnished in the beneficiary's home or, at the State's option, in another location
- B. Medicaid restricts coverage of personal care to services directly helping a beneficiary with certain specified routines and activities, regardless of the beneficiary's ability or inability to execute other non-covered routines and activities. Personal care services may be provided in a beneficiary's home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities, subject to the restrictions on travel time in this section.
- C. Travel Time of Personal Care Aide Accompanying Beneficiary:
1. Personal care only covers personal care aide travel time when all of the following apply:
    - a. The personal care aide accompanies the beneficiary in the same vehicle as the beneficiary travels to and returns from a community location for medical appointment or community activity;
    - b. The travel time billed is solely for necessary time in transit from the beneficiary's home to the community location and the return travel from the community location to the beneficiary's home;
    - c. The beneficiary's participation in the local community activity is for the benefit of the beneficiary and to meet the beneficiary's goals for independent living in the community, and the travel, including stops, is not for the benefit or convenience of any other person (including the personal care aide, a family member, the driver, or other passengers);
    - d. The traveling activity itself is for practical transit within the community and not for diversional or recreational purposes of any kind;
    - e. The beneficiary's Individualized Service Plan includes Personal Care service hours for one or both of the following activities of daily living (ADLs): toileting and mobility / ambulating;
    - f. While in transit to and from the community location, the beneficiary requires, or

is likely to need given assessed functional limitations, hands-on assistance with the ADL task of toileting or the ADL task of mobility / ambulating; and

- g. The travel time is reasonable given driving distances, traffic conditions, and weather, with time and locations documented.
2. Travel time is not reimbursable if any other adult person accompanying (or driving) the beneficiary is a family member and is reasonably able to assist the beneficiary in transit if needed.
3. Travel time accompanying a beneficiary will count against the total number of Personal Care hours per month authorized in the participant's Individualized Service Plan and prior authorization.
4. Requesting Hours for Travel Time of Attendant Accompanying Participant:

Beneficiaries vary in their medical appointments, participation in community activities, the availability of family or other assistance they may need while traveling, and the time involved when traveling to medical appointments and local community activities. When covered, travel time of a personal care aide accompanying a beneficiary is incident to but itself not the ADL task of toileting or the ADL task of mobility/ambulating. Therefore, the Task and Hour Standards are not currently used to help determine the number of Personal Care hours, if any, associated solely with travel time of a personal care aide accompanying a beneficiary to a medical visit or community activity.

For an ARChoices beneficiary, the number of hours allowed for travel time of a personal care aide will be determined by the DHS nurse in the beneficiary's Person-Centered Service Plan.

For other beneficiaries, the provider may include in the prior authorization request justification for travel time, based on the beneficiary's community activities, need for a personal care aide to accompany them, and the distances and roundtrip travel times typically involved. Based on this information and consistent with the above requirements, the contractor designated by DHS to process prior authorization requests, or if there is no contractor designated by DHS, DHS professional staff, may increase the number of Personal Care hours per month covered in the Individualized Service Plan and prior authorization to reasonably accommodate the travel time of a personal care aide accompanying the beneficiary.

**216.140****Service****1-1-19**

- A. A "personal care service" is a covered task or a related group of covered tasks.
- B. A "personal care aide service" is a personal care service.
  1. "Personal care services" and "personal care aide services" are interchangeable expressions that mean "covered tasks."
  2. Only a certified personal care aide, or an individual who meets or exceeds the qualifications of a personal care aide, as defined in Section 222.100, who is also in the employ of a Medicaid-enrolled personal care provider, may provide covered personal care services or personal care aide services as defined in this manual.
- C. As a condition of coverage and reimbursement, all personal care services must be:
  1. Reasonable and medically necessary, supported by the individual's latest nursing evaluation, and consistent with the individual's service plan;
  2. Expressly authorized in the individual's approved personal care services prior authorization;



3. Not available from another source (including, but not limited to, family members, a member of the beneficiary's household, or other unpaid caregivers; another Medicaid State Plan covered service; the Medicare program; the beneficiary's Medicare Advantage plan or Medicare prescription drug plan; or the beneficiary's private long-term care, disability, or supplemental insurance coverage);
  4. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services, including without limitation the aggregate weekly or monthly limits calculated by DHS for the beneficiary in accordance with the Arkansas Medicaid Task and Hours Standards;
  5. Provided by qualified, Medicaid-enrolled, DPSQA-certified providers and in compliance with all applicable Arkansas Medicaid program regulations and provider manuals; and
  6. Provided in compliance with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.
- D. Personal care services exclude all of the following:
1. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including, but not limited to, aseptic or sterile procedures, application of dressings, medications administration, injections, observation and assessment of health conditions, insertion, removal, or irrigation of catheters, tube or other enteral feedings, tracheostomy care, oxygen administration, ventilator care, drawing blood, and care and maintenance of any medical equipment;
  2. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
  3. Services provided for a person other than the beneficiary, including but limited to a provider, family member, household resident, or neighbor;
  4. Companion, socialization, entertainment, or recreational services or activities of any kind (including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship);
  5. Habilitation services, including assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and
  6. Mental health counseling or services.

#### **216.210 Eating**

See Section 216.212, Consuming Meats, below

#### **216.212 Consuming Meals**

**1-1-19**

- A. The service related to this routine includes the tasks involved in giving the beneficiary hands-on assistance to consume a meal and fluids. It does not include meal preparation.
- B. To receive personal care assistance with this routine, a beneficiary's physical dependency needs must prevent or substantially impair his or her ability to execute tasks such as cutting food in bite-size pieces or negotiating food from plate to mouth.
- C. The related service is hands-on assistance with the beneficiary's physical dependency needs to accomplish eating. The aide may only assist with or perform functional tasks the beneficiary cannot physically perform, in accordance with the beneficiary's physical dependency needs described in the assessment.

- D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following examples.
  - 1. An assessment states, "Beneficiary's arthritis prevents him from gripping slender objects such as eating utensils with either hand." The related task in the service plan is for the aide to "cut items into bite-size pieces and deliver them from plate to mouth for the beneficiary."
  - 2. The same assessment also states, "Effects of a recent stroke cause the beneficiary to choke or to risk choking unless food is pureed."
    - a. The related task in the service plan is for the aide to "puree food items for the beneficiary."
    - b. A separate statement, "The aide will deliver spoonfuls from plate to mouth for the beneficiary," addresses the arthritic condition.
- E. Observing a beneficiary eat is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the beneficiary's eating places the beneficiary at risk of injury or harm.

**216.240****Personal Hygiene**

1-1-19

- A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's personal hygiene. "Personal hygiene" means grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, and menstrual hygiene.
  - 1. An aide's time spent reminding a beneficiary to perform personal hygiene tasks is not a covered service unless the beneficiary's service plan includes hands-on assistance with personal hygiene.
  - 2. An aide's time spent observing a beneficiary perform personal hygiene tasks is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the activity places the beneficiary at risk of injury or harm.
- B. Beneficiaries eligible for this service must have a physical dependency preventing or substantially impairing their ability to perform hair and skin care and grooming, oral hygiene, shaving and nail care.
- C. The aide's service in regard to this routine is hands-on assistance with personal hygiene tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.
- D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

**216.260****Medication**

1-1-19

- A. Personal care aide services regarding medication routines are covered only to the extent that they are permitted by the Arkansas Nurse Practice Act and implementing rules and regulations.
- B. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's medications.



- C. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability to safely and correctly dispense and ingest orally administered prescription medications.
- D. The aide's service in regard to the beneficiary's medication routines is hands-on assistance with tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment, as described in the Arkansas State Board of Nursing Position Statement 97.2.
- E. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

**216.270****Mobility and Ambulation****1-1-19**

- A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's mobility and ambulation. "Mobility and ambulation" mean functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive equipment.
- B. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability:
  - 1. To turn themselves in bed,
  - 2. To move from bed to chair (including wheelchair or motorized chair),
  - 3. To walk (alone or with a device) or
  - 4. To operate a push wheelchair or a motorized chair.
- C. The aide's service in this routine is hands-on assistance with ambulation and mobility tasks the beneficiary cannot physically perform alone, according to the detailed physical dependency needs described in the assessment.
- D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

**216.310****Incidental Housekeeping****1-1-19**

- A. "Incidental housekeeping" means cleaning of the floor, furniture, and areas that are directly used by the beneficiary.
- B. The aide's service in regard to incidental housekeeping is hands-on assistance with covered tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.
- C. The assessment must describe the impairments that prevent or impede the beneficiary's ability to move freely and safely about their living area and clean the floor and furniture in the area they occupy.
- D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

**216.330****Shopping****1-1-19**

"Shopping" means services to address the beneficiary's physical dependency need by assisting the beneficiary with shopping or by shopping for the beneficiary.

- A. Assisting a beneficiary with shopping is a covered service only when the beneficiary is purchasing items that are necessary for the beneficiary's health and maintenance in the home (such as food, clothing, and other essential items) and that are used primarily by the beneficiary or, are used primarily by the beneficiary and other Personal Care Program beneficiaries who reside in the same service delivery location, and whose service plans include assistance with shopping.
  - 1. The aide's service in regard to shopping is hands-on assistance with covered shopping tasks the beneficiary cannot physically perform, according to the beneficiary's physical dependency needs detailed in the assessment.
  - 2. The assessment must describe the impairment(s) that prevent or impede the beneficiary's ability to move freely and safely in stores and perform some or all of the shopping tasks necessary to maintain his or her health and comfort.
  - 3. The service plan must correlate each required task with the beneficiary's corresponding physical dependency need. See Sections 215.300 and 215.310.
- B. If the service plan requires the aide to shop for the beneficiary:
  - 1. The beneficiary, or the beneficiary's representative, has freedom of choice to describe the items to be purchased (within the constraints stated herein) for the beneficiary's maintenance in the home.
  - 2. The beneficiary has freedom of choice to designate the individual stores at which to purchase the items.
    - a. If the designated stores are within the beneficiary's normal retail service area the service plan need not identify the specific stores.
    - b. If the designated stores are outside the normal retail service area for residents of the beneficiary's locale, the service plan must include the stores' names and locations.
- C. If there are other members of the beneficiary's household, the service plan must not include shopping, or assistance with shopping, unless the assessment fully documents all reasons each household member can neither:
  - 1. Assist with or do the beneficiary's shopping, nor
  - 2. Arrange for someone else to assist with or to do the beneficiary's shopping.
- D. Medicaid provides no additional coverage for an aide's mileage incurred performing shopping tasks.

**216.400****Personal Care Aide Service and Documentation Responsibility****1-1-19**

**NOTE: This section is not applicable to the IndependentChoices program.**

It is the responsibility of the personal care aide to accomplish the following:

- A. Perform authorized tasks as instructed by the supervising RN or QIDP.
- B. Maintain a service log.
  - 1. The service log must be completed at the time services are delivered. In the service log, it is not necessary to itemize the time spent on each individual ADL or IADL task for a given beneficiary, provided these tasks were performed by the same personal care aide in the same visit on the same day and at the same location.
  - 2. If the service log is not completed concurrently with service delivery, coverage may be denied.
  - 3. Refer to Sections 220.110 through 220.112 for service log requirements.

- C. Provide necessary documentation showing the date, time, location, nature and scope of authorized services delivered.
- D. Provide necessary documentation showing the date, time, location, nature and scope of emergency services delivered.
  - 1. If an emergency requires the personal care aide to perform a personal care service task not included on the personal care service plan, the personal care aide must receive when possible, prior approval from the supervising registered nurse or QIDP to perform the task.
  - 2. When prior approval is not possible, the personal care aide may perform the emergency service task, but she or he must receive post-service approval from the supervising registered nurse or QIDP.
  - 3. Document the circumstances in detail, describing:
    - a. The nature of the emergency,
    - b. The action or task required to resolve the emergency and
    - c. The justification for the unscheduled service.
- E. If a personal care aide does not perform a particular task scheduled on the service plan, the personal care aide must document why she or he did not perform the task that day.

**217.000****Benefit Limits**

1-1-19

- A. Medicaid imposes a 64-hour benefit limit, per month, per beneficiary, on personal care aide services for beneficiaries aged 21 and older.
- B. The 64-hour limitation applies to the monthly aggregated hours of personal care aide services.
- C. This 64 hour limit on personal care services for beneficiaries aged 21 and older is a firm cap for which there will be no extensions or exceptions.
- D. The hour limit does not apply to beneficiaries under age 21.

**220.100****Service Supervision**

1-1-19

Effective for dates of service on and after March 1, 2008, RNs supervising RCF and ALF Personal Care providers' personal care aides shall write, in a designated area on form DMS-873, instructions to aides and comments regarding the beneficiary and/or the aide.

- A. The provider must assure that the delivery of personal care services by personal care aides is supervised.
  - 1. Supervision must be performed by a registered nurse (RN).
  - 2. Alternatively, a Qualified Intellectual Disabilities Professional (QIDP) may fulfill the RN supervision requirement for personal care services to beneficiaries residing in alternative living situations or alternative family homes, licensed and certified by DPSQA as personal care providers.
- B. The supervisor has the following responsibilities.
  - 1. The supervisor must instruct the personal care aide in
    - a. Which routines, activities and tasks to perform in executing a beneficiary's service plan,
    - b. The minimum frequency of each routine or activity and

- c. The maximum number of hours per month of personal care service delivery, as authorized in the service plan.
  2. At least once a month, the supervisor must
    - a. Review the aide's records,
    - b. Document the record review and
    - c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.
  3. At least three times every 183 days (six months) at intervals no greater than 62 days, the supervisor must visit the beneficiary at the service delivery location to conduct on-site evaluation.
    - a. Medicaid requires that at least one of these supervisory visits must be when the aide is not present.
    - b. At least one visit must be while the aide is present and furnishing services.
  4. When the aide is present during the visit the supervising RN or QIDP must
    - a. Observe and document
      - (1) The condition of the beneficiary,
      - (2) The type and quality of the personal care aide's service provision and
      - (3) The interaction and relationship between the beneficiary and the aide;
    - b. Modify the service plan, if necessary, based on the observations and findings from the visit and
    - c. If necessary, further instruct the aide and document the nature of and the reasons for further instructions.
  5. When the aide is not present during the visit, the supervising RN or QIDP must
    - a. Observe and document the condition of the beneficiary,
    - b. Observe and document, from available evidence, the type and quality of the personal care aide's service provision, and
    - c. Query the beneficiary or the beneficiary's representative and document pertinent information regarding the beneficiary's opinion of
      - (1) The type and quality of the aide's service,
      - (2) The aide's conduct and
      - (3) The adequacy of the working relationship of the beneficiary and the aide;
    - d. Modify the service plan, if necessary, based on observations and findings from the visit, and
    - e. Further instruct the aide, if necessary, and document the nature of and the reasons for further instructions.
- C. The provider must review the service plan and the aide's records as necessary, but no less often than every 62 days. The review will ensure that the daily aggregate time estimate in the service plan accurately reflects the actual average time the aide spends delivering personal care aide services to a beneficiary.

**220.111 Service Log for Multiple Beneficiaries**

1-1-19

**Effective for dates of service on and after March 1, 2008, the rules in this section do not apply to RCF and ALF Personal Care providers.**

An aide delivering services to two or more beneficiaries at the same service location, during the same period (discontinuing or interrupting a beneficiary's service plan required tasks to begin or

resume service plan required tasks for another beneficiary, or performing an authorized service simultaneously for two or more beneficiaries. For example, cleaning a living space used by more than one beneficiary or preparing a meal that will be eaten by more than one beneficiary), must comply with the applicable instructions in parts A or B below:

- A. If providing services for only two beneficiaries, the aide must record in each beneficiary's service log
  - 1. The name of each individual for whom they are simultaneously performing personal care service;
  - 2. The beginning and ending times of service for each beneficiary and the beginning and ending times of each interruption and of each resumption of service; and
  - 3. Which services or services were performed simultaneously for more than one beneficiary.
- B. If services are performed in a congregate setting (more than two beneficiaries) the service log must state
  - 1. The actual time of day (clock-time) that the congregate services begin and end;
  - 2. The number of individuals, and the name of each individual, both Medicaid-eligible and non-Medicaid eligible, who received the documented congregate services during that period; and.
  - 3. Which services or services were performed simultaneously for more than one beneficiary.
- C. For services performed simultaneously for more than one beneficiary, the provider must split the time among the beneficiaries (for example, if the aide cleaned a bathroom shared by two beneficiaries and it took 20 minutes, the aide would document only half of that time - 10 minutes - for each beneficiary for the task).
- D. If the beneficiaries have different providers and different aides, both providers may not bill for cleaning a shared living space (e.g., a bathroom) or performing another task that benefits both beneficiaries (e.g., preparing a meal for both). The providers must determine which of their aides will be responsible for performing the task. The provider whose aide did not perform the task may not bill for it.
- E. A provider who knowingly bills twice for the same service or for a service that has been billed by another provider is committing a fraudulent act and may be referred by DHS to the Medicaid Fraud Control Unit.

**221.000 Documentation**

1-1-19

**NOTE: This section is not applicable to the IndependentChoices program.**

**Rule D in this section is effective for dates of service on and after March 1, 2008.**

The personal care provider must keep and make available to authorized representatives of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services and its authorized agents or officials; records including:

- A. If applicable, certification by the Home Health State Survey Agency as a participant in the Title XVIII Program. Agencies that provided Medicaid personal care services before July 1, 1986 are exempt from this requirement.
- B. When applicable, copies of pertinent residential care facility license(s) issued by the Office of Long Term Care.

- C. Medicaid contract.
- D. Effective for dates of service on and after March 1, 2008, RCF Personal Care providers will be required, when requested by DHS, to provide payroll records to validate service plans and service logs.
- E. Documents signed by the supervising RN or QIDP, including:
  - 1. The initial and all subsequent assessments.
  - 2. Instructions to the personal care aide regarding:
    - a. The tasks the aide is to perform,
    - b. The frequency of each task and
    - c. The maximum number of hours and minutes per month of aide service authorized by DHS professional staff or contractor(s) designated by DHS.
  - 3. Notes arising from the supervisor's visits to the service delivery location, regarding:
    - a. The condition of the beneficiary,
    - b. Evaluation of the aide's service performance,
    - c. The beneficiary's evaluation of the aide's service performance and
    - d. Difficulties the aide encounters performing any tasks.
  - 4. The service plan and service plan revisions:
    - a. The justifications for service plan revisions,
    - b. Justification for emergency, unscheduled tasks and
    - c. Documentation of prior or post approval of unscheduled tasks.
- F. Any additional or special documentation required to satisfy or to resolve questions arising during, from or out of an investigation or audit. "Additional or special documentation," refers to notes, correspondence, written or transcribed consultations with or by other healthcare professionals (i.e., material in the beneficiary's or provider's records relevant to the beneficiary's personal care services, but not necessarily specifically mentioned in the foregoing requirements). "Additional or special documentation," is not a generic designation for inadvertent omissions from program policy. It does not imply and one should not infer from it that, the State may arbitrarily demand media, material, records or documentation irrelevant or unrelated to Medicaid Program policy as stated in this manual and in official program correspondence.
- G. The personal care aide's training records, including:
  - 1. Examination results,
  - 2. Skills test results and
  - 3. Personal care aide certification.
- H. The personal care aide's daily service notes for each beneficiary, reflecting:
  - 1. The date of service,
  - 2. The routines performed on that date of service, noted to affirm completion of each task.
  - 3. The time of day the aide began performing the first service-plan-required task for the beneficiary;
  - 4. The time of day the aide stopped performing any service-plan-required task to perform any non-service-plan-required function;
  - 5. The time of day the aide stopped performing any non-service-plan-required function to resume service-plan-required tasks and

6. The time of day the aide completed the last service-plan-required task for the day for that beneficiary.
- I. Notes, orders and records reflecting the activities of the physician, the supervising RN or QIDP, the aide and the beneficiary or the beneficiary's representative; as those activities affect delivering personal care services.

**222.120 Personal Care Aide Training Subject Areas**

1-1-19

**NOTE: This section is not applicable to the IndependentChoices program.**

- A. Correct conduct toward beneficiaries, including respect for the beneficiary, the beneficiary's privacy and the beneficiary's property.
- B. Understanding and following spoken and written instructions.
- C. Communications skills, especially the skills needed to:
  1. Interact with beneficiaries,
  2. Report relevant and required information to supervisors and
  3. Report events accurately to public safety personnel and to emergency and medical personnel.
- D. Record-keeping, including:
  1. The role and importance of record keeping and documentation.
  2. Service documentation requirements and procedures, especially all documentation Medicaid requires of personal care aides, as described in Medicaid Personal Care Program policy statements current at the time of the aide's training.
  3. Reporting and documenting non-medical observations of beneficiary status.
  4. Reporting and documenting, when pertinent, the beneficiary's observations regarding their own status.
- E. Recognizing and reporting, to the supervising RN or QIDP, when changes in the beneficiary's condition or status require the aide to perform tasks differently than instructed.
- F. State law regarding delegation of nursing tasks to unlicensed personnel as designated by the Arkansas State Board of Nursing.
- G. Basic elements of body functioning, and the types of changes in body function, easily recognizable by a layperson, that an aide must report to a supervisor.
- H. Safe transfer techniques and ambulation.
- I. Normal range of motion and positioning.
- J. Recognizing emergencies and knowledge of emergency procedures.
- K. Basic household safety and fire prevention.
- L. Maintaining a clean, safe and healthy environment.
- M. Instruction in appropriate and safe techniques in personal hygiene and grooming that include how to assist the beneficiary with:
  1. Bed bath
  2. Sponge, tub or shower bath

3. Shampoo; sink, tub or bed
4. Nail and skin care
5. Oral hygiene
6. Toileting and elimination
7. Shaving
8. Assistance with eating
9. Assistance with dressing
10. Efficient, safe and sanitary meal preparation
11. Dishwashing
12. Basic housekeeping procedures
13. Laundry skills

## 240.000 PRIOR AUTHORIZATION

1-1-19

- A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for all beneficiaries, including beneficiaries participating in the IndependentChoices Program.
- B. Prior authorization does not guarantee payment for the service.
  1. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits.
  2. The provider must follow the billing procedures in this manual.
- C. The Arkansas Independent Assessment (ARIA) is the assessment instrument used by registered nurses of the DHS Independent Assessment Contractor to collect information used in determining the beneficiary's physical dependency needs for "hands-on" services with activities of daily living (ADL), and in calculating the number of personal care hours that can be authorized for the beneficiary. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each beneficiary is assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment.
  1. Tier 0 (zero) indicates the individual's assessed needs, if any, do not support the need for personal care services.
  2. Tiers 1 (one), 2 (two), or 3 (three) indicate the individual's assessed needs do support the need for personal care services.
- D. The Task and Hour Standards will be used by DHS RNs and DHS contractors to calculate the number of personal care hours that can be authorized for the beneficiary.

## 240.100 Task and Hour Standards (THS)

1-1-19

- A. Background on THS

The Arkansas Medicaid Task and Hour Standards (THS) is the written methodology used by the DHS RNs and DHS contractor RNs to calculate the number of personal care hours that are reasonable and medically necessary to perform needed ADL and IADL tasks.

The current DAABHS approved THS is located on the web at

<https://medicaid.mmis.arkansas.gov/Download/provider/provdocs/Manuals/ARCHOI CES/THS.doc>



The THS includes the following four components, described in a grid format:

1. The beneficiary's Needs Intensity Score (0, 1, 2, or 3) for each task;
2. The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score;
3. The frequency with which a task is necessary and reasonably performed; and
4. The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.

The THS provides a standardized process for calculating the amount of reasonable, medically necessary personal care services hours, with the minute ranges and frequencies, providing the ability to adjust service plans based on unique factors related to a given beneficiary's needs, preferences, and risks.

The number of personal care hours/minutes that are authorized for each necessary task by week/month are calculated by the DHS RN or by the contractor(s) designated by DHS consistent with the THS grid and based on:

1. Responses by the beneficiary and their representatives to certain relevant questions in the ARIA assessment instrument, and
2. As appropriate, information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representatives or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.

DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the ARIA assessments and electronic visit verification system; DPSQA audits of providers; and beneficiary and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.

**B. Needs Intensity Score:**

For each task, the DHS RN or the contractor(s) designated by DHS will assign a Needs Intensity Score to the beneficiary based on the beneficiary's and/or representative's responses to questions during the ARIA assessment and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS. The four Needs Intensity Scores are defined as follows:

Impairment Score 0 – The beneficiary has no functional impairment with regard to the task and can perform it without assistance.

Impairment Score 1 (Mild): Minimal/mild functional impairment. The beneficiary is able to conduct activities with minimal difficulty and needs minimal assistance.

Impairment Score 2 (Severe): Extensive/severe functional impairment. The beneficiary has extensive difficulty carrying out activities and needs extensive assistance.

Impairment Score 3 (Total): The beneficiary is completely unable to carry out any part of the activity.

A Needs Intensity Score is separate and distinct from a Tier Level under the ARIA system.

C. Number of minutes allowed for each Needs Intensity Score for each task

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. The DHS RN or contractor(s) designated by DHS will determine the number of minutes within the range that are appropriate for the beneficiary based on conditions specific to the beneficiary. For example, if a beneficiary has cognitive or behavioral issues, the maximum number of minutes in the range for bathing may be warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a beneficiary who is bald.

If the beneficiary has extenuating circumstances and requires time outside the range (either more or less) for the task, the DHS RN or designated contractor RN must obtain supervisory approval. For supervisory approval, the RN must document the participant's extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the participant's assessed or observed medical needs, and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor's approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the personal care prior authorization or ARChoices PCSP must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the personal care prior authorization or PCSP.

D The frequency with which a task is performed

The THS methodology takes into account the frequency with which each ADL and IADL is performed and reasonably necessary. The frequency with which a given task is performed for a beneficiary will be determined based on the ARIA assessment results and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

E. The amount of assistance with ADLs and IADLs provided by other sources

Personal care services are not available for assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.

If instances of a needed assistance with an ADL or IADL are generally provided through another source, then personal care services are not necessary and no time for that task is included. When another source is available to provide some instances of a needed ADL or IADL task, the frequency and time associated with these other sources are adjusted to correspond with the remaining assessed needs.

The amount of support with ADLs and IADLs provided by other sources is informed by the ARIA assessment results and information obtained by the provider RN during their individualized service plan meeting with the beneficiary and beneficiary's representative or from the beneficiary's physician, and submitted by the provider to DHS or to the contractor(s) designated by DHS.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g., supplemental services). Other support is calculated for each task based on how much

support is provided with the task (e.g., the beneficiary's daughter bathes her mother once a week and prepares all meals on weekends). For example, where a needed meal is supplied by Meals on Wheels, minutes for meal preparation may not be necessary and should be adjusted.

F. Calculation of total hours of personal care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of personal care hours approved for the beneficiary for a month.

**241.000**      **Personal Care Program Prior Authorization (PA) Responsibility**      **1-1-19**

- A. DHS professional staff or contractor(s) designated by DHS are responsible for prior authorization of personal care services for beneficiaries.
- B. DHS professional staff or contractor(s) designated by DHS reviews the personal care provider's completed form designated by DHS and submitted documentation for personal care services. Based on the information in the ARIA assessment and the form designated by DHS, they authorize a set amount of service time per month (expressed in service-time increments, four per hour) and issue a prior authorization control number (PA Number) for the approved service.
- C. DHS professional staff or contractor(s) designated by DHS have a right to review the beneficiary's medical information.

**242.000**      **Personal Care PA Request Procedure**      **1-1-19**

- A. Providers must use the form designated by DHS to request PA. [View or print the form designated by DHS \(English\)](#). [View or print the form designated by DHS \(Spanish\)](#).
- B. Requests for prior authorization must be submitted within thirty calendar days of the start of care. Approvals for beneficiaries who are assessed at Tier 1, 2, or 3 will be retroactive to the beginning date of service if the request is received within the 30-day time frame. There will be no prior authorization, including any retroactive prior authorization, if the beneficiary is assessed at Tier 0.
- C. Providers should submit prior authorization forms to the contractor(s) designated by DHS, or if there is no contractor designated by DHS, to DHS professional staff

**243.000**      **Provider Notification Procedure**      **1-1-19**

Reviews will be completed by DHS professional staff or contractor(s) designated by DHS within fifteen (15) working days of receipt of a complete PA request.

- A. For approved cases, an approval letter will be mailed to the requesting provider, detailing the procedure codes approved, total number of service time increments, beginning and ending dates and the authorization number.
- B. For denied or partially denied cases, a denial letter with reason for denial will be mailed to the beneficiary and the requesting provider. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests for reconsideration must be made in writing and include additional documentation. The letter shall specify why the prior authorization request was denied or partially denied and shall give the beneficiary

notice of the right to file a request for a fair hearing and where to file the request. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests for reconsideration must be made in writing and include additional documentation.

**244.000 Duration of PA 1-1-19**

Personal Care PAs are generally assigned for 12 months or for the life of the service plan, whichever is shorter, unless the beneficiary has a change in condition.

**245.000 Provider Process for Reconsideration of PA Determination 1-1-19**

Reconsideration of a denial may be requested within thirty calendar days of the denial date. Reconsideration requests must be made in writing to DHS professional staff or the contractor(s) designated by DHS and must include additional documentation to substantiate the medical necessity of the requested services.

If the decision is reversed during the reconsideration review, an approval is forwarded to all relevant parties specifying the approved units and services. If the denial is upheld, the DHS professional staff or the contractor(s) designated by DHS issues a written notification of the decision to the beneficiary and provider. [View or print AFMC contact information.](#)

**246.000 Beneficiary Process for Appeal of PA Determination 10-1-08**

When the beneficiary receives an adverse decision concerning a request for PA determination, the beneficiary may request a fair hearing of the reconsideration decision of the denial of services from the Department of Human Services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter from the DHS professional staff or contractor(s) designated by DHS explaining the denial. Appeal requests must be submitted to the Department of Human Services, Appeals and Hearings Section. [View or print the Department of Human Services, Appeals and Hearings Section contact information.](#)

**250.000 REIMBURSEMENT**

**250.100 Reimbursement Methods 1-1-19**

- A. Reimbursement for personal care services is the lesser of the billed amount per unit of service or Medicaid's maximum allowable fee (herein also referred to as "rate" or "the rate") per unit.
- B. Reimbursement for Arkansas Medicaid Personal Care services is based on a 15-minute unit of service.
- C. RCF Personal Care provider reimbursement is in accordance with a multi-hour daily service rate system, employing Medicaid maximum allowable fees (Daily Service Rates) determined by individual beneficiaries' Payment Levels.
- D. ALF Personal Care provider reimbursement is in accordance with a multi-hour daily service rate system, employing Medicaid maximum allowable fees (Daily Service Rates) determined by individual beneficiaries' Payment Levels. This excludes the Living Choices Assisted Living waiver beneficiaries.

**250.200 RCF and ALF Personal Care Reimbursement Methodology 1-1-19**

- A. The RCF and ALF Personal Care reimbursement methodology is designed with the intent that reimbursement under the multi-hour Daily Service Rate system closely approximates what reimbursement would have been if the providers were to have billed by units of service furnished.
- B. Whenever the unit rate (i.e., the maximum allowable amount per fifteen minutes service) for personal care services changes, Daily Service Rates under the RCF and ALF methodology are correspondingly adjusted in accordance with the initial methodology by which they were established and which is described in detail in the following sections.
- C. The Daily Service Rate paid for personal care services is based on a Payment Level determined from the resident's service plan.

#### 250.210 Payment Level

1-1-19

There are 10 Payment Levels, each based on the average number of 15-minute units of service per month required to fulfill a beneficiary's service plan.

- A. Level 1 includes RCF and ALF Personal Care beneficiaries whose service plans comprise 100 units or less per month of medically necessary personal care.
- B. Level 10 includes RCF and ALF Personal Care beneficiaries whose service plans comprise 256 or more units per month of medically necessary personal care.
- C. Level 2 through Level 9 were established in equal increments between 101 and 255 units per month.

#### 250.211 Payment Level Determination

1-1-19

- A. The average of a service plan's monthly units of service is used to determine each beneficiary's Payment Level.
- B. Calculate a beneficiary's average number of monthly units of personal care as follows.
  1. Add the Weekly Minute Totals from the prior authorization approved by DHS using the Task and Hour Standards..
  2. Divide the minutes by **15** (*15 minutes equals one unit of service*) to calculate weekly average units of service.
  3. Multiply the weekly average units from step 2 by **52** (*Weeks in a year*) and divide the product by **12** (*Months in a year*) to calculate monthly average units of service.
  4. Consult the "RCF and ALF Personal Care Service Rate Schedule" on the Arkansas Medicaid Personal Care Fee Schedule to find the applicable Daily Multi-Hour Service Rate for each Payment Level . Procedure code T1020 is the applicable code for RCF and ALF Personal Care providers.

#### 250.212 Rate Development

1-1-19

- A. The Level 1 Daily Service Rate was calculated as follows.
  1. Multiplied **100** (*15-minute units*) by **12** (*Months in a year*)
  2. Divided units per year calculated in step 1 by **365** (*The average number of days in a year*) to calculate average units per day
  3. Multiplied average units (*Unrounded*) per day obtained in step 2 by the current Personal Care maximum allowable fee per unit and rounded the product to the nearest 100<sup>th</sup> to calculate the Level I Daily Service Rate
- B. The Level 10 Daily Service Rate was calculated as follows.

1. Multiplied **256** (*Maximum monthly units*) by **12** (*Months per year*)
  2. Divided the product calculated in step 1 by **365** (*The average number of days in a year*) to calculate average maximum units per day
  3. Multiplied average maximum units per day from step 2 by the current Personal Care maximum allowable fee per unit and rounded the product to the nearest 100<sup>th</sup> to calculate the Level 10 Daily Service Rate
- C. The Daily Service Rates for Level 2 through Level 9 were calculated as follows.
1. The difference between 255 and 101 (154) was divided into eight equal increments that then were designated Payment Levels (“Levels”) 2 through 9.
  2. The sum of the beginning and ending values within each Payment Level was divided by **2** to calculate the Level’s average units per month.
  3. The average units per month was multiplied by **12** (*Months per year*) to calculate average annual units.
  4. The average annual units calculated in step 3 was divided by **365** (*The average number of days in a year*) to arrive at average units per day.
  5. The average units per day calculated in step 4 was multiplied by the current Personal Care maximum allowable fee per unit and the product was rounded to the nearest 100<sup>th</sup>.

**251.121 Fee Schedules**

1-1-19

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

**262.101 Personal Care for a Beneficiary Aged 21 or Older (Non-RCF)**

1-1-19

Procedure Code	Modifier	Service Description
T1019	U3	Personal Care for a non-RCF Beneficiary Aged 21 or Older, per 15 minutes (requires prior authorization)

**262.104 Personal Care in an RCF or ALF**

1-1-19

- A. To bill for RCF or ALF Personal Care, use HCPCS procedure code **T1020** and the modifier corresponding to the beneficiary’s Payment Level in effect for the date(s) of service being billed.
- B. The Payment Level that a provider bills must be consistent with the beneficiary’s service plan in effect on the day that the provider furnished the personal care services billed.

**Payment Level Specifications and Modifiers for Procedure Code T1020**

Payment Levels	Minimum Service Units	Maximum Service Units	Modifier
Level 1	Less than 100	100	U1
Level 2	101	119	U2
Level 3	120	139	U3
Level 4	140	158	U4
Level 5	159	177	U5
Level 6	178	196	U6
Level 7	197	216	U7
Level 8	217	235	U8
Level 9	236	255	U9
Level 10	256	256	UA

**262.105 Employment-Related Personal Care Outside the Home**

1-1-19

Procedure Code	Modifier	Service Description
T1019	U5	Employment-related personal care outside the home, beneficiary aged 16 or older, per 15 minutes. All personal care services require prior authorization.

**262.410 Completing a CMS-1500 Claim Form for Personal Care**

1-1-19

When a provider must bill on a paper claim, the fiscal agent accepts only red-lined, sensor-coded CMS-1500 claim forms. Claim photocopies and claim forms that are not sensor-coded cannot be processed.

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's 10-digit Medicaid or ARKids First-A identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's date of birth as given on the individual's Medicaid or ARKids First-A identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's complete mailing address (street address or post office box).

Field Name and Number	Instructions for Completion
CITY	Name of the city in which the beneficiary resides.
STATE	Two-letter postal code for the state in which the beneficiary resides.
ZIP CODE	Five-digit ZIP code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's telephone number or the number of a reliable message/contact/ emergency telephone
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if the insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED SEX	Reserved for NUCC use. Not required.
c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9a and d are required. Name of the insured individual's employer and/or school.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.



Field Name and Number	Instructions for Completion
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition codes is found at <a href="http://www.nucc.org">www.nucc.org</a> under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH SEX	Not required. Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a, 9c and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.  Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness ; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	<p>Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.</p> <p>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:</p> <p>454 Initial Treatment</p> <p>304 Latest Visit or Consultation</p> <p>453 Acute Manifestation of a Chronic Condition</p> <p>439 Accident</p> <p>455 Last X-Ray</p> <p>471 Prescription</p> <p>090 Report Start (Assumed Care Date)</p> <p>091 Report End (Relinquished Care Date)</p> <p>444 First Visit or Consultation</p>
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of the referral source.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not applicable.
19. LOCAL EDUCATIONAL AGENCY (LEA) NUMBER	Insert LEA number.
20. OUTSIDE LAB? \$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use "9" for ICD-9-CM.</p> <p>Use "0" for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>

Field Name and Number	Instructions for Completion
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization number.
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> <li>1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month.</li> <li>2. A provider may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the date sequence.</li> <li>3. RCFs may bill for a date span of any length within the same calendar month, provided the beneficiary was present every day of the date span and all services provided within the date span were at the same Payment Level.</li> </ol>
B. PLACE OF SERVICE	Two-digit national standard place of service code.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	<p>CPT/HCPCS One CPT or HCPCS procedure code for each detail.</p> <p>MODIFIER Modifier(s) when applicable.</p>
E. DIAGNOSIS POINTER	<p>Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.</p>

Field Name and Number	Instructions for Completion
F. \$ CHARGES	<p>The full charge for the services totaled in the detail. This charge must be the usual charge to any beneficiary patient, or other recipient of the provider's services.</p> <p>RCFs' charges should equal no less than the product of the number of units (days) times the beneficiary's Daily Service Rate. If the charge is less, Medicaid will pay the billed charge.</p>
G. DAYS OR UNITS	The units (in whole numbers) of service provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening and referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, advise Provider Enrollment so that the year-end 1099 will be correct and reported correctly.
26. PATIENT'S ACCOUNT NO.	Optional entry for providers' accounting and account-retrieval purposes. Enter up to 16 numeric, alphabetic or alpha-numeric characters. This character set appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum of all charges on the claim.
29. AMOUNT PAID	Enter the total of payments received from other sources on this claim. Do not include amounts previously paid by Medicaid.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PROVIDER	<p>The performing provider or an individual authorized by the performing provider or by an institutional, corporate, business or other provider organization, must sign and date the claim, certifying that the services were furnished by the provider, under (when applicable) the direction of the individual provider or other qualified individual, and in strict and verifiable accordance with all applicable rules of the Medicaid program in which the provider participates. A “provider’s signature” is the provider’s or authorized individual’s personally written signature, a rubber stamp of the signature, an automated signature or a typed signature. The name of a group practice, a facility or institution, a corporation, a business or any other organization will prevent the claim from being processed.</p>
32. SERVICE FACILITY LOCATION INFORMATION	<p>If services were not performed at the beneficiary’s home or at the provider’s facility (e.g., school, etc.) enter the name, street address, city, state and zip code of the facility, workplace etc. where services were performed. If services were furnished at multiple sites (for instance, when job-seeking), indicate “multiple locations” or leave blank.</p>
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	<p>Billing provider’s name and complete address. Telephone number is requested but not required.</p>
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

**TOC required****201.100 PACE Provider Enrollment Requirements**

1-1-19

To ensure quality and continuity of care, all PACE providers approved to receive Medicaid reimbursement for services provided must meet specific qualifications. PACE providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. PACE providers must be certified by the Division of Provider Services and Quality Assurance (DPSQA) as having met all Centers for Medicare and Medicaid Services (CMS) approved provider criteria for the service(s) they wish to enroll to provide.

**Certification by the DPSQA does not guarantee enrollment in the Medicaid program.**

All providers must maintain their provider files at the Provider Enrollment Unit by submitting current certification, licensure, etc., all DPSQA-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider.

Copies of certifications and renewals required by DPSQA must be maintained by DPSQA to avoid loss of provider certification.

- B. A PACE provider application must be approved by the Centers for Medicare and Medicaid Services (CMS) and the Division of Aging, Adult and Behavioral Health Services (DAABHS). Failure to submit a PACE provider application to DAABHS at the same time or prior to submitting the application to CMS shall constitute grounds for DAABHS denying or delaying approval of the application.
- C. A three-way Provider Agreement must be signed by the DAABHS, CMS, and the provider.
- D. The PACE Organization must be licensed by the Arkansas Department of Human Services, DPSQA, as an Adult Day Health Care.

**204.200 Medical Criteria**

1-1-19

PACE participants must meet one of the following criteria:

The individual is unable to perform either of the following:

- A. At least one (1) of the three (3) activities of daily living (ADL) of transferring and/or locomotion, eating or toileting without extensive assistance from or total dependence upon another person;
- B. At least two (2) of the three (3) activities of daily living (ADL) of transferring and/or locomotion, eating or toileting without limited assistance from another person;
- C. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to themselves or others;
- D. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life threatening; or,
- E. Individuals diagnosed with a serious mental illness or mental retardation are not eligible for the Program of All-Inclusive Care for the Elderly unless they have medical needs unrelated to the diagnosis of mental illness or mental retardation and meet the other qualifying

criteria. A diagnosis of severe mental illness or mental retardation must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation when they meet the other qualifying criteria.

**212.100 PACE Enrollment**

1-1-19

Participant enrollment into the PACE Program is voluntary. Prospective PACE beneficiaries may apply for PACE services through their local Department of Human Services (DHS) county offices. Applicants may apply by referral from the PACE provider, by referral from a DHS RN, or without a referral from any source. Regardless of the origin of the inquiry, the prospective participant must meet the medical and financial eligibility criteria.

If the prospective PACE beneficiary makes the initial inquiry with the PACE provider or the DHS-Registered Nurse (RN), the provider or RN will instruct the applicant to make application at the local DHS county office for a determination of financial eligibility. The local DHS county office will make the proper referral to the DHS RN for the medical assessment.

The Office of Long Term Care, Division of Provider Services and Quality Assurance, of the Department of Human Services must determine, based on the functional assessment conducted by the Independent Assessment Contractor, that the potential enrollee meets the requirements for nursing facility care prior to enrollment. The DHS RN must certify that an assessment has been completed and that it is safe for the participant to live in the community. The DHS RN will notify the local DHS county office and the Provider Organization (PO) that all requirements have been met.

The PACE provider must explain to the potential enrollee that enrollment in PACE results in disenrollment in any other Medicare or Medicaid plan and the provider is required to complete an intensive assessment that includes a minimum of one home visit and one visit by the potential enrollee to the PACE center unless otherwise approved by CMS.

**212.200 Disenrollment**

1-1-19

Participants may voluntarily disenroll from the PACE program at any time for any reason.

Participants may be involuntarily disenrolled due to:

- A. Participant's failure to pay if he or she has a payment responsibility
- B. Participant's disruptive or threatening behavior
- C. Participant moves out of the PACE service delivery area
- D. Participant no longer meets the nursing facility level of care requirement
- E. The PACE program agreement with the Centers for Medicare and Medicaid Services (CMS) and the state is not renewed
- F. The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers

To involuntarily disenroll a participant, the PACE Organization must obtain the prior review and approval of the Department of Human Services. The request to disenroll a participant and documentation to support the request must be sent to the DHS-RN. The DHS- RN will review the request and corresponding documentation and will make a recommendation to the DHS- RN Supervisor and DHS PACE Program Manager regarding whether the PACE Organization should proceed with the involuntary disenrollment. The DHS-RN Supervisor, in consultation with PACE Program management will make a final determination regarding the appropriateness of the involuntary disenrollment and will notify the PACE Organization and the DHS-RN.

The PACE Organization may request an administrative reconsideration pursuant to Section 190.003. A request for administrative reconsideration must be directed to the Division of Aging, Adult and Behavioral Health Services.

**215.000 Interdisciplinary Teams**

1-1-19

The PACE interdisciplinary team must meet regularly as indicated in the Provider Agreement between the PO, CMS, and the Division of Aging, Adult and Behavioral Health Services to provide overall assessment of care needs and subsequent management, supervision and provision of care for eligible individuals.

**215.200 Assessment/Treatment Plan**

1-1-19

An interdisciplinary team is responsible for assessment, treatment planning and care delivery after the Independent Assessment Contractor has completed an initial assessment using the ARIA assessment instrument to determine the individual's functional needs and eligibility for nursing facility level of care. The team must meet the following assessment requirements:

- A. An initial in-person comprehensive assessment must be completed promptly following enrollment by the:
  1. Primary care physician,
  2. Registered nurse,
  3. Master's-level social worker,
  4. Physical therapist,
  5. Occupational therapist,
  6. Recreational therapist or activity coordinator,
  7. Dietitian and
  8. Home care coordinator.
- B. At least semi-annually, an in-person assessment and treatment plan must be completed by the:
  1. Primary care physician,
  2. Registered nurse,
  3. Master's-level social worker and
  4. Recreational therapist/activity coordinator.
- C. Annually, an in-person assessment and treatment plan must be completed by the:
  1. Physical therapist,
  2. Occupational therapist
  3. Dietitian and
  4. Home care coordinator.

PACE organizations consolidate discipline specific plans into a single plan of care semi-annually through discussion and consensus of the interdisciplinary team. The consolidated plan is then discussed and finalized with the PACE participant and/or his or her significant others.

Reassessments and treatment plan changes are completed when the health or psychosocial situation of the participant changes.



**220.100**      **Monitoring by the Division of Provider Services and Quality Assurance**      **1-1-19**

Due to the requirement that PACE Organizations be licensed as Arkansas Adult Day Health Care Centers, the Division of Provider Services and Quality Assurance will be conducting monitoring and oversight of the PACE Center operations.

**220.400**      **Monitoring by the Centers for Medicare and Medicaid Services (CMS) and the State Administering Agency (SAA)**      **1-1-19**

In compliance with federal requirements, each PACE Organization will enter required information for nine (9) key indicators into the Health Plan Management System (HPMS), or any successor data elements or data system on a quarterly basis. Both CMS and the State Administering Agency (SAA) will use the data entered into HPMS or its successor system to monitor the ongoing operations of the PACE Organization and identify potential problems or unusual events that may be the first indication of problems in patient care, site operations or financial solvency. These reviews will also be used to determine if further onsite monitoring will be necessary.

A. The nine (9) key indicators are as follows:

1. Routine Pneumococcal Immunizations
2. Grievances & Appeals
3. Enrollments
4. Disenrollments
5. Prospective Enrollees
6. Unscheduled Hospitalizations
7. Emergency (Unscheduled) Care
8. Unusual Incidents for participants and the PACE site (such as falls, attempted suicides, staff criminal records, infectious diseases, food poisoning, participant injury, Medication errors, lawsuits, any type of restraint use, etc.)
9. Participant Deaths