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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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*):
Living Choices

C. **Type of Request:new**

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**

☑ **New to replace waiver**

Replacing Waiver Number:
AR.0195, AR.0400, and AR.0312

☐ **Migration Waiver** - this is an existing approved waiver

Provide the information about the original waiverbeing migrated

Base Waiver Number:

Amendment Number
(if applicable):

Effective Date: *(mm/dd/yy)*

Draft ID: **AR.35.00.00**

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

E. **Proposed Effective Date:** *(mm/dd/yy)*
07/01/14

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

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

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

☐ **Intermediate Care Facility for 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)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The Living Choices waiver offers HCBS as an alternative to nursing home placement for individuals requiring an intermediate level of care in a nursing home who are aged 21 through 64 and have been determined to have a physical disability by the SSA or the Department of Human Services Medical Review Team (DHS MRT), or individuals who are aged 65 and older. These HCBS aim to prevent or delay institutionalization for these individuals, allowing them to remain in their homes and in their communities.

The services provided in the Living Choices waiver are Case Management (CM), Assisted Living Services (ALS) and Extended Medicaid State Plan Prescription Drugs for those receiving ALS, and the Health Care Component of Adult Day Health Care (ADHC) facilities.

Each Living Choices service plan (of care) includes case management, unless refused by the waiver participant. Living Choices Case Management is designed to assist individuals in gaining access to needed medical, social, educational, and other services throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the participant and the Medicaid State plan and Medicaid HCBS waiver program.

Living Choices participants who receive Assisted Living Services live in apartment-style living units in licensed level II assisted living facilities (ALFs) 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.

Extended Prescription Drug Coverage is available for Living Choices participants living in licensed level II ALFs and receiving Assisted Living Services, 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 Medicare Part D, through the Arkansas Medicaid State Plan Pharmacy Program.

All Living Choices services are provided on a regular basis according to individualized, person-centered service plans (of care) that are developed and authorized by a DAAS RN. Services adapt to changing needs and individual preferences; promote dignity, autonomy, privacy and safety; permit family and community involvement; and, minimize the need to move away from the individual'™s home or community.

Living Choices is administered by a state agency, the Division of Aging and Adult Services (DAAS), which serves as the Operating Agency. DAAS operates under the authority of the Division of Medical Services (DMS), which is the Medicaid Agency. These two separate divisions are under the umbrella of the DHS.

The Director of Home and Community-Based Services (HCBS) within DAAS administers Living Choices. The Director of HCBS oversees the DAAS RNs responsible for assessments, reassessments and assisting participants in developing a person-centered service plan (of care). The HCBS Director and DAAS Assistant Director of Support Services have joint responsibility for the DAAS central office support staff, which works with waiver participants and providers.

Individuals access services by applying for the waiver program at the DHS office in the county of their residence, or in the county where the ALF is located if they wish to receive Assisted Living Services. The DHS county office makes a referral to the DAAS RN and determines financial eligibility for the program. The DAAS RN completes a face-to-face medical assessment with the applicant. The assessment is reviewed by qualified medical personnel for determination of medical need, and a DHS-704, Decision for Nursing Home Placement, is issued which reflects the level of care. If an applicant is determined both financially and medically eligible, the DHS county office approves the application.

The DAAS RN assesses the participant's needs and develops an individualized, person-centered service plan (of care) detailing the needed waiver, State Plan, and other services and the delivery of services. Waiver and State Plan services are provided by qualified Arkansas Medicaid providers.

In addition to completing the initial assessment and developing the service plan (of care), the DAAS RN completes reassessments at least annually and performs face-to-face monitoring visits as needed. For those participants receiving Case Management Services, case managers must routinely monitor the participant'™s needs and circumstances. This consists of maintaining regular contact, either face-to-face or by telephone with participants, and reporting the participant'™s status and any changes in a participant'™s condition, needs or circumstances to the DAAS RN via the Change of Client Status form (AAS-9511) immediately upon learning of the change. The AAS-9511 may be transmitted to the DAAS RN by fax or email. All changes to the service plan (of care) will be authorized by the DAAS RN after consultation with the participant and/or family members.

3. Components of the Waiver Request

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

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

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

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
  Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
  Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/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:
Policies, forms and procedures for the waiver have been developed through twenty years of experience in operating waiver programs. The services provided through this waiver were previously provided through AR.0400 (Living Choices Assisted Living), AR.0312 (ElderChoices) and AR.0195 (Alternatives for Adults with Physical Disabilities), with the exception of Case Management services.

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 has been taken to incorporate changes or modifications 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, Office of Medicaid Inspector General audits, monitoring of participants and contact with stakeholders. The experiences and lessons learned from the public and the resulting improvements have been applied to the development of the policies, forms and procedures for the new waiver.

The proposed waiver and subsequent updates and revisions to the waiver are posted on the DMS website to allow for general public comment. Notices of the proposed waiver, updates or revisions are also published in a statewide newspaper for 30 days to allow for public review and comment.

Regulations, policies, rules and procedures are promulgated in accordance with the Arkansas Administrative Procedure Act. This act allows another opportunity for public comment. Promulgation includes review and advice from the Arkansas Legislative Sub-Committee(s), which is open to the public, and the opportunity is given to those wanting to speak in support of, or in opposition to, the rule. After review and advice from the sub-committee, 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. Toll-free

numbers are also available for the public to call with input regarding the waiver.

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

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

7. Contact Person(s)

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

Last Name:	Higgs
First Name:	Glenda
Title:	Medical Assistance Manager/Program Development & QA
Agency:	Arkansas Department of Human Services, Division of Medical Services
Address:	P.O. Box 1437, Slot S-295
Address 2:	
City:	Little Rock
State:	**Arkansas**
Zip:	72203-1437
Phone:	(501) 320-6425 **Ext:** ☐ **TTY**
Fax:	(501) 682-2480
E-mail:	glenda.higgs@arkansas.gov

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

Last Name:	Blocker
First Name:	Stephenie
Title:	DAAS Director of Home & Community-Based Services
Agency:	Arkansas Department of Human Services, Division of Aging and Adult Services
Address:	P.O. Box 1437, Slot S-530
Address 2:	
City:	Little Rock

State:	**Arkansas**
Zip:	72203-1437
Phone:	(501) 320-6569 **Ext:** ☐ **TTY**
Fax:	(501) 682-8155
E-mail:	stephenie.blocker@arkansas.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	
	State Medicaid Director or Designee
Submission Date:	

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

Last Name:	Allison
First Name:	Andrew
Title:	Director
Agency:	Arkansas Department of Human Services, Division of Medical Services
Address:	P.O. Box 1437, Slot S-401
Address 2:	
City:	Little Rock
State:	**Arkansas**
Zip:	72203-1437
Phone:	(501) 682-8740 **Ext:** ☐ **TTY**
Fax:	(501) 682-1197
E-mail:	andy.allison@arkansas.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

All ElderChoices, Alternatives for Adults with Physical Disabilities, and Living Choices Assisted Living waiver participants will be transitioned to the new Living Choices 1915(c) waiver and the Community First Choice Option (CFCO) 1915(k) state plan, when applicable.

ElderChoices Transition Plan to Living Choices and CFCO

All services currently covered in the ElderChoices waiver will continue to be provided as a CFCO state plan service under 1915(k) or as a Living Choices waiver service when CFCO and the new Living Choices waiver are implemented. All participants of ElderChoices will automatically convert to the Living Choices waiver when the new Living Choices waiver and CFCO state plan amendment are implemented. All waiver participants will receive case management through the Living Choices waiver instead of through state plan Targeted Case management. All other HCBS services included on the ElderChoices plan of care will be received either through CFCO, or through the new Living Choices. This change will be automatic, seamless and unnoticeable to the participant. The current level of care and plan of care will remain in effect, and the same services will continue through CFCO and the new Living Choices waiver until the next reassessment. When the individual is reassessed, a new care plan will be developed and will include both waiver and non-waiver services, as is current practice.

ElderChoices and CFCO or Living Choices Services Compared

All ElderChoices (EC) participants will continue to receive all services currently included on the waiver plan of care in the same scope and amount when the new Living Choices and CFCO are implemented.

Participants receiving the EC Adult Companion service through an agency or participant-directing through Arkansas's 1915 (j) program (Independent Choices) will continue to receive the same services from the same provider in the same manner as CFCO Attendant Services. The CFCO Attendant Services definition includes all aspects of the EC Adult Companion definition plus is broadened to include additional tasks and services. The participant-directed (PD) model for CFCO will be similar to the current 1915(j) model. The same attendant care provider will continue to provide services and the provider will continue to bill as they always have during the transition until reassessment. At the next reassessment, the CFCO Counseling Support provider and the CFCO FMS provider will work with the participant and provider to provide training, support and assistance in understanding any differences with the CFCO PD model and in completing the paperwork necessary to transition to the new model.

Participants receiving the EC Homemaker service through an agency or participant-directing through Arkansas's 1915(j) program (Independent Choices) will continue to receive the same services from the same provider in the same manner as CFCO Homemaker service. The CFCO Homemaker service definition is identical to the EC Homemaker definition. The transition to the CFCO PD model will follow the same process as described for the EC Adult Companion service above.

Participants receiving the EC Home-Delivered Meals service will continue to receive the same service from the same provider in the same manner as CFCO Home-Delivered Meals service. The CFCO Home-Delivered Meals service definition is identical to the EC Home-Delivered Meals definition.

Participants receiving the EC Personal Emergency Response System (PERS) service will continue to receive the same service from the same provider in the same manner as CFCO PERS service. The CFCO PERS service definition is identical to the EC PERS definition.

Participants receiving the EC Adult Day Care service will continue to receive the same service from the same provider in the same manner as CFCO Adult Day Care service. The CFCO Adult Day Care service definition is identical to the EC Adult Day Care definition.

Participants receiving the EC Adult Day Health Care service will continue to receive the same service from the same provider in the same manner as Living Choices Health Care Component of Adult Day Health Care service and the non-health related services provided by the ADHC will be provided as CFCO Attendant Services and Supports, Supportive Living Services, and Consultation Services. The Living Choices Health Care Component of Adult Day Health Care service and CFCO Attendant Services and Supports, Supportive Living Services, and Consultation Services definitions meet and exceed the EC Adult Day Health Care definition.

Participants receiving the EC Adult Family Home service will continue to receive the same service from the same provider in the same manner as CFCO Adult Family Home service. The CFCO Adult Family Home service definition is identical to the EC Adult Family Home definition.

Participants receiving the EC Respite service will continue to receive the same service from the same provider in the same manner as CFCO Respite service. The CFCO Respite definition is identical to the EC Respite definition.

Alternative for Adults with Physical Disabilities Transition Plan to Living Choices and CFCO

All services currently covered in the AAPD waiver will continue to be provided as a CFCO state plan service under 1915(k) or as a new Living Choices waiver service when the CFCO and new Living Choices waiver are implemented. All participants of AAPD will automatically convert to the Living Choices waiver when the new Living Choices waiver and CFCO state plan amendment are implemented. All waiver participants will receive case management through the new Living Choices waiver and will receive all other HCBS services included on the waiver plan of care through CFCO. This change will be automatic, seamless and unnoticeable to the participant. The current level of care and plan of care will remain in effect and the same services will continue through CFCO and the new Living Choices waiver until the next reassessment. When the individual is reassessed, a new care plan will be developed and will include both waiver and non-waiver services, as is current practice.

AAPD and CFCO or Living Choices Services Compared

All AAPD participants will continue to receive all services currently included on the waiver plan of care in the same scope and amount when CFCO is implemented.

Attendant Care – Agency and Participant-Directed

Participants receiving AAPD Attendant Care through an agency either under the traditional model or as a co-employer will continue to receive the same services from the same provider as CFCO Attendant Services. The CFCO Attendant Services definition includes all aspects of the AAPD Attendant Care definition, plus is broadened to include additional tasks and services.

Participants receiving AAPD Attendant Care under the Participant-Directed (PD) model will continue to receive the same services from the same provider under CFCO Attendant Services as a PD service. The PD model for CFCO will be different from the PD model for AAPD as CFCO will develop the model based on 1915(k), which is similar to the 1915(j) Cash and Counseling model. The same attendant care provider will continue to provide services and the provider will continue to bill as they always have during the transition until reassessment. If the provider's annual certification expires before reassessment, the state will automatically extend the certification until the reassessment, when they will be transitioned to the new PD model. At the next reassessment, the CFCO Counseling Support provider and the CFCO FMS provider will work with the participant and provider to provide training, support and assistance in understanding the changes in the CFCO PD model and in completing the paperwork necessary to transition to the new model.

Other AAPD Services Compared

AAPD Counseling Support Management (CSM) will automatically continue for all participants as Living Choices Case Management and as CFCO Counseling Support. The AAPD CSM waiver service currently provides both counseling support for participant direction and case management functions in the single service. When CFCO is implemented, Case Management will be provided as a separate service under the Living Choices waiver to all current AAPD participants. Counseling Support will be a separate service and covered under the CFCO state plan amendment. Those who currently PD services under AAPD will automatically continue receiving Counseling Support for PD as a 1915(k) service under CFCO.

AAPD Environmental Accessibility Adaptations/Adaptive Equipment will automatically be available to those in need of this service as CFCO Environmental Accessibility Adaptations and as CFCO Adaptive Equipment. The limitations for the CFCO services will be more liberal than the AAPD service. Current AAPD providers will automatically be certified providers for the CFCO services.

Living Choices Assisted Living Transition Plan to the New Living Choices Waiver

All services currently covered in the Living Choices Assisted Living waiver will continue to be provided as a new Living Choices waiver service when the new waiver is implemented. All participants of Living Choices Assisted Living will automatically convert to the new Living Choices waiver when it is implemented. All waiver participants will continue to receive all HCBS services included on the waiver plan of care through the new Living Choices waiver. Additionally, all waiver participants will now receive case management through the Living Choices waiver. This change will be automatic, seamless and unnoticeable to the participant. The current level of care and plan of care will remain in effect and the same

services will continue through the new Living Choices waiver until the next reassessment. When the individual is reassessed, a new care plan will be developed and will include both waiver and non-waiver services as is current practice.

Living Choices Assisted Living and Living Choices Services Compared

All Living Choices Assisted Living (LCAL) participants will continue to receive all services currently included on the waiver plan of care in the same scope and amount when the new Living Choices waiver is implemented. In addition, each LCAL participant will now receive case management as a distinct waiver service.

Participants receiving the LCAL Extended Medicaid State Plan Prescription Drug service will continue to receive the same service from the same provider in the same manner as the new Living Choices Extended Medicaid State Plan Prescription Drug service. The new Living Choices Extended Medicaid State Plan Prescription Drug service definition is identical to the LCAL Extended Medicaid State Plan Prescription Drug service definition.

Participants receiving the LCAL Living Choices Assisted Living Service will continue to receive the same service from the same provider in the same manner as the new Living Choices Assisted Living Service. The new Living Choices Assisted Living Services definition is identical to the LCAL Living Choices Assisted Living Services definition.

All LCAL waiver participants will now additionally receive case management through the new Living Choices Case Management service. Under the LCAL waiver, case management was provided as an administrative activity. Social workers and licensed nurses employed by the Assisted Living Facility conducted case management activities at the assisted living facility for LCAL waiver participants. Under the new Living Choices waiver, case management is furnished as a Living Choices waiver service, as defined in Appendix C-3.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

N/A

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

Specify the division/unit name:
Arkansas Department of Human Services, Division of Aging and Adult Services

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The state utilizes the Interagency Agreement to define each agency's responsibilities in administering the Living Choices waiver program. This agreement is reviewed annually and updated as needed. DMS monitors this agreement to assure that the provisions specified are executed.

As part of the Interagency Agreement, DMS requires DAAS to develop and implement a Quality Assurance Protocol, which is reviewed annually, that demonstrates how the operating agency will meet the following criteria:
• Assure the health and welfare of waiver participants;
• Assure the adequacy of service plans (of care) for waiver participants;
• Assure that all waiver services are provided by qualified providers;
• Implement the processes and instruments for evaluating/re-evaluating level of care need; and,
• Assure that an adequate system for assuring financial accountability is in place.

Each year, DMS runs a report to identify the number of the active Living Choices waiver population. A sample is drawn from the active Living Choices waiver population. 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, then DMS divides the sample into a monthly sample and reviews the participant records. As part of DMS's review of a random sample of all active waiver participants' records, DMS verifies the following:

Health and welfare
• Participants, family members, legal guardians and caregivers' complaints are identified, tracked and addressed
• Abuse, neglect and exploitation incidents are identified, tracked and actions are taken to assure the participant's safety
• Participants, family members, legal guardians and caregivers are provided information regarding how to report concerns or incidents of abuse, neglect and exploitation
• The participant's health and welfare have been safeguarded and any situations where the participant's health and welfare may have been jeopardized were identified and acted upon timely and/or appropriately

Service Plans
• The service plan is current and was received and approved prior to the expiration of the previous service plan• The participant is receiving at least one waiver service per month
• The participant is receiving the type, amount, duration, scope and frequency of services as identified in the service plan, and it is updated or revised as the participant's needs change
• The services specified in the service plan match the usage from MMIS
• The participant was given a choice between waiver and institutional services and that choice was properly documented

Qualified provider
• The participant is given a choice of qualified providers and that choice was properly documented;
• The provider's enrollment in Medicaid is current and was current during the timeframe services were provided

Level of care
• The level of care evaluation is current and was completed by the appropriate person using the appropriate assessment instrument
• The annual level of care re-evaluation was completed prior to the expiration of the previous evaluation by the appropriate person using the appropriate assessment instrument

Financial accountability
• The participant is not being financially exploited
• The operating agency has policies and procedures to assure financial accountability
• Claims are coded and paid according to the reimbursement methodology specified in the waiver
• The necessary edits and audits are in place in MMIS for proper billing and payment
• The operating agency uses the Medicaid Management Information System (MMIS) for billing and payment

DMS and its fiscal agent maintain MMIS and the Decision Support System (data warehouse). The Office of Medicaid Inspector General reviews a valid sample of participant records annually. This unit reviews for compliance with key assurances and reports the findings to the DMS Waiver QA Unit. The DMS Waiver QA Unit will share review results with the operating agency and will track any necessary remediation and improvement.

The DMS QA unit conducts chart reviews monthly. Review of the operating agency's monitoring activities is part of that review. Results of each DMS QA chart review are transmitted to the operating agency (DAAS) monthly. The monthly results are combined into a quarterly report. DMS and DAAS meet quarterly or more often as necessary to discuss findings of the reports and any issues or concerns. At these meetings priorities are established and strategies are developed for any necessary remediation and improvement. Communication between DMS and DAAS regarding chart reviews is continuous and ongoing.

At the end of each waiver year, DMS compiles an annual report based on discovery findings from the reviews. The annual report includes any key findings, including status of remediation and improvement activities.

If DMS discovers that DAAS has failed to comply with the terms of the Interagency Agreement within their scope of control including attachments, DMS requires corrective action within timeframes suited to the area of non-compliance. DMS reserves the right to terminate the Interagency Agreement and the Medicaid waiver depending on the severity and nature of non-compliance. Continued non-compliance will be reported to the DMS Chief Operating Officer and guidance will be sought from the CMS Regional Office HCBS waiver staff if corrective action is not successful.

The State Medicaid Agency DMS and the Operating Agency DAAS ensure enrollment stays within approved limits by monitoring both the number of active and the number of unduplicated participants served within the approved limits. The monthly ACES Report of Active Cases and queries run from the MMIS are utilized to determine the number of active and the number of unduplicated participants served at any point in time.

The State Medicaid Agency DMS has oversight over the Operating Agency's level of care evaluations and Review of Participant service plans.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative

functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
- **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

- **Not applicable**
- **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

    Specify the nature of these agencies and complete items A-5 and A-6:
  - **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number 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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number of active (point-in-time) 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)

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of LOC assessments completed by DAAS in the time specified in the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by DAAS in time frame; Denominator: Number of LOC assessments reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Monthly Activity Report

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Average Days Report

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

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

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

	Ongoing	Specify: DMS performs a validation review on 20% of the charts reviewed by DAAS during Chart Record Reviews.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of LOC assessments completed by a DAAS qualified evaluator according to the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by a DAAS qualified evaluator; Denominator: Number of LOC assessments reviewed.

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

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review on 20% of the charts reviewed by DAAS during Chart Record Reviews.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of LOC assessments completed using the approved instrument according to the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed using the approved instrument; Denominator: Number of LOC assessments reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review on 20% of the charts reviewed by DAAS during Chart Record Reviews.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Number and percent of service plans (of care) completed by DAAS in the time frame specified in the agreement with the Medicaid Agency. Numerator: Number of service plans (of care) completed by DAAS in time frame; Denominator: Number of service plans (of care) reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review on 20% of the charts reviewed by DAAS during Chart Record Reviews.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of participants with delivery of at least one waiver service per month as specified in the service plan (of care) 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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of provider certifications that are issued as current by DAAS according to the agreement with the Medicaid Agency. Numerator: Number of current provider certifications by DAAS; Denominator: Number of providers participating in the waiver program.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review on 20% of the charts reviewed by DAAS during Chart Record Reviews.
	☐ **Other**	

	Specify:	

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

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

Data Aggregation and Analysis:

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

☐ **Other**
Specify:

Performance Measure:
Number and percent of policies and/or procedures developed by DAAS that are reviewed and approved by the Medicaid Agency prior to implementation. Numerator: Number of policies and procedures developed by DAAS reviewed by Medicaid before implementation; Denominator: Number of policies and procedures developed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Policy Development/Quality Assurance Request Forms

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of waiver claims on the Overlapping Services Report (OSR) having the same date of service as a claim for institutional services, which correctly paid only for the date of discharge, or date of admission according to policy. Numerator: Number of waiver claims on the OSR which correctly paid according to policy; Denominator:Number of waiver claims reviewed from the OSR .

Data Source (Select one):
Other
If 'Other' is selected, specify:
Overlapping Services Report (OSR)

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Aging and Adult Services (operating agency) and the Division of Medical Services (Medicaid Agency) participate in quarterly team meetings to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DAAS 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 implementing waiting lists. DMS reviews and approves all policies and procedures (including waiver amendments) developed by DAAS 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 review of the policy upon discovery, and approval or removal of 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 (of care) not completed in specified time frames includes completing the service plan (of care) upon discovery, additional training for staff, staff counseling or disciplinary action. DAAS 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 (of care) and the agreement with DMS includes closing a case, conducting monitoring visits, revising a service plan (of care) to add a service, checking on provider billing and providing training.

Remediation associated with provider certifications that are not current according to the DAAS/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 the certification expired, and allowing the participant to choose another provider. DAAS conducts remediation in these areas.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	21	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐

	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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 who ages out in the Disabled (Physical) target subgroup at age 65 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

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	12650
Year 2	12650
Year 3	12650
Year 4	12650
Year 5	12650

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	11250
Year 2	

	11250
Year 3	11250
Year 4	11250
Year 5	11250

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 in the custody of DHS Adult Protective Services (APS) or wards under the guardianship of the Office of Public Guardian;
c) Waiver application determination date for persons residing in a nursing facility who have been approved at an intermediate level of care and who are being discharged after a 90 day stay;
d) Waiver application determination date for all other persons, prioritized on the intermediate level of care determination, with Level I being the highest priority, and Level III being the lowest.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

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

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

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

SSI recipients with disabilities who work and have continued Medicaid under 1619(b)

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- ☐ **Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

The State uses the post-eligibility rules at 42 CFR 435.726 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:

For waiver participants living in Assisted Living Level II facilities, the allowance will be 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

For all other waiver participants, the allowance will be the special income level for an institutionalized person of 300% of the SSI FBR.

- **Other**

Specify:

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 4)

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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:

The following formula is used to determine the needs allowance:

For waiver participants living in Assisted Living Level II facilities, the allowance will be up to 200% of the Individual SSI FBR, which includes:

• 9% of the SSI FBR, rounded up to the nearest dollar, for a personal needs allowance
• 90.8 of the rate rounded to the nearest dollar for room and board
• 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

For all other waiver participants, the allowance will be the special income level for an institutionalized person of 300% of the SSI FBR.

- **Other**

Specify:

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

B-6: Evaluation/Reevaluation of Level of Care

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

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

reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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:

Individuals who perform the initial evaluation of level of care for waiver applicants, and all annual reevaluations are State employed Registered Nurses licensed in the State of Arkansas.

DAAS RNs receive extensive training on the tool used to perform LOC evaluations before any evaluations are performed. New DAAS RNs are trained by their supervisors as well as other nurses who are experienced in using this tool. In addition, new RNs shadow experienced RNs in performing LOC evaluations before ever performing them on their own.

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.

INSTRUMENTS/TOOLS USED - The electronic interRAI home care instrument, called ArPath, is the instrument/tool used to collect information to determine the initial and continuing level of care and medical need eligibility for home and community-based services (HCBS) waiver participants.

Based on the information that the participant and/or parties on behalf of the participant provide during the assessment, ArPath uses algorithms to evaluate and categorize participant information into scales, Client Assessment Protocols (CAPs), Resource Utilization Groups (RUGs) and levels of care, which correspond to the eligibility criteria listed in this section.

LEVEL OF CARE CRITERIA - To be eligible, the waiver participant must meet at least one of the following three criteria as determined by a licensed medical professional:

1. The participant is unable to perform either of the following:

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

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

2. Medical assessment results in a score of three or more on Cognitive Performance Scale; or

3. Medical assessment results in a Changes in Health, End-Stage Disease and Symptoms and Signs (CHESS) score of three or more.

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.

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 nurse and includes information obtained from the participant, family members, caregivers and others. The DHS-703 was designed based on the MDS and the state'™s nursing home admission criteria. It is the nurse'™s professional assessment of the participant and includes 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.

ArPath, the electronic interRAI home care instrument is used to evaluate level of care for the Living Choices program. Both the ArPath and the DHS-703 assess needs and are person-centered, focusing on the participant's functioning and quality of life. However, ArPath applies algorithms in the system that automatically determine functional eligibility and where assistance is needed. Based on the information provided during the assessment, ArPath uses the algorithms to evaluate and categorize participant information into scales, Client Assessment Protocols (CAPs), Resource Utilization Groups (RUGs) and levels of care, which correspond to the eligibility criteria listed in section B-6-d. This system provides an analysis of the data. Its standardization and automation of eligibility determinations will promote and support accurate assessments and appropriate service level authorizations. It will also enhance the ability to gather more comprehensive individualized data about participants, which will ultimately better serve the waiver participants.

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 process for the initial evaluation and re-evaluation of level of care and medical need eligibility for waiver participants is the same.

An individual assessment of the participant is performed by the waiver DAAS RN utilizing the electronic interRAI home care instrument, called ArPath. Each DAAS RN is a licensed registered nurse, employed by the Department of Human Services, Division of Aging and Adult Services. Once the assessment is completed by the DAAS RN, it is signed and dated by the DAAS RN and participant. The assessment is reviewed by qualified medical personnel for determination of medical need, and a DHS-704, Decision for Nursing Home Placement, is issued which reflects the level of care. Medical need eligibility is valid for one year, unless specified otherwise on the DHS-704.

FACTORS ASSESSED IN EVALUATING LEVEL OF CARE - The DAAS RN primarily utilizes information from the participant and/or other parties familiar with the participant's condition and circumstances to complete the interRAI home care assessment. Information obtained covers the participant's ability to perform activities of daily

living and focuses on the individual'™s functioning and quality of life by assessing needs, strengths and preferences. The DAAS RN utilizes all resources necessary to obtain accurate information in order to complete the interRAI instrument giving a complete functional ability assessment. This may include, but is not limited to, the DAAS RN's assessment of the participant and information obtained from the participant and his or her caregiver, family, physician, nurse, local pharmacists, assisted living facility staff (if applicable), and other current providers. This includes the participant's ability to transfer, ambulate and eat. The participant's continence and nutritional status is assessed indicating the type of assistance needed, the frequency of the assistance and who provides the assistance. The ArPath assessment tool also includes information regarding the participant's hearing, vision, speech/language and skin; behavior/attitude and mental status, orientation level and other medical conditions; the medications taken by the participant, identifying type of assistance needed in taking medication, the frequency of the assistance and who provides the assistance; and, any treatments or therapy the participant is receiving, any durable medical equipment or specialized equipment being used.

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):*

The waiver DAAS RN is responsible for tracking the review dates and initiating timely re-evaluations prior to the level of care review date and prior to the expiration of the service plan (of care). The DAAS RN establishes a Tickler file to track these dates and begins the reassessment process two months prior to the expiration date on the service plan (of care) or two months prior to the date the ArPath assessment was signed in the previous year, whichever is earlier. This process ensures timely re-evaluations prior to the level of care review date and the expiration of the service plan (of care) so that no lapse in service occurs.

The DAAS RN supervisory staff, through the record review process and through routine monitoring and auditing procedures, notifies the appropriate DAAS RN and RN supervisor if a re-assessment has not been completed within the specified DAAS policy timeframes. The ACES report produced by the Division of County Operations is used as a tool by the DAAS RN and RN supervisor to determine if the assessment is current or has expired. Patterns of non-compliance are documented and disciplinary action is taken if necessary. The DAAS RN will then complete the reassessment.

Each case manager is also required to maintain a Tickler system to track the Medicaid eligibility reevaluation date and the service plan (of care) expiration date. If the reassessment process has not been completed timely, the case manager notifies the DHS DAAS RN prior to the expiration date of the current service plan (of care).

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 the Division of Aging and Adult Services (DAAS), the primary authority for the daily operation of the waiver program, and the agency responsible for the final

level of care determinations and redeterminations. DAAS 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
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 reevaluation.
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

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

Data Aggregation and Analysis:

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

☐ **Other**
Specify:

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

Performance Measures

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

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

Performance Measure:
Number and percentage of participants' annual re-evaluation LOC determinations that were completed as required by the state. Numerator: Number of participants with re-evaluation LOC determinations completed correctly; Denominator: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error.

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

Data Aggregation and Analysis:

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

Performance Measure:
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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The state currently implements a system of monitoring that assures timeliness, accuracy, appropriateness and quality. Data is collected from individual participant assessments, aggregated to produce summation reports, and compared with periodic randomly sampled record reviews and sampled Office of Medicaid Inspector General reviews.

Participant records undergo record reviews performed by DAAS RN supervisors. Monthly activity reports track assessments and reassessments performed by DAAS RNs. DAAS 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, DAAS maintains a daily log of assessments and reassessments sent to the medical review agency for medical determination. Data from all assessment and review activity is aggregated to produce a Level of Care Monthly Report, and an annual Record Review Summary.

Level of Care is provided to all applicants for whom there is reasonable indication that services may be needed. DAAS 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. DAAS RNs are required to include the number of reassessments due in their regular Monthly Activity Report. The RN supervisors monitor this information month-to-month to track the reassessment process. The same record review process, described above, is utilized for the re-evaluation process.

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 DAAS 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 is electronic to allow reviewers to evaluate trends and identify where additional training for DAAS 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. DAAS 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. Reviews include, but are not limited to: Completeness of the Functional Assessment; Appropriateness of medical eligibility recommendation based on the medical assessment process and the state’s nursing home admission criteria; Timeliness of assessment process; Consistency of medical and non-medical facts and information obtained during the medical assessment.

The Division of Medical Services (DMS) QA review process includes review of the billing process by Living Choices Medicaid providers. A systematic random sampling of the active cases includes every "nth" name in the population. 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. To determine the "nth" integer, the sample is divided by the population. Those names are drawn until the sample size is reached, then DMS divides the sample into a monthly sample and reviews the participant records.

In addition to the record review process, an office review is completed by the DAAS RN supervisor, at a minimum, annually for each DAAS RN. Office reviews include, but are not limited to:
•Tickler system utilized appropriately;
•Assessment/Reassessment Log maintained;
•Processing system clearly defined and office organized;
•Required follow-up for any problems or concerns documented.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Aging & Adult Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems associated with level of care determination and system improvement, as well as problem correction and remediation. DAAS 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, DAAS requires that all initial assessments and reassessments of level of care are completed by a registered nurse. Therefore, performance measures related to these processes will always result in 100% compliance, and not allow for the possibility of remediation.

Level of Care assessments are required annually using the electronic interRAI home care instrument, called ArPath, and applying the nursing home admission level of care criteria. The DAAS 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 DAAS RN supervisors' monthly report.

The DAAS RN supervisors complete an electronic review to evaluate trends and identify where additional training for DAAS RNs is needed. Remediation in these areas includes ongoing training by DAAS for the DAAS RNs who perform these assessments to ensure that the proper nursing home admission criteria are applied and that initial and annual re-evaluation of level of care are completed within the required time frames. DAAS RN supervisors develop a corrective action plan when remediation in this area is needed.

ii. Remediation Data Aggregation

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

NOTE: For reassessments, the Freedom of Choice form is utilized to document 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 (of care), 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 DAAS 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 DAAS 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 (of care) are maintained with the Division of Aging & Adult Services (operating agency) and with the providers serving the participant and included on the service plan (of care). Freedom of Choice forms and service plans (of care) 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 Arkansas 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. DAAS RNs provide written materials to participants and will read any information to participants if needed. DAAS RNs may utilize assistance from other divisions within the Arkansas DHS, such as the Division of Services to the Blind, in these instances. When this occurs, it is documented in the participant's 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	Case Management
Statutory Service	Health Care Component of Adult Day Health Care
Extended State Plan Service	Extended Medicaid State Plan Prescription Drugs
Other Service	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:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Covered case management services are:
- Assessment/Service Plan Development
- Service Management/Referral and Linkage
- Service Monitoring/Service Plan Updating

Assessment/Service Plan Development: After the development of the initial waiver service plan (of care) by the DAAS RN, the case manager is responsible for monitoring the waiver service plan (of care), based on the individual circumstances of the waiver participant. The DAAS RN is the sole individual with authority to revise a waiver service plan (of care).

Service Management/Referral and Linkage: The case manager must assist waiver participants in gaining access to needed waiver and other State plan services to meet their assessed needs; facilitate access to medical, social, educational and other services appropriate to the participant's needs, regardless of the funding source for the services to which access is gained; and refer waiver participants for community resources, such as energy assistance, legal assistance, or emergency housing.

Service Monitoring/Service Plan Updating: The case manager must routinely monitor the provision of services, and the participant's needs and circumstances to determine whether:
- services are being furnished in accordance with the individual's service plan (of care);
- services in the service plan (of care) are adequate;
- and, changes in the needs or status of the individual are reflected in the service plan (of care).

Monitoring consists of maintaining regular contact, either face-to-face or telephone, with participants, and reporting the participant's status and any changes in a participant's condition, needs or circumstances to the DAAS RN immediately.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Case Management services must be billed on a per unit basis, as reflected in a daily total per participant, per CM service. One unit equals 15 minutes.

One (1) unit = 5-15 minutes
Two (2) units = 16-30 minutes
Three (3) units = 31-45 minutes
Four (4) units = 46-60 minutes

Based on the state fiscal year (SFY) July through June:

Participants receiving Case Management are limited to fifty (50) hours (200 units) of case management services per year.

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 Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
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 §20-10-809.

The Arkansas Department of Health's rules and regulations include specific experience, education and qualifications for Class A and Class B Home Health Agencies and their staff. Agencies must fulfill these regulations prior to licensure.

Certificate *(specify):*
Providers of case management who are restricted to serving persons in the Living Choices waiver are certified by the Division of Aging and Adult Services as an organization qualified to provide case management services.

Other Standard *(specify):*
In order to be certified by the Division of Aging and Adult Services as a Living Choices Case Management provider, the agency must meet the following qualifications:

A. Be located in the state of Arkansas
B. Be licensed as a Class A or Class B Home Health Agency by the Arkansas Division of Health or a unit of state government or be a private or public incorporated agency whose stated purpose is to provide case management to the elderly
C. Be able to demonstrate one year of experience in performing case management services (experience must be within the past 3 years)
D. Be able to demonstrate one year of experience in working specifically with individuals in the targeted group (experience must be within the past 3 years)

E. Have an administrative capacity to insure quality of services in accordance with state and federal requirements
F. Have the financial management capacity and system that provides documentation of services and costs
G. Have the capacity to document and maintain individual case records in accordance with state and federal requirements
H. Be able to demonstrate that the provider has current liability coverage
I. Employ qualified case managers who:
1. Reside in or near the area of responsibility; and
2. Are licensed in the state of Arkansas as a social worker (Licensed Master Social Worker, Licensed Certified Social Worker, or Licensed Social Worker), a registered nurse or licensed practical nurse; or
3. Have a bachelor's degree from an accredited institution in a health and human services field, plus two years' experience in the delivery of human services to the elderly; or
4. Have performed satisfactorily as a case manager serving the targeted population for a period of two (2) years (experience must be within the past 3 years).

Verification of Provider Qualifications

Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Aging & Adult Services
Frequency of Verification:
Every three years for recertification; however, DAAS must maintain a copy of the provider's current Home Health Agency license in the provider file at all times.

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):
Health Care Component of Adult Day Health Care

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

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Licensed Adult day health care (ADHC) facilities provide services furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan (of care), 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.

The Health Care Component of ADHC waiver service covers the following health related services provided by the ADHC:
1. Rehabilitative therapies;
2. Pharmaceutical supervision;
3. Diagnostic evaluation;
4. Health monitoring.

Participants of an ADHC will also receive any of the following ancillary services in accordance with their service plan through State Plan Community First Choice. These services are non-medical in nature and are an important supplement to the basic health care functions. These services will not be part of the Adult Day Health Care per diem, but will be paid through Community First Choice as Attendant Services and Supports, Supportive Living Services, and Consultation Services:
1. Assistance with the activities of daily living;
2. Social work;
3. Recreation therapy;
4. Exercise;
5. Counseling.

Adult day health care 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 care center for more than five (5) hours in that day.

The goals of adult day health care go beyond the custodial and personal care goals of adult day care. The emphasis is on rehabilitative and health services. The goals of adult day health care are:
1. To enable the participant to function physically, mentally and socially at the highest possible level.
2. To enable functionally impaired waiver 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 care 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 care providers are required to develop a written individual service plan to guide the delivery of adult day health care services provided to each waiver participant in the adult day health care 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 care programs provide health services that cannot be provided by adult day care programs. Adult day health care is appropriate only for participants whose service plans specify one or more of the above health related care components that are not consistently provided by adult day care programs.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The health care component of adult day health care can be utilized by waiver participants for four (4) 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. The health care component of adult day health care services of less than four (4) hours per day are not reimbursable. The health care component of adult day health care services may be utilized up to fifty (50) hours (200 units) per week, not to exceed two hundred thirty (230) hours (920 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	Licensed Adult Day Health Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Health Care Component of Adult Day Health Care

Provider Category:
Agency
Provider Type:
Licensed Adult Day Health Care
Provider Qualifications

License *(specify):*
Licensed by the Arkansas Department of Human Services, Division of Medical Services, Office of Long Term Care 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 Aging & Adult Services as a Living Choices waiver provider of Adult Day Health Care services. To be certified, providers must provide a copy of their current adult day health care agency license through the DHS Division of

Medical Services, Office of Long Term Care.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Arkansas Department of Human Services, Division of Aging & Adult Services
Frequency of Verification:
Every three years for recertification; however, DAAS must maintain a copy of the agency's current Adult Day Health Care license at all times.

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:

11 Other Health and Therapeutic Services

Sub-Category 1:

11060 prescription drugs
Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Living Choices waiver participants who live in licensed level II assisted living facilities and receive Assisted Living Services 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 participants receiving Assisted Living Services..

A waiver participant 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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Pharmacist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Extended Medicaid State Plan Prescription Drugs

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 Care's 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

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:

Assisted Living Services

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

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:

11020 health assessment

Category 4:

11 Other Health and Therapeutic Services

Sub-Category 4:

11030 medication assessment and/or management

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
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 (ALS) 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 client's 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.

ALS 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 ALS participants 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 ALS 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. 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 ALS are not services requiring substantial and specialized nursing skills that are provided by home health agencies or other licensed health care agencies. Living Choices ALS 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 client's 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 client's health condition and notification of the RN if there are significant changes in the waiver client's 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 resident's 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 are 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.

An annual assessment is completed for each client by the DAAS RN. The electronic interRAI home care instrument, called ArPath, is completed and used by the Office of Long-Term Care to establish the client's level of care for the waiver and medical eligibility for the waiver. ArPath is also used to establish the tier level of need for the assisted living facility.

ArPath, which establishes the candidate's "tier of need" is completed by the DAAS RN for each applicant/participant. Tier assignment is based on the assessment process, the level of ADLs and the Psychosocial/Cognitive status of the applicant/participant. The daily rate pays for all direct care services in the participant's plan of care. There are four tiers of need in the Living Choices ALS Program, each tier progressively requiring more bundled services. The rate increases with the need for each higher tier and more services .

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:

Aside from case management and Extended Medicaid State Plan Prescription Drugs, a participant receiving Assisted Living Services is not eligible to receive any other State plan or Living Choices service that is duplicative of the services included in the service definition of Assisted Living 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 Class A Home Health Agency
Agency	Licensed Level II Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living Services

Provider Category:
Agency
Provider Type:
Licensed Class A Home Health Agency
Provider Qualifications
License *(specify):*
Licensed by the Arkansas Department of Health as a Class A Home Health Agency.

The Arkansas Department of Health's rules and regulations include specific experience, education and qualifications for Class A Home Health Agencies and their staff. Agencies must fulfill these regulations prior to licensure.
Certificate *(specify):*

Other Standard *(specify):*
Living Choices Assisted Living Services (ALS) waiver providers must meet the provider participation and enrollment requirements detailed in the Medicaid provider manual as well as be licensed by the Arkansas Department of Health as a Class A Home Health Agency to be eligible to participate in the Arkansas Medicaid Program. A copy of the ALFs current license must accompany the provider application and Medicaid contract. A licensed Class A Home Health Agency is eligible only if it has a contract with a Level II Assisted Living Facility to deliver all Living Choices ALS 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 ALS provider.

A provider must submit to the Medicaid program's Provider Enrollment Unit 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 ALS bundled services to the ALF's Living Choices participants, or 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 ALS bundled services.

Providers must also be enrolled in the Arkansas Medicaid program as an Assisted Living Services waiver provider before reimbursement may be made for services provided to Living Choices participants.

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 participant's condition; and, a participant'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:
The Medicaid program's Provider Enrollment Unit

Frequency of Verification:
Annual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living Services

Provider Category:
Agency

Provider Type:
Licensed Level II Assisted Living Facility

Provider Qualifications

License *(specify):*
Licensed by the Arkansas Division of Medical Services, Office of Long Term Care as a Level II Assisted Living Facility.

The Division of Medical Services, Office of Long-Term Care's 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):*

Other Standard *(specify):*
Living Choices Assisted Living Services waiver providers must meet the provider participation and enrollment requirements contained within the Medicaid provider manual as well as be licensed by the Arkansas Division of Medical Services, Office of Long Term Care, as an Assisted Living Level II facility to be eligible to participate in the Arkansas Medicaid Program. A copy of the ALFs current license must accompany the provider application and Medicaid contract.

Providers must also be enrolled in the Arkansas Medicaid program as an Assisted Living Services waiver provider before reimbursement may be made for services provided to participants. 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 participant's condition; and, a participant'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.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Medicaid program's fiscal agent, Provider Enrollment Unit

Frequency of Verification:
Annual. The Medicaid program's fiscal agent must receive a copy of the agency's current Level II Assisted Living Facility license each year.

Appendix C: Participant Services

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

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

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

Check each that applies:

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

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

Appendix C: Participant Services

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

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

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

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

State and national criminal background checks are conducted for managing directors and employees of Living Choices provider agencies.

All Living Choices waiver providers employing persons providing direct services or case management services shall not knowingly employ a person who has been found guilty or has pled guilty or nolo contendere (no contest) to any disqualifying criminal offense.

Each Living Choices waiver provider must obtain from each employee and from each applicant for employment a signed authorization permitting disclosures to the Living Choices provider of criminal history information as defined in Arkansas Code Annotated §12-12-1001.

Each provider receiving payment under the Living Choices 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. This requirement applies to any employee who in the course of employment may have direct contact with a Living Choices participant.

If the results of the criminal history check establish that the applicant or employee was found guilty of, or pled

nolo contendere to, a disqualifying offense under A.C.A. §20-33-205 ("disqualifying offense"), the Living Choices provider may not employ, or continue to employ, the applicant/employee. 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.

In addition, 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 Medical Services, 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.

Home Health Agencies that contract with the assisted living facilities must meet the same requirements for initial criminal history record checks.

Facilities and Living Choices providers are required to comply with AR DHS Policy 1088.2.3, DHS Participant Exclusion Rule:

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 nolo contendere, 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;
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.

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 Medical Services, Office of Long-Term Care requires that assisted living facilities, nursing facilities and residential care 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 Registry maintained by the Adult Protective Services Unit within the Division of Aging and Adult 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 of long-term care facilities 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 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.

Adult Abuse Registry screenings of the direct care staff of all Living Choices provider agencies are monitored by the entity responsible for verification of provider qualifications at initial certification and re-certification, or intial enrollment and re-enrollment, as part of the certification/enrollment requirements. Criminal background checks are required for provider agencies every five years pursuant to Act 762 of 2009. Providers are required to follow all requirements related to employee criminal background checks as explained in the Medicaid Provider Manual. In addition, during the DAAS certification process, the provider agencies must submit a list of all employees who in the course of employment may have direct contact with a Living Choices participant, and the dates of their last criminal background checks. As part of the qualified provider review of DAAS certified providers, the DMS Waiver QA Unit verifies that the provider file contains all required documentation, including information regarding the criminal background checks.

Appendix C: Participant Services

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

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

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

Facility Type	
Level II Assisted Living Facility	

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

Home and community-based character is maintained at Level II Assisted Living Facilities (ALF) via the provision that personalized care is furnished to persons in their own home-like environment. Level II ALF provide clients with their own living unit/apartment, or the living unit/apartment may be dually occupied when both occupants consent to the arrangement. These living units/apartments contain

bedrooms and toilet facilities, and may or may not include a kitchenette and/or living room, depending on the facility. Each living unit/apartment is separate and distinct from all others.

Assisted living facilities allow persons to live in congregated housing with 24-hour supervision and services that support independence. Assisted living facilities assure that residents receive supportive health and social services that are needed to enable them to maintain their independence, individuality, privacy and dignity in an apartment-style living unit that includes a living room and dining area, sleeping area and private bath. These apartment-style units range from studio apartments to one or two bedroom apartments. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility program operation. The environment promotes resident self-direction and personal decision-making while protecting residents' health and safety. Services adapt to changing needs and individual preferences; promote dignity, autonomy, privacy and safety; permit family and community involvement; and minimize the need to move away from the assisted living facility apartment-style living unit when needs change.

The ALF resident has a right to privacy in his/her own apartment or unit. Living units/apartments may be locked at the discretion of the participant, except when a physician/primary care physician or mental health professional has certified in writing that the participant is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. This requirement does not apply where it conflicts with fire code.

The ALF must have a congregate dining room, living room or parlor, and common activity center(s) that may also serve as living rooms or dining rooms, which the participant may access easily. The participant retains the right to assume risk, tempered only by the participant's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each participant to facilitate aging in place and promotes community living. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible and must treat each person with dignity and respect.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Level II Assisted Living Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Health Care Component of Adult Day Health Care	☐
Assisted Living Services	☑
Case Management	☑
Extended Medicaid State Plan Prescription Drugs	☑

Facility Capacity Limit:

Capacity limits vary and are determined by the Office of Long Term Care as a part of the licensing regulations.

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑

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

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

Appendix C: Participant Services

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

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

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

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

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

- ○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**

The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

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

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 or the Living Choices provider agency. These services include Assisted Living Services, Case Management, and Adult Day Health Care.

For the purposes of this section, relative shall be defined as all persons related to the participant by virtue of blood, marriage, or adoption. Relatives other than a spouse, legal guardian, or attorney-in-fact granted authority to direct the participant's care can provide all Living Choices services.

Individuals who are legally responsible for the participant (i.e., spouse, legal guardian, attorney-in-fact granted authority to direct the participant's waiver services) are prohibited from receiving reimbursement for direct provision of covered services for the Living Choices participant.

All Living Choices providers, including relatives, are required to meet all Living Choices provider certification requirements and Arkansas Medicaid enrollment requirements, and provide services according to any established benefit limits for that specific service, as identified in Appendix C-1/C-3.

To ensure that payments are made only for services rendered, DAAS reviews weekly worksheets generated from the MMIS, detailing instances where the tier levels for which Living Choices ALS providers billed do not match what is listed in MMIS for that participant. These instances are researched and appropriate action is taken, depending on the situation. Discrepancies are resolved. Some weeks have no data to report, and worksheets are not generated from MMIS in those weeks.

Controls are maintained through the required documentation for all Living Choices providers. This documentation must support each service for which billing is made and include a copy of the participant's service plan (of care), 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. DAAS RN supervisory staff conducts chart reviews to ensure that services were provided according to the service plan.

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 Services 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.

Those interested in becoming a Living Choices provider of any Living Choices waiver service may contact DAAS Provider Enrollment 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 Division of Aging and Adult Services' website lists information for potential Living Choices providers. In addition, the Office of Long-Term Care 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent 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 providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Certification Unit (DAAS) Provider Database

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers, by provider type, which obtain recertification in accordance with state law and waiver provider qualifications. Numerator: Number of providers with recertification; Denominator: Total number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Certification Unit (DAAS) Provider Database

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

Performance Measure:
Number and percentage 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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The state identifies and rectifies situations where providers do not meet requirements. Through monitoring certification/license expiration dates within MMIS and continuing communication with the Medicaid fiscal agent responsible for provider enrollment functions, monthly reports are reviewed that identify providers whose participation is terminated for inactivity or violations. Participation in provider training is documented and monitored with monthly activity reports.

The state verifies that providers meet required licensing and certification standards and adhere to other state standards. License expiration dates are maintained in MMIS and tracked for all participating and active providers.

Each month, the DAAS RN receives a provider list for each county included in their geographical area. This provider list must be used at each assessment and reassessment to give participants a choice of providers for each service included on the service plan (of care). 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.

DAAS and DMS 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, the DAAS RN 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, the DAAS RN must meet with each new provider face-to-face to

discuss all of the above, plus any problems noted in the first three months of participation.

The DAAS RN and RN supervisor must participate in provider in-services as required by the DAAS Director of HCBS. Evaluations from in-services are reviewed and guide DMS and DAAS in choosing topics for future in-services.

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 DAAS 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 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 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.

The Division of Medical Services (DMS) QA review process includes review of the billing process by Medicaid providers of Living Choices. The DMS QA completes a systematic random sampling of the active provider case population, where 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 the waiver provider population. To determine the "nth" integer, the population size is divided by the sample size. Those names are drawn until the sample size is reached, then DMS divides the sample into a monthly sample and reviews the participant records.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Aging & Adult Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems related to qualified providers, as well as problem correction and remediation The Interagency Agreement between DAAS and DMS includes measures regarding qualified providers 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 its Medicaid enrollment, a Living Choices waiver provider must maintain certification by DAAS, and/or licensure to participate in the waiver program. In cases where providers do not maintain certification and/or licensure, DAAS's remediation may include requesting termination of a provider's Arkansas Medicaid enrollment, recouping payment for services provided after certification/licensure has expired and allowing the participant to choose another provider. This requirement is monitored in the MMIS.

The tool used for record review documents and tracks remediation in these areas.

ii. Remediation Data Aggregation

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

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

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

When scheduling the assessment and service plan (of care) development visit, the DAAS RN explains to participants or authorized representatives the process and informs participants that they may invite anyone that they choose to participate in the service plan (of care) development process. Involved in this assessment visit is the participant and anyone they choose to 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 or service plan (of care) development process. It is the participant or family member’s responsibility to notify interested parties to attend the assessment.

During the assessment and prior to the service plan (of care) development, the DAAS RN explains to the participant the services available through the Living Choices waiver.

When developing the service plan (of care), 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 (of care). All services must be justified, based on need and available support services.

During the service plan (of care) development process, the DAAS RN discusses goals and objectives with the participant and his or her family members or anyone else that the participant chooses to participate in this process. This information is recorded on the service plan (of care), which is signed by the participant.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request

through the Medicaid agency or the operating agency (if applicable):

((a) – DAAS RNs develop initial service plans (of care) for Living Choices participants based on the assessment of the participant's needs. The DAAS RN informs participants that they may invite anyone that they choose to participate in the service plan development process. Involved in this service plan development meeting is the participant, their family, their representative, caregivers, assisted living facility staff (if applicable) 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's or family member's responsibility to notify interested parties to attend the service plan development meeting.

The DAAS RN works with the waiver participant to schedule a convenient time and location for the assessment and/or service plan development meeting. Often the visit occurs in the participant's home or at the assisted living facility (if applicable). During each initial assessment of the participant, the DAAS RN develops a service plan (of care). Each assessment is scheduled and completed within 10 working days of the DAAS RN receiving a referral from the DHS county office. Each reassessment is completed annually or more often, if deemed appropriate by the DAAS RN. At the time of reassessment, the DAAS RN will develop a service plan (of care). The service plan (of care) may be revised at any time, based on information relevant to the participant's condition or circumstances. Service plans (of care) are developed and sent to all providers before services may begin.

(b) - The DAAS RN assesses the participant's needs and reviews the participant's comprehensive goals and objectives related to their care and the appropriateness of Living Choices services. If necessary, the 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 DAAS 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. DAAS RNs provide written materials to participants and will read any information to participants if needed. DAAS RNs may utilize assistance from other divisions within the Arkansas Department of Human Services, such as the Division of Services to the Blind, in these instances. When this occurs, it is documented in the participant's record.

The DAAS RN uses ArPath, the electronic interRAI home care instrument, to complete the assessment and establish the tier level. The assessment in ArPath is also utilized by the Office of Long Term Care to evaluate the level of care. Information collected for ArPath includes 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/language; skin condition; behavior/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 DAAS RN evaluates the participant's physical, functional, mental, emotional and social status, and obtains a medical history to ensure that the service plan (of care) addresses the participant's strengths, capabilities, goals, health care, other needs, preferences, desired outcomes and risk factors. Support systems available to the participant are identified and documented, along with services currently in place. If the participant is an assisted living resident, the DAAS RN must review all facility medical records and documentation, and make copies, if needed, to support the assessment. Based on this assessment information, the DAAS RN discusses the service delivery plan with the participant.

Provisional (Temporary Interim) Service Plan (of Care) Policy: A provisional service plan (of care) may be developed by the DAAS RN prior to determination of Medicaid eligibility, based on information obtained during the in-home medical assessment if the applicant is medically eligible based on the ArPath assessment AND the DAAS RN believes, in his or her professional judgment, the individual meets the level of care criteria. The DAAS RN must discuss the Provisional Service Plan (of Care) Policy and have approval from the applicant prior to completing and processing a provisional service plan (of care), which will then be signed by the applicant or the applicant's representative and the DAAS RN. The provisional service plan (of care) will be provided to the waiver applicant and each provider included on the service plan. If the applicant and the provider accept the risk of Medicaid ineligibility, the provider will notify the DAAS RN via form AAS-9510 (Start of Care Form), indicating the date services begin. No provisional service plans (of care) will be developed if the waiting list process has been implemented.

Provisional service plans (of care) for the Living Choices participant expire 60 days from the date signed by the DAAS RN and the participant. A comprehensive service plan (of care) 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 (of care). Prior to its expiration date, the DAAS RN will provide a signed, comprehensive service plan (of care) to the

Living Choices provider. For Assisted Living Services providers only, a DHS-704 (Decision for Nursing Home Placement) will also be provided.

The DAAS RN completes a face-to-face medical assessment, develops a Living Choices service plan (of care) and explains the provisional service plan policy within 10 working days of receiving a referral from the DHS county office. Once the service plan (of care) is signed by the DAAS RN and the applicant, it is considered a provisional service plan (of care).

If waiver services are started based on the provisional service plan (of care), providers will send the start of care form to the DAAS RN indicating the date services started. No additional notification to the DAAS RN is required when the comprehensive service plan (of care) is received.

(c) - During the assessment and/or service plan development process, the DAAS 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 service plan (of care). 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 DAAS RN develops the service plan (of care) based on the information gathered through the assessment process and the discussion of available services with the participant. Both the assessment and the service plan (of care) address the participant's needs, goals and preferences. The participant may also invite anyone they choose to participate in the assessment and service plan development process, including family members, caregivers and assisted living facility staff (if applicable). Also, the DAAS RN may contact anyone who may be able to provide accurate and pertinent information regarding the participant's medical condition and functional ability.

If there is any indication prior to or during the assessment or 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 medical 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 service plan (of care), the participant and their representatives participate in all decisions regarding the types, amount and frequency of the services included on the service plan (of care). 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, both assessments and reassessments, the DAAS RN informs the participant or their legal guardian or family member of the available services, and for those receiving Living Choices ALS, the available assisted living facilities. 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 service plan (of care), 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 DAAS RN supervisory review process. Each service included on the service plan (of care) is explained by the DAAS RN. The amount, frequency, scope and provider of each service is also discussed and entered on the service plan (of care). The DAAS RN sends a copy of the service plan (of care) to the waiver provider, as well as the participant. The case manager 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 service plan (of care) is the responsibility of DAAS (Operating Agency), DMS (Medicaid Agency) and providers of Living Choices waiver services.

Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, time frames, reporting and documentation requirements. Providers are required to report any change in the participant's condition to the DAAS RN, who is the only authorized individual who may adjust a participant's service plan (of care). Providers agree to render all services in accordance with the Arkansas Medicaid Living Choices Home & Community-Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAAS; to notify the DAAS 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 service plan (of care); to continually monitor participant satisfaction and quality of service delivery; and, to notify the DAAS RN in writing within one week of services being terminated, documenting the termination effective date and the reason for termination.

For those participants receiving Living Choices ALS, the ALS provider employs or contracts with a registered nurse (ALF RN) who implements and coordinates service plans (of care), supervises nursing and direct care staff and monitors participants' status. The ALF RN is responsible for immediately notifying the DAAS RN regarding participants whose status or condition has changed and who need re-evaluation and reassessment.

Providers assure DAAS 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 waiver service plan (of care). Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the service plan (of care) developed by the DAAS RN. Providers acknowledge that the DAAS RN is the only authorized individual who may adjust a Living Choices waiver participant's service plan (of care). Providers accept full responsibility for the quality and number of service units provided to a Living Choices waiver participant by their staff, and assure DAAS appropriate management and supervision of services takes place at all times.

Service plans (of care) are revised by DAAS RNs as needed between assessments, based on reports secured through providers, waiver participants and their support systems.

(g) - Each reassessment and service plan development is completed annually or more often, if deemed appropriate by the DAAS RN. The service plan (of care) may be revised at any time, based on information relevant to the participant's condition or circumstances. Changes are reported to the DAAS RN by the participant, the participant's family or representatives, and service providers. The DAAS RN has sole authority for all development and revisions to the waiver service plan (of care). Service plan updates must be based on a change in the participant's status or needs.

For a participant who receives Living Choices ALS, any time an assessment is completed that results in a tier level change, the service plan (of care) must be revised. The effective date of the tier level will be the date the DAAS RN completes the assessment that results in the tier level change. A copy of the revised service plan (of care) must be sent to the assisted living facility showing the new tier level. The DAAS central office must also be notified of the tier level change.

The DAAS RN or Living Choices case manager immediately informs the participant and his or her family members upon receiving notification that services are being terminated. The DAAS RN or case manager begins working immediately to find a solution for the participant and puts into place the emergency backup plan listed on the participant's service plan (of care). For a Living Choices ALS participant, this may result in the participant moving to a different assisted living facility.

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.

DAAS RNs assess a participant's needs, preferences, functional abilities, performance of activities of daily living, risks, dangers and supports during the assessment. These factors are considered by the DAAS RN when developing a service plan (of care). 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 service plan (of care) and in the participant's record. Services are started as soon as possible in order to mitigate risk.

The service plan (of care) 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 service plan (of care). Back-up caregivers are often family members, neighbors or others familiar with the participant.

Routine monitoring of Living Choices participants also helps to assess and mitigate risk. DAAS RNs make at least annual contact with participants and take action to mitigate risks if an issue arises. Living Choices case managers are required to monitor the participant monthly at a minimum, and must follow frequency requirements as described in the Living Choices Medicaid Provider Manual regarding face-to-face or telephone contacts with the

participant. Potential risks identified during these monitoring contacts require the case management provider to take action to mitigate the risk.

Also, providers, assisted living facility staff, 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 DAAS RNs also re-evaluate potential participant risks during each reassessment and during monitoring visits. DAAS RNs and Living Choices case managers refer any high risk participants to Adult Protective Services immediately if it is felt that the participant is in danger. DAAS RNs also provide patient education on safety issues during the assessment and annual reassessment. The annual contact by the DAAS 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 DAAS 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 DAAS 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 DAAS 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 (of care).

For participants receiving Living Choices ALS, staff at the assisted living facility routinely monitors participants to ensure safety and compliance with the service plan (of care). Any time a change is needed to the service plan (of care) or there is a change in the participant’s status, staff report this to the DAAS RN immediately. Also, participants, family members or the participant's representative may also contact the DAAS RN or Living Choices case manager any time a change is needed or a safety issue arises. Additional monitoring is performed by DMS QA as part of the chart review, by Office of Medicaid Inspector General audits, and in response to any complaints received.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Participants must choose a provider for each waiver service selected. When a service plan (of care) is developed, the DAAS RN must inform the individual or their legal guardian of all Living Choices qualified providers. The participant or guardian/family member may choose the providers from which to receive services. The name of the providers chosen by the participant or legal guardian/family member must be included on the service plan (of care) prior to securing the individual’s signature. Along with signing the service plan (of care), the Freedom of Choice form and an up-to-date provider listing must be signed and initialed. If a family member chooses a provider for the participant, the DAAS RN must identify the relative who chose the provider(s) on the service plan (of care) and on the Freedom of Choice form. Documentation is also included in the participant's record. The freedom of choice form and all related documents are placed in the participant's record and reviewed during the 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's choices are documented and reviewed during the record review process by both DAAS RN supervisory staff and the DMS QA unit.

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.

DAAS RNs and Living Choices case managers leave contact information with participants at each visit. The

participant may contact the DAAS RN at any time to find out more information about providers.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

All waiver service plans (of care) are subject to the review and approval by both the Division of Aging & Adult Services (operating agency) and the Division of Medical Services (Medicaid agency).

DMS does not review and approve all service plans (of care) prior to implementation; however, all are subject to the Medicaid Agency's approval and are made available by the operating agency upon request. DMS, through the Quality Assurance unit, reviews a random sampling of participants' records which includes the service plan (of care). Reviewed service plans (of care) are compared to policy guidelines, the functional assessment, and the case note written detailing the participant's living environment, physical and mental limitations, and overall needs. The Office of Medicaid Inspector General also reviews a valid sample of participant records annually for compliance with key assurances, and reports the findings to DMS.

A statistically valid random sample of service plans (of care) is determined, using the Raosoft software calculations program, for review monthly by the DAAS RN supervisory staff to assess the appropriateness of the service plan (of care), 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 (of care) is deemed inappropriate or service provision is lacking, the DAAS 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 or DMS QA Unit.

Each year, DAAS reports to the DMS Waiver Quality Management Administrator the findings of the service plan review process. If this review process produces results below a 90% accuracy rate statewide, DAAS and DMS jointly develop a corrective action plan that addresses each component falling below the acceptable accuracy rate. The goal is 100% compliance.

In addition, DMS completes a validation review of participant records reviewed by DAAS, and a random sampling of provider files annually. For the validation review, DMS reviews 20% of the records reviewed by DAAS. 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 DAAS and DMS during the record review process includes, but is not limited to: development of an appropriate individualized service plan (of care), completion of updates and revisions to the service plan (of care) and coordination with other agencies as necessary to ensure that services are provided according to the service plan (of care).

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 (of care) is maintained by the DAAS RN in the participant's record, by the Living Choices case manager, and by the Living Choices waiver provider of any other waiver services.

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.

Waiver participants are monitored through a variety of means and all monitoring by DMS and DAAS waiver staff, Living Choices case management providers, and assisted living facility RNs includes compliance with the service plan (of care), the health and welfare of the participant, access to services, effectiveness of back-up plans, and complaints or problems. Contact with Living Choices participants is maintained to ensure that services are furnished according to the service plan (of care) and that the services meet the participant's needs.

DAAS RNs:
DAAS 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 DAAS 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 DAAS can ensure prompt follow-up to problems.

LIVING CHOICES CASE MANAGEMENT PROVIDERS:
Living Choices 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 service plan (of care), the adequacy of the services in the service plan (of care), 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 Living Choices Medicaid Provider Manual. 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.

Living Choices 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, 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. A Living Choices 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 Living Choices case manager must document the participant's condition, the condition of the home, living environment, adequacy of the participant's service plan (of care), and overall success of service plan (of care) 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 DAAS RN via the Change of Client Status form (AAS-9511) or email. The AAS-9511 may be transmitted via fax or email to the DAAS RN. Copies of required forms and/or communication must be maintained in the participant's record.

Living Choices case managers review the service plan (of care) with the participant during all face-to-face visits to ensure that services are being provided according to the plan. The Living Choices 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 service plan (of care), and the integrity of services billed to the Medicaid Program, it is the Living Choices 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.

ALF RNs:
For participants who receive Living Choices Assisted Living Services (ALS), the assisted living provider employs or contracts with a registered nurse (ALF RN) who implements and coordinates service plans (of care), supervises nursing and direct care staff and monitors participants' status. At least once every three months, the ALF RN must evaluate each Living Choices ALS participant. ALF RNs are responsible for assessing each Living Choices ALS participant's health care needs, implementing and coordinating the delivery of services ordered on the service plan (of care), monitoring and assessing the participant's health status on a periodic basis and monitoring each waiver participant's health status.

The ALF RN is responsible for immediately notifying the DAAS RN via the AAS-9511 if a participant's status or condition has changed and may need re-evaluation and reassessment. The DAAS RN must visit the participant within 10 working days of receiving notification to complete a new assessment, which, depending on the situation, may or may not result in a revision to the participant's service plan (of care).

INFORMATION EXCHANGE:
Both DMS and DAAS perform regular reviews to support proper implementation and monitoring of the service plan (of care). Record reviews are thorough and include a review of all required documentation regarding compliance with the participant-centered planning and service delivery assurance. Reviews include, but are not limited to, completeness of the service plan (of care); 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 DAAS RN maintains an established caseload, covering certain counties in Arkansas. Each participant knows his or her DAAS RN and has the DAAS RN's contact information. RN supervisors assist in the resolution of problems, monitor the work performed by the DAAS RN by making periodic visits with DAAS RNs, and assist in overall program monitoring and quality assurance. Additionally, a record review process is conducted on a monthly basis by DAAS RN supervisors. Records are pulled in a systematically random process and reviewed for accuracy and appropriateness in the areas of medical assessments, service plans (of care), 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 records being reviewed for program and procedural compliance. DAAS supervisory staff uses the Raosoft Calculation System to determine the appropriate sample size for record review with a +/- 5% margin of error and 95% confidence level, and selects every "nth" name on the list to be included in the sample.

The Division of Medical Services QA review reflects internal review of the billing process by Living Choices Medicaid providers. DMS QA conducts a validation review of the records reviewed by DAAS 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. DMS reviews 20% of the records reviewed by DAAS. As a part of the review process, the DMS QA unit surveys respective Living Choices participants to verify service delivery, service plan compliance and

participant satisfaction. In addition to the record review and survey contact, the DMS QA unit conducts home visits on a random basis to monitor service delivery, participant health and welfare, and participant satisfaction with Living Choices services. Home visits are made to a number of participants equal to one-third the sample size selected for record review.

The following reports are used to compile monitoring information and reported as indicated:
1. Monthly Reports - compiled by each DAAS RN and reported monthly to the RN supervisor. All monitoring visits are reported.
2. RN Supervisor Report - compiled by each RN supervisor and reported monthly to the HCBS Director. All monitoring visits are reported.
3. Monthly Record Reviews - performed monthly by RN supervisors and reported monthly to HCBS Director.
4. Monthly Record Reviews - performed monthly by DMS QA Unit and reported monthly to DAAS.
5. Annual QA Report - compiled annually by DMS QA Unit and reported to DAAS.

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:*

For participants who receive Living Choices Assisted Living Services (ALS), the assisted living provider employs or contracts with a registered nurse (ALF RN) who implements and coordinates service plans (of care), supervises nursing and direct care staff and monitors participants' status. ALF RNs are responsible for assessing each Living Choices ALS participant's health care needs, implementing and coordinating the delivery of services ordered on the service plan (of care), monitoring and assessing the participant's health status on a periodic basis.

The ALF RN is responsible for immediately notifying the DAAS RN of participants whose status or condition has changed and who may need re-evaluation and reassessment, via the Client Change of Status form (AAS-9511). The AAS-9511 may be transmitted via fax or email to the DAAS RN. The DAAS RN must visit the ALS participant within 10 working days of receiving notification to complete a new assessment, which, depending on the situation, may or may not result in a revision to the participant's service plan (of care).

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 DAAS 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 (of care).

Living Choices providers agree to render all services in accordance with the Arkansas Medicaid Living Choices Home & Community-Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAAS; to continually monitor participant satisfaction and quality of service delivery; and, to notify the DAAS RN in writing within one week of services being terminated documenting the termination effective date and the reason for termination.

Living Choices providers assure DAAS 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 waiver service plan (of care). Providers acknowledge that they may render and pursue reimbursement for services delivered in accordance with the service plan developed by the DAAS RN. Providers acknowledge that the DAAS RN is the only authorized individual who may adjust a Living Choices waiver participant's service plan (of care). Providers accept full responsibility for the quality and number of service units provided to a Living Choices waiver participant by their staff, and assure DAAS appropriate management and supervision of services takes place at all times.

Service plans (of care) are revised by DAAS RNs as needed between assessments, based on information secured through providers, waiver participants and their support systems.

DAAS RNs and Living Choices 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 service plan (of care).

DAAS RNs and Living Choices 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, DAAS RNs and case managers are responsible for following through and taking any action deemed appropriate. Monitoring visits must be completed according to the established policy, as instructed by RN supervisors or the DAAS Home & Community-Based Services Director.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants reviewed who had service plans (of care) that were adequate and appropriate to their needs as indicated by the assessment(s). Numerator: Number of participants with service plans (of care) that address needs; Denominator: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants reviewed who had service plans (of care) that addressed personal goals. Numerator: Number of service plans (of care) that address personal goals; Denominator: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants reviewed who had service plans (of care) that addressed risk factors. Numerator: Number of service plans (of care) that addressed risk factors; Denominator: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

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

Data Aggregation and Analysis:

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

	Specify:

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

Performance Measures

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

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

Performance Measure:
Number and percent of service plan development procedures that are completed as described in the waiver application. Numerator: Number of participants' service plans (of care) completed according to waiver procedures; Denominator: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of service plans (of care) that were reviewed and revised as warranted on or before waiver participant's annual review date. Numerator: Number of participants' service plans (of care) 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

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

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants reviewed who received services in the type, scope, amount, frequency and duration specified in the service plan (of care). Numerator: Number of participants' service plans (of care) who received services specified in service plan (of care); Denominator: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participant records reviewed with an appropriately completed service plan (of care) 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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The 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 DAAS for completeness and accuracy and resulting data is made available for the production of the Record Review Summary Report. A DMS QA validation review is conducted on 20% of the records previously reviewed by DAAS.

DAAS supervisory staff uses the Raosoft calculation system to determine the appropriate sample size for Record Review with 95% confidence level and +/- 5% margin of error. The size of the active population is divided by the sample size to determine the “nth” integer, and every "nth" name on the list of active participants is selected to be included in the sample for review. The sample is drawn annually, and divided by twelve for monthly review.

Record reviews of the participant files are thorough and include a review of all required documentation regarding compliance with the participant-centered planning and service delivery assurance. Reviews include, but are not limited to, completeness of the service plan (of care); 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.

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 service plans (of care) 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.

The Division of Medical Services (DMS) QA validation review reflects internal review of the billing process by Medicaid providers of Living Choices waiver services. DMS QA conducts a validation record review of 20% of the records previously reviewed by DAAS 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. As a part of the review process, the DMS QA unit surveys the respective Living Choices participant to verify service delivery, service plan compliance, and participant satisfaction.

In addition to the record review and survey contact, the DMS QA unit conducts home visits on a random basis to monitor service delivery, participant health and welfare, and participant satisfaction with Living Choices services. Home visits are made to a number of participants equal to one-third the sample size selected for record review.

The State Medicaid Agency assures compliance with the service plan sub-assurances through the validation review of waiver participants' records conducted by the State Medicaid Agency, DMS QA. DAAS provides DMS with copies of any data analysis of the findings and plans for remediation of data analysis, including trend identification. DMS and DAAS participate in quarterly team meetings to review findings and discuss resolution.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Aging & Adult Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems related to service plans (of care), as well as problem correction and remediation. DAAS and DMS have an Interagency Agreement that includes measures related to the service plans (of care) as part of the waiver.

If a participant record lacks required documentation regarding this assurance, DAAS'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)

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

c. Timelines

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

- ◉ **No**
- ○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to

participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The form DCO-707 is issued by the Division of County Operations (DCO) 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 DCO 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 Division of County Operations (DCO) when adverse action is taken to deny, suspend, reduce or terminate eligibility for Living Choices. 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 DCO 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, Office of Appeals and Hearings. This information and the contact information for the Office of Appeals and Hearings 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.

The DCO has set guidelines for retention of the form DCO-707 in the applicant's or participant's DCO 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 DCO. 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 DCO case record for five years from the date of the last approval, closure, or denial.

Living Choices participants also have the right to appeal if they disagree with a revision to their service plan (of care) which reduces or terminates services, while their eligibility remains active. Information regarding appeals and hearings is included with the participant's service plan (of care). The DHS Office of Appeals and Hearings is also responsible for these types of appeals. Requests for appeals must be received by the DHS Office of Appeals and Hearings no later than 30 days from the business day following the postmark on the envelope with the service plan (of care) 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 provider.

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 Living Choices waiver providers and the Department of Human Services county office inform the participant of his/her 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 assessment and service plan development process, the DAAS RN explains these rights to the participant, family member or representative. Signatures on the service plan (of care) 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 DAAS 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 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

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 and Adult 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 DAAS Central Office or their DAAS RN. When a DAAS RN is contacted regarding a complaint or dissatisfaction, the DAAS RN explains the complaint process to the participant, and completes the HCBS Complaint Intake Report (AAS-9505). Any DAAS 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 DAAS staff and DAAS 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, DAAS, 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 DAAS central office administrative staff to resolve.

DAAS 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 (of care), if necessary. The Nurse Manager at the DAAS 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 DAAS RN explains the hearings and appeals process to the participant at this time.

DAAS RNs follow-up with participants after a complaint has been made at each reassessment or monitoring contact. DAAS RN supervisors may also participate in follow up. Depending on the type of complaint, the DAAS RN may take action to assure continued resolution by revising the participant's service plan (of care) or assisting the participant in changing providers.

A complaint received on regarding a DAAS 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 DAAS staff receives the complaint. Complaints must be resolved within 30 days. To ensure that participants are safe during these time frames, the DAAS RN may put in place the backup plan on the participant's service plan (of care) or report the situation to Adult Protective Services, if needed.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Arkansas state law requires that suspected abuse, neglect, and exploitation of endangered and impaired adults be reported to the Adult Maltreatment Hotline for investigation. For the purposes of the Adult and Long-Term Care Facility Resident Maltreatment Act (Arkansas Code Annotated (A.C.A.) §12-12-1701 et. seq.), a resident of a long-term care facility is considered an impaired adult. Arkansas Department of Human Services (AR DHS) Policy 1090 Incident Reporting requires that abuse, neglect, exploitation, serious or significant injury, and unexpected death of participants receiving DHS services or residing in DHS facilities be reported for review and follow-up action.

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. Living Choices Assisted Living waiver staff, providers, and DAAS contractors are mandatory reporters. The statute requires immediate reporting to Adult Protective Services and/or the Office of Long-Term Care when any mandated reporter has observed or has reasonable cause to suspect adult maltreatment or long-term care facility resident 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; failure to carry out a prescribed treatment plan; or failure to provide goods or services to a long-term care facility resident necessary to avoid physical harm, mental anguish, or a mental illness.

The Office of Long-Term Care regulations for Assisted Living Facilities, Level II, 507 Reporting Suspected Abuse, Neglect, or Misappropriation of Resident Property, require that any alleged, suspected, or witnessed occurrences of abuse, including verbal statements or gestures, or neglect to residents; or misappropriation of resident property or exploitation of a resident; or sexual abuse to residents by any individual must be reported. All facility personnel who have reasonable cause to suspect abuse, neglect or exploitation of a resident are required to immediately notify the facility administrator or his or her designated agent. The facility administrator or his or her designated representative is required to immediately report all cases of suspected abuse or neglect of residents to the local law enforcement agency, and to make a report to the Office of Long Term Care no later than 11:00 am on the next business day following discovery by the facility.

AR DHS Policy 1090, Incident Reporting, requires that incidents which may affect the health and safety of DHS participants while receiving DHS services must be reported to the Division Director or Designee, and the DHS Director's Office. These incidents are defined as adult abuse, maltreatment and exploitation, significant or serious injury, threatened or attempted suicide. Any DHS employee or contractor who is aware of facts and circumstances that would cause a reasonable person to suspect that an incident took place must report that incident. Any incident that has, or is expected to, receive media attention must be reported to the DHS Communications Director within one hour of the incident, regardless of the hour. Incidents regarding suicide, death from adult abuse, maltreatment or exploitation, or serious injury must be reported to the DHS Chief Counsel within one hour of the occurrence, regardless of the hour. All other reports must be filed with the DHS Division Director or Designee and the DHS Client Advocate no later than the end of the second business day following the incident. The DHS Incident Reporting Information System is a web- and network-based system which enables online submission and transmittal of incident reports. Information received by phone or in writing is entered into the system as well.

AR DHS policy 1106, DHS Client Injury or Death Review, establishes a review procedure for unexpected DHS participants deaths that occur while the participants is receiving direct personal services that are provided by DHS, by

a DHS agent, or under a care plan subject to DHS approval. An unexpected death is defined as a death that occurs accidentally, or as a result of an undiagnosed condition. Unexpected death does not include death that is medically determined to have resulted solely from a diagnosed degenerative condition or similar circumstance. "While the participant is receiving services," means that the participant is or should be under the control, supervision, or monitoring of a DHS employee or agent.

Any employee of DAAS must immediately notify the division contact of unexpected DHS participant deaths that occur while the participant is receiving direct personal services as defined above.

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.

An Adult Protective Services (APS) brochure is provided to the waiver applicant and his or her family by the DAAS RN when initial contact is made. Additional copies of the brochure are available to other interested parties upon request. 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 the Adult Maltreatment Hotline number. The Adult Maltreatment Hotline is accessible 24 hours a day, seven days a week. DAAS RNs review this information with participants and family members at the initial assessment, at each annual reassessment, and at monitoring contacts. APS brochures are also provided at reassessments, monitoring visits, during all provider workshops and in-services.

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.

Adult Protective Services (APS) receives, investigates, evaluates and resolves reports of suspected abuse, neglect or exploitation of impaired or endangered adults who do not live in long-term care facilities, or whose alleged offender is a family member, regardless of where the endangered or impaired adult lives. The Office of Long Term Care (OLTC) receives, investigates, evaluates and resolves reports of suspected abuse, neglect or exploitation of impaired or endangered adults who live in long-term care facilities. Arkansas state law grants investigative powers to the Department of Human Services (DHS). As statutorily directed in Arkansas Code Annotated §12-12-1701 et. seq., dependent upon the circumstances of the alleged maltreatment, one of these entities of DHS (APS or OLTC) will have the responsibility for review and response to these critical events or incidents for Living Choices waiver participants.

APS visits participants 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 Arkansas Code Annotated §12-12-1703(8). Non-emergency cases refer to situations when the allegations do not meet the definition of imminent danger to health or safety. APS fast-tracks waiver participants so they can be seen within 24 hours if possible.

OLTC regulations for ALF Level II's require facility owners, administrators and staff to comply with Arkansas law regarding the immediate reporting of suspected maltreatment to law enforcement and to the facility administrator or designated representative. As detailed in Section 507 of the regulations, all suspected maltreatment must also be reported to OLTC by the next business day by facsimile on Form DMS-731, Incident and Accident Next Day Reporting Form. At that time, the facility is required to ensure that all incidents of resident abuse, exploitation, neglect, or misappropriation of property are thoroughly investigated, in conformance with the process and documentation requirements specified on Form DMS-742, Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property and Exploitation of Residents in LTC Facilities. The results of the initial facility investigation must be reported to OLTC within five working days of the facility's knowledge of the incident, and the completed Form DMS-742 must be mailed to OLTC.

The requirements of the law regarding time-frames for investigations and reporting apply to both APS and OLTC. The law requires that investigations be completed and an investigative determination entered within 60 days. The investigative entity notifies the participant and other relevant parties, including the offender and the current administrator of the long-term facility if the incident occurred in a long-term facility, of the determination. The availability of investigative reports is also governed by the statute, as such reports are confidential. A.C.A. §12-12-1717(a)(16) and §12-12-1718(c)(12) specify that the Division of Aging and Adult Services (DAAS) is a party entitled to receive copies of investigative reports as to participants of the waiver programs.

APS communicates with the waiver program staff, as needed, on all appropriate and relevant information. APS investigations include site visits and interviews with the participant, offender, reporter, doctors, family, police and other collateral witnesses that can be found. DAAS staff are also interviewed by APS and asked to provide any necessary documentation for the investigation. Investigations conducted by Assisted Living facilities include interviews with the participant, facility staff, other residents, and other collateral witnesses, and are documented on the Form DMS-742. The OLTC staff conducts its investigations with site visits and interviews with participant, reporter, the injured party, the perpetrator if known, any guardian(s) of the injured party and/or perpetrator, facility staff, hospital staff, doctors, and other collateral witnesses.

Reports to APS are logged into a database, and DAAS uses this resource to monitor active participants of the waiver for critical incidents. Reports to OLTC are entered into a tracking system which OLTC uses to determine if further investigation is needed in the event of multiple complaints at one facility.

Unexpected participant deaths must be reported immediately to the DAAS contact using the DHS Client Unexpected Death Report. The DAAS contact investigates the report within two days of the occurrence, and will determine the facts and circumstances of the occurrence within five days of the occurrence. The DAAS contact prepares a report of the investigation within 30 days of the occurrence. The investigation includes reviewing a written report of the facts and circumstances of the unexpected death and documentation listing the participant's condition, including diagnoses, prescriptions and service plan (of care). The DAAS contact may ask other DAAS staff, such as the DAAS RN or RN supervisor, or others involved with the situation to assist with aspects of the investigation.

DAAS's oversight includes performing a thorough investigation, reviewing current policy and making corrections if necessary and identifying patterns during the process. Final results of investigations are reported to the Division of Medical Services (DMS).

All reports to the Adult Maltreatment Hotline and to the Office of Long Term Care, and instances of unexpected participant deaths are investigated and addressed. 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 Aging & Adult Services (DAAS) assumes responsibility for compiling all incident reports for review and action. Incidents are reported to the DAAS Director using the Incident Reporting Information System (IRIS) online by DAAS staff. The information entered into this system is compiled into the DHS-1910 (Incident Report Form) and sent directly to the DAAS Assistant Director of Support Services. Incidents or events involving abuse, neglect or exploitation must also be reported immediately to the Adult Maltreatment Hotline.

The DAAS Assistant Director reviews the reports as events and incidents occur, identifies patterns, and makes systemic corrections when necessary. Current policy is reviewed at each occurrence and revisions may be made if necessary.

Final results of APS investigations, final results of unexpected death findings, and results of incident reports are reported to DMS.

DMS review of a sample of participants' records includes verification that:
1) the participants, family members, legal guardians and caregivers' complaints are identified, tracked and addressed;
2) any identified incidents of abuse, neglect and exploitation are tracked and actions taken to assure the participant's safety;
3) the participants, family members, legal guardians and caregivers are informed of how to report concerns or incidents of abuse, neglect and exploitation; and,
4) any situation in which the participant's health or welfare may be in jeopardy are acted upon timely and appropriately.

The Adult Protective Services unit tracks APS incidents. DAAS RNs and DMS are informed of the outcomes of incidents reported to APS applicable to waiver participants. There is a Memorandum of Understanding between the DAAS waiver unit and the APS unit (within the same division) detailing the relationship and activities of each unit, as they relate to the waiver program.

All reports to the Adult Maltreatment Hotline and to the Office of Long Term Care, and instances of unexpected

participant deaths are investigated and addressed. Incidents reported to the DHS Incident Reporting Information System (IRIS) are investigated depending on the type of incident reported.

Appendix G: Participant Safeguards

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

a. Use of Restraints. *(Select one)*:

- **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 and Adult Services (DAAS) is responsible for detecting the unauthorized use of restraints or seclusion. This oversight is conducted through incident reports received; and regular monitoring of the participant by the DAAS RN, if needed; and monitoring by the case manager.

  DAAS RNs reassess participants annually.

  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 case management provider is required to immediately contact the DAAS 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

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 and Adult Services (DAAS) is responsible for detecting unauthorized use of restrictive interventions. This oversight is conducted through incident reports received; monitoring of the participant by the DAAS RN, if needed; and monitoring by the case manager.

  DAAS RNs reassess participants annually.

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 case management provider is required to immediately contact the DAAS 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

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

c. Use of Seclusion. *(Select one)*:

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

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

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix

does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

For participants receiving Living Choices Assisted Living Services, waiver services are furnished in licensed Level II Assisted Living Facilities where the assisted living services provider has round-the-clock responsibility for the health and welfare of residents. Each assisted living facility must have written policies and procedures to ensure that residents receive medications as ordered.

The administrator of the Level II Assisted Living Facility is responsible for full compliance with Federal and State laws governing procurement, control and administration of all drugs. Full compliance with the Comprehensive Drug Abuse Prevention and Control Act of 1970, Public Law 91-513 and all amendments of this set and all regulations and rulings passed down by the Federal Drug Enforcement Agency, Arkansas Act No. 590 and all amendments to it.

Each facility must contract with, or otherwise employ, a consultant pharmacist, licensed or certified by the Arkansas State Board of Pharmacy as a Consultant Pharmacist in Charge. The Consultant Pharmacist in Charges performs legally required quality assurance and patient safety functions with respect to purchasing, storage, handling, dispensing and administering prescription drugs.

The consultant pharmacist must, at least quarterly per year:
1. Review the methods employed by the facility to store, label, distribute, administer and safeguard all medication. The consultant pharmacist must prepare a written report to the facility detailing:

a. Any areas in which the consultant pharmacist determines that the methods employed by the facility are deficient, or have the potential to adversely affect the health, safety or welfare of residents; and

b. The recommended alterations to the methods, or additions to the methods, to correct any methods determined by the consultant pharmacist to have the potential to adversely affect the health, safety or welfare of residents.

2. Review all orders for medication prescribed since the last review and prepare a report to the facility detailing:

a. All instances in which medication has been improperly prescribed or administered; and

b. Instances in which, in the opinion of the consultant pharmacist, the facility should seek physician review of the number or types of prescribed medications for residents.

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 consultant pharmacist must quarterly review the methods employed by the Level II Assisted Living Facility, and review each participant's medication record, consult with and provide a written report of findings to the director of nursing at the facility or the participant's physician.

The primary duty of the consultant pharmacist to the participant's concerns is to apply his or her expertise on drugs the to the participant's specific situation. State and Federal regulations shall be the minimum standards for an adequate drug regimen review.

The consultant pharmacist reviews each participant's chart quarterly and:
A) Ascertains that participant history and drug utilization is being properly recorded.
B) Reviews drug usage (including O.T.C. and prescriptions).
C) Reviews participant compliance with drug regimen.
D) Reviews drug allergies or sensitivities.
E) Determines whether the participant is predisposed to side effects due to disease, illness, or age.
F) Determines whether potential exists for significant drug interaction.
G) Develops procedures to monitor participant's records for signs that indicate abuse or misuse of drugs by the participant or individuals.
H) Makes recommendations regarding drug therapy to the physician, nurse or other persons involved in the participant's care.
I) Communicates to the facility procedures that ensure adequate pharmacy services are available for emergencies that might develop in the facility for a specific participant.

The consultant pharmacist prepares a written report detailing all instances in which medication has been improperly prescribed or administered, and instances in which, in the opinion of the consultant pharmacist, the facility should seek physician review of the number or types of prescribed medications for participants. The director of nursing will relay issues regarding specific participants to the participant's physician for review.

The facility is required by Department of Human Services, Office of Long Term Care (OLTC) regulations to develop and maintain a quality assessment unit to meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and to develop and implement appropriate plans of action to correct identified deficiencies. The consultant pharmacist's reports are part of the quarterly review. Additionally, a consultant pharmacist may be included as a member of the quality assessment unit.

The facility is required to retain the consultant pharmacist's quarterly reports for a period of eighteen (18) months, or until the Level II Assisted Living Facility is reviewed by the Department of Human Services, Office of Long Term Care (OLTC), which has authority conferred by Arkansas Code Annotated §20-10-203 and A.C.A. §25-10-129 for oversight of the facility and imposition of remedies.

The facility is required to submit to regular and unannounced inspection surveys and complaint investigations in order to receive or maintain a license. Inspections are performed by the Department of Human Services, OLTC, or the Office of Attorney General. An inspection may occur at any time, in the discretion of DHS, OLTC, or the Attorney General's Office or its agents.

During inspection surveys, all participant records, including but not limited to participants' medical records maintained by the facility, are open for inspection by qualified medical staff with OLTC. All facility records related to the care or protection of participants, and all employee records related to the care or protection of participants are open for inspection by OLTC for the purpose of enforcing Assisted Living Facility regulations and applicable laws.

During inspection surveys, the OLTC survey staff determines the facility's medication error rate. If the medication error rate of a Level II Assisted Living Facility is determined to be greater than 5%, a deficiency will result. Facilities must provide a written acceptable plan of correction within 15 days of receipt of written notification of deficiencies (Statement of Deficiencies) found during routine inspections or surveys, special visits, or complaint investigations. The plan of correction must provide corrective actions to address the cited deficiencies, the time frames in which the corrective actions will be completed, and the manner to be utilized by the facility to monitor the effectiveness of the corrective action. The OLTC shall determine whether the proposed plan of correction, including any proposed dates by which correction will be made, is acceptable. Failure to provide an acceptable plan of correction may result in the imposition of additional remedies pursuant to OLTC regulations at the discretion of the agency, or in a finding of a violation and imposition of additional remedies set forth in Title 20 of the Arkansas Code Annotated, or set forth in OLTC regulations, or both.

Additional remedies available are civil money penalties, denial of new admissions, directed in-service training, directed plan of correction, state monitoring, temporary administrator, termination of license, and transfer of residents. Unless otherwise provided by law or applicable regulations, remedies continue until the facility has corrected the cited deficiencies, as determined by OLTC based on a revisit, or after an examination of credible written evidence that it can verify without an on-site visit, or both; or, OLTC terminates the Level II assisted living facility license.

A report of all Level II Assisted Living Facilities deficiencies and the Plans of Corrections is sent weekly by

OLTC to the Living Choices waiver operating agency, the Division of Aging and Adult Services, for review.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

For participants who receive Living Choices Assisted Living Services, the ALS waiver provider is responsible for the administration of medications to waiver participants who cannot self-administer, and/or has responsibility to oversee participant self-administration of medications.

Level II Assisted Living facilities must comply with applicable state laws and regulations governing the administration of medications and restrictions applicable to non-licensed personnel/staff/employees. However, licensed nursing personnel, (RN, LPN) may administer medication in accordance with OLTC regulations in cases in which the participant is assessed as being unable to self-administer his or her medication. In such cases, the facility shall document, and shall be responsible to ensure, that medications are administered by licensed personnel/staff/employees, and are administered without an error rate greater than 5%.

Assessment of the health care services needs of all Living Choices ALS participants is performed at least quarterly by qualified assisted living facility medical staff. Each assessment or reassessment includes an evaluation of the participant's ability to self-administer medication. To be determined as capable of self-administration, the resident, without cueing, must be capable of storing, managing and self-administering his or her own medications. The facility will document in the participant's record whether the participant or the facility is responsible for storing the participant's medication, and whether the participant will self-administer medication or the facility will administer medication to the participant.

OLTC Rules and Regulations for Assisted Living Facilities regulate the facility with regard to medication administration, and medication assistance and monitoring.

Medication administration is provided only by licensed medical staff, either directly or through contract, and in accordance with the Nurse Practice Act (A.C.A. §17-87-101 et seq.) and interpretations of the Arkansas State Board of Nursing.

Medication assistance and monitoring is provided by the facility, either directly or through contract, in accordance with the Nurse Practice Act and interpretations by the Arkansas State Board of Nursing, designed to ensure that residents receive necessary or prescribed medication, and to prevent wastage of medication.

Facility staff shall provide assistance to enable participants to manage their medications, when the participant is determined after assessment to be able to self-administer medication. For clarification, examples for acceptable practices are listed below:

1. The medication regimen on the container label may be read to the participant;
2. The participant may be reminded of the time to take the medication and be observed to ensure that the participant follows the directions on the container;
3. Facility staff may assist participants in the management of their medications by:

a. Taking the medication in its container from the area where it is stored and handing the container with the medication in it to the participant;

b. In the presence of the participant, facility staff may remove the contain cap or loosen the packaging. If the participant is physically impaired, but cognitively able (has awareness with perception, reasoning, intuition, and memory) facility staff, upon request by or with the consent of the participant, may assist the participant by removing oral medication from the container and in taking the medication;

c. If the resident is physically unable to place a dose of oral medication in his or her mouth without spilling or dropping it, facility staff may place the dose of medication in another container and place that container to the mouth of the resident.

Changes in dosage or schedule of the medication shall be made only upon authorization of the participant's physician or advance practice nurse, for those participants who do not self-administer their medications.

Medication Charting:
If a facility supervises a participant's medication, a notation must be made on the individual record for each participant who refuses, either through affirmative act, omission, or silence, or is unable, to self-administer his or her medications. The notation must include the date, time and dosage of medication that was not taken or administered to or by the participant, including a notation that the participant's attending physician or advance practice nurse was notified, as required by physician or advance practice nurse orders.

Medication administered by the facility shall be recorded in each participant's medical record no less than once each shift in which the medication is administered. The notation must be in ink, and shall state, at a minimum:

a. The name of the medication;
b. The dosage prescribed and the dosage taken or administered;
c. The method of administration;
d. The date and time of the administration.

All controlled drugs procured or administered must be recorded in a bound ledger book, in ink, with consecutively numbered pages. The record must contain:

1. Name, strength and quantity of drug;
2. Date received and date, time and dosage administered;
3. Name of the participant for whom the drug was prescribed, or received the drug;
4. Name of the prescribing physician or advance practice nurse;
5. Name of the dispensing pharmacy;
6. Quantity of drug remaining after each administrated dosage;
7. Signature of the individual administering the drug.

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:

Living Choices ALS providers are required to report medication errors to the Department of Human Service, Office of Long Term Care (OLTC).

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

Medication error means the observed preparation or administration of drugs or biological which is not in accordance with:

1. Physician's orders;

2. Manufacturer's specifications (not recommendations) regarding the preparation and administration of the drug or biological; or,

3. Accepted professional standards and principles which apply to professionals providing services. Accepted professional standards and principles include the various practice regulations in Arkansas, and current commonly accepted health standards established by national organizations, boards, and councils.

Errors in medication administration the provider must record in the participant's chart include the following situations:
- Incorrect medication administered to participant
- Incorrect medication dose administered to participant
- Medication administered without a physician's order
- Medication not administered as ordered
- Medication administered after date of expiration on label

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

AR DHS Policy 1090, Incident Reporting, requires that incidents which may affect the health and safety of DHS participants while receiving DHS services must be reported to the Division Director or Designee, and the DHS Director's Office. Included in the incidents which must be reported are significant or serious injuries. Any medication error, including those listed above, which causes a significant or serious injury to the participant must be reported.

A serious injury is defined as an injury that may cause death or which is likely to result in substantial permanent impairment.

A significant injury is defined as any injury that requires the attention of an Emergency Medical Technician (EMT), a paramedic, or physician.

○ **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.

The Department of Human Services, Office of Long Term Care (OLTC) is responsible for inspection of assisted living facilities. When OLTC performs regular and unannounced inspection surveys of the assisted living facility, the survey team examines medical records and reports. The surveyors perform Medication Pass Observation on-site at each inspection survey, which occurs annually at a minimum. Current practice is for the OLTC to inspect facilities every six months.

During Medication Pass Observation, the OLTC surveyor, who is a qualified medical professional, observes medication administration in a neutral, unobtrusive manner. The surveyor is required to observe 20-25 opportunities for error, at least two staff administering medications, and different routes of administration (oral, eye drops, inhalation, injection, transdermal, etc.) After the first pass is completed, the surveyor reconciles the observations with medical records to identify medication error. If any error is identified, the surveyor is required to observe another 20-25 opportunities for error in another medication pass, and again reconcile the observations with the medical record. The survey staff then calculates the medication error rate as follows:

Medication error rate means the percentage of both significant and non-significant medication errors. Significant medication error means one which causes the participant discomfort or jeopardizes his or her health and safety. Whether a medication error is significant is determined by consideration of the participant's condition, the drug category, and the frequency of the error. Non-significant medication error means a medication error that does not meet the definition of a significant medication error. The medication error rate is determined by dividing the number of errors by the opportunities for errors and multiplying by 100. The opportunities for error include all the doses administered plus the doses ordered but not administered.

Medication errors which are identified by the OLTC survey staff include the errors as listed in G-3-c (iii) (b), and other observed errors in administration such as:
- Medication not administered as ordered before, after, or with foods/antacids
- Administration of medications without adequate fluid as manufacturer specifies

- Crushing tablets or capsules that manufacturer states “do not crush”
- Failure to “shake” a drug product that is labeled “shake well”
- Multiple eye drops administered without adequate time sequence between drops

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

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

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

Performance Measure:
Number and percent of participant records reviewed where the participant and/or family member 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 how to report a/n/e and critical incidents; Denominator: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of critical incidents that were reported within required time frames. Numerator: Number of critical incidents reported within the required time frames; Denominator: Number of critical incidents reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of

		error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of unexplained, suspicious and untimely deaths for which

review/investigation resulted in the identification of unpreventable 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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of substantiated complaints. Numerator: Number of substantiated complaints; Denominator: Number of complaints.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
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

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

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
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 DAAS RN supervisors to assure that DAAS 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 DAAS waiver staff. Findings are reported to the DMS QA Unit.

DAAS staff is 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 DAAS 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 case note. Record reviews include verification of this requirement and are included on the annual report. The memorandum of understanding between the DAAS waiver unit and APS includes additional reporting and tracking of APS activities involving waiver participants.

The process for reporting abuse as established in Arkansas Code Annotated Â§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.

In addition to DMS audits and/or reviews and existing reporting, the record review process includes policy compliance assuring health and safety, meetings between DAAS waiver staff and APS staff, and regular communication between other divisions, including the Division of County Operations and DMS.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Aging & Adult Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems related to participant health and welfare, as well as problem correction and remediation. DAAS and DMS have an Interagency Agreement that includes measures related to participant health and welfare for the waiver.

DAAS'€™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 DAAS RNs and considering this remediation as part of the DAAS RN's€™ performance evaluations.

In cases where critical incidents were not reported within required time frames, DAAS provides remediation, including reporting the critical incident immediately upon discovery, and providing additional training and counseling to staff. The case record review tool allows for the collection of data related to reporting critical incidents within the required time frames.

If critical incident reviews and investigations are not initiated and completed according to program policy and state law, DAAS'€™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, DAAS provides immediate follow-up to the incident and staff training as remediation.

DAAS 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 DAAS 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 DAAS addressing the complaint immediately upon discovery, and providing additional staff training and counseling. In addition, the complaint database tracks remediation when complaints have not been resolved within 30 days.

The case record review tool also captures and tracks remediation in all of these areas.

All substantiated incidents are investigated by the DAAS Assistant Director or his/her designee. DAAS 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)

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

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

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to

undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DMS analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, DMS will meet with the operating agency (DAAS) 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 is 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 the DMS QA Unit monitor the system changes. An online CSR management System is used to monitor and track the status of computer service requests.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: 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 and Adult Services (DAAS) and the Division of Medical Services 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, Office of Medicaid Inspector General staff, and DAAS waiver staff are held to address needs and resolve issues, including development 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 DAAS Director of Home and Community Based Services, DMS 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.

DAAS 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 strategy is indicated, a collaborative effort between DMS and DAAS is set in motion to complete a revision to the Quality Improvement Strategy, which may include submission of a waiver amendment. DMS QA staff utilizes the Quality Improvement Strategy during all levels of QA review.

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 CMS-372 reports and CMS-64 reports. The DMS QA staff reviews claims paid in accordance with waiver participants' service plans (of care). DMS QA reviews are validation reviews of 20% of the records reviewed by DAAS.

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. In addition, the Office of Medicaid Inspector General conducts an annual random review of HCBS waiver programs. If the review finds errors in billing, and fraud is not suspected, Medicaid recoups the money from the waiver provider. If fraud is suspected, the Office of Medicaid Inspector General refers the waiver provider to the Arkansas Attorney General's Office for appropriate action.

The DHS Office of Policy and Legal Services, 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 DAAS Home and Community Based Services 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.

DMS Quality Assurances also reviews the services billed compared to the services listed on a participant's service plan (of care). DMS record reviews include a review of the billing by Living Choices providers. DMS QA conducts a validation review on 20% of the record previously reviewed by DAAS in their Record Review process.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

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

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

Performance Measure:
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)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review on 20% of the charts reviewed by DAAS during Chart Record Reviews.
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent 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:
Daily LTC Update Error Report

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Daily Waiver Update Error Report

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

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of reviewed claims with services specified in the participant's services plan (of care). Numerator: Number of claims with services specified in service plan (of care); Denominator: Number of claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient Claims History Profiles (Chart Reviews)

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

(check each that applies):	*(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: DMS performs a validation review on 20% of the charts reviewed by DAAS during Chart Record Reviews.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by

the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Aging and Adult Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. DAAS 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 as 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.

DAAS's remediation for failed MMIS checks not corrected to assure appropriate payment includes correcting the issue upon discover, making system changes and training staff.

DAAS's remediation for claims for services not specified in the participant's service plan includes adding the 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)

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

c. Timelines

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

◉ **No**

○ **Yes**

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

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).

The operating agency (DAAS) is responsible for the rate determination with oversight conducted by the 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 Living Choices 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. 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. Additionally, DAAS RNs may explain rate information to participants during assessment.

Various methodologies are used for rate determination depending on the waiver service. The following are the methods used for rate setting for the Living Choices waiver services:

Case Management – Case Management rates were developed based on the Sterling and Associates workload standards model to effectively meet the needs of clients, with a case ratio of 1:100 “case touching” full time staff to Living Choices waiver recipients. Funding allocation based on the Bureau of Labor Statistics wage averages per model unit was used to determine the rate per unit. The rate is consistent with efficiency, economy, and quality of care, and is sufficient to enlist a sufficient number of providers.

Assisted Living Services – Assisted Living Services rates reflect the amount for services, not room and board. The rates are tiered at 4 levels, consistent with the levels of care established by the Office of Long Term Care. Policy and reimbursement for the Assisted Living Service were studied by comparing services and rates to other sources. The rate analysis looked at service rates in the ElderChoices 1915(c) waiver program, the average cost of the ElderChoices service plan, and services provided in an assisted living level II facility. The rates for Assisted Living Service are established and approved by the DMS (Medicaid agency), and are consistent with efficiency, economy and quality of care, and sufficient to enlist a sufficient number of providers.

The health care component of adult day health care – The various health care components included in the provision of adult day health services and their costs were supplied by providers of adult day health services. The component costs supplied included both administrative costs and costs for the provision of the health care components of adult day health services. The components included salaries, fringe, supplies, travel, facilities and equipment, communications, meals, education and training, maintenance, insurance and other fees, RN supervision and management and general expenses. Fringe and travel/transportation are not a part of adult day health services provided to Living Choices waiver recipients, thus are not a part of the service definition, and were not considered in the rate determination for the health care component of adult day health services, as these costs are considered administrative costs. Using the actual costs of appropriate health care components included in the provision of adult day health services for the latest State Fiscal Year (SFY), the rate/unit cost of the health care components of adult day health services was determined. The rate is consistent with efficiency, economy, and quality of care, and is sufficient to enlist a sufficient number 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:

Living Choices providers bill for the services and are reimbursed directly through the 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

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. DMS QA staff verifies services were provided according to the service plan (of care) 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

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- **No. The State does not make supplemental or enhanced payments for waiver services.**
- **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private**

providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for

designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

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

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

For participants who receive Assisted Living Services: Room and board costs are separate and excluded from payments for services provided by the ALS provider. 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 recipient's income. Nine percent of the Individual SSI FBR rounded to the nearest dollar is deducted for personal needs allowance.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - **i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

◉ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver**

participants.

Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: 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	2389.75		2389.75			0.00	-2389.75
2	2433.46		2433.46			0.00	-2433.46
3	2478.50		2478.50			0.00	-2478.50
4	2524.87		2524.87			0.00	-2524.87
5	2572.57		2572.57			0.00	-2572.57

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	12650	12650
Year 2	12650	12650
Year 3	12650	12650
Year 4	12650	12650
Year 5	12650	12650

Appendix J: Cost Neutrality Demonstration

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 annnual reports (CMS-372) for the 2011 reporting year for each of the three existing DAAS 1915(c) waivers which are being replaced with the new Living Choices waiver were tabulated to estimate the average length of stay on the waiver.

A total of 10,849 unduplicated participants were served by the three waivers, with a total of 2,948,698 days of waiver coverage. The average length of stay on the waiver(s) is estimated at 272 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:

Historic untilization and cost data from CY2012 were used to derive utilization rates and cost for the elderly in home-based settings (ElderChoices waiver - EC), adults with physical disabilities in home-based services (Alternatives for Adults with Physical Disabilities waiver - AAPD) and Assisted Living residents (Living Choices Assisted Living waiver - LCAL). The utilization rates for the existing EC and AAPD were used to estimate the future utilization of these services for individuals residing outside of Assisted Living, assuming that the elderly will have similar utilization rates to those found among adults with physical disabilities and vice versa. The utilization rates for LCAL were used to estimate future utilization rates among residents of Assisted Living facilities.

Costs per unit - Historically, Assisted Living services have gotten 3% annual increases. That increase is carried forward; however, consistent with historic practice, other service rates are projected to be static.

Average units per user - Calculated using the historic average cost per unit and number of users in CY2012.

Health Care Components of Adult Day Health - Due to an increase in the limit from 8 hours per day to 10 hours per day, it is estimated that the average units per user will increase 25% over historic utilization.

Case Management - The proportion of current waiver recipients living in the counties affected by traditional vs. conflict-free case management was used to estimate the number of future waiver recipients receiving these services.

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:

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:

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:

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Case Management
Health Care Component of Adult Day Health Care
Extended Medicaid State Plan Prescription Drugs
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
Case Management Total:						**10321875.00**
Case Management Provider	15 minutes	9175	150.00	7.50	**10321875.00**	
Health Care Component of Adult Day Health Care Total:						**1375105.20**
Health Care Component of Adult Day Health Care	Hour	105	1289.00	10.16	**1375105.20**	
Extended Medicaid State Plan Prescription Drugs Total:						**111385.28**
Extended Medicaid State Plan Prescription Drugs	Month	89	4.00	312.88	**111385.28**	
Assisted Living Services Total:						**18422005.26**
Assisted Living Services	Day	1167	206.00	76.63	**18422005.26**	
				GRAND TOTAL:		**30230370.74**
				Total Estimated Unduplicated Participants:		**12650**
				Factor D (Divide total by number of participants):		**2389.75**
				Average Length of Stay on the Waiver:		272

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg.

Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**10321875.00**
Case Management Provider	15 minutes	9175	150.00	7.50	**10321875.00**	
Health Care Component of Adult Day Health Care Total:						**1375105.20**
Health Care Component of Adult Day Health Care	Hour	105	1289.00	10.16	**1375105.20**	
Extended Medicaid State Plan Prescription Drugs Total:						**111385.28**
Extended Medicaid State Plan Prescription Drugs	Month	89	4.00	312.88	**111385.28**	
Assisted Living Services Total:						**18974929.86**
Assisted Living Services	Day	1167	206.00	78.93	**18974929.86**	
				GRAND TOTAL:		**30783295.34**
				Total Estimated Unduplicated Participants:		**12650**
				Factor D (Divide total by number of participants):		**2433.46**
				Average Length of Stay on the Waiver:		272

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**10321875.00**
Case Management Provider	15 minutes	9175	150.00	7.50	**10321875.00**	
Health Care Component of Adult Day Health Care Total:						**1375105.20**
Health Care Component of Adult Day Health Care	Hour	105	1289.00	10.16	**1375105.20**	
Extended Medicaid State Plan Prescription Drugs Total:						**111385.28**
Extended Medicaid State Plan Prescription Drugs	Month	89	4.00	312.88	**111385.28**	
Assisted Living Services Total:						**19544682.60**

Assisted Living Services	Day	1167	206.00	81.30	19544682.60	
				GRAND TOTAL:		31353048.08
				Total Estimated Unduplicated Participants:		12650
				Factor D (Divide total by number of participants):		2478.50
				Average Length of Stay on the Waiver:		272

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**10321875.00**
Case Management Provider	15 minutes	9175	150.00	7.50	**10321875.00**	
Health Care Component of Adult Day Health Care Total:						**1375105.20**
Health Care Component of Adult Day Health Care	Hour	105	1289.00	10.16	**1375105.20**	
Extended Medicaid State Plan Prescription Drugs Total:						**111385.28**
Extended Medicaid State Plan Prescription Drugs	Month	89	4.00	312.88	**111385.28**	
Assisted Living Services Total:						**20131263.48**
Assisted Living Services	Day	1167	206.00	83.74	**20131263.48**	
				GRAND TOTAL:		31939628.96
				Total Estimated Unduplicated Participants:		12650
				Factor D (Divide total by number of participants):		2524.87
				Average Length of Stay on the Waiver:		272

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	Total Cost

					Cost	
Case Management Total:						**10321875.00**
Case Management Provider	15 minutes	9175	150.00	7.50	**10321875.00**	
Health Care Component of Adult Day Health Care Total:						**1375105.20**
Health Care Component of Adult Day Health Care	Hour	105	1289.00	10.16	**1375105.20**	
Extended Medicaid State Plan Prescription Drugs Total:						**111385.28**
Extended Medicaid State Plan Prescription Drugs	Month	89	4.00	312.88	**111385.28**	
Assisted Living Services Total:						**20734672.50**
Assisted Living Services	Day	1167	206.00	86.25	**20734672.50**	

GRAND TOTAL:	**32543037.98**
Total Estimated Unduplicated Participants:	**12650**
Factor D (Divide total by number of participants):	**2572.57**
Average Length of Stay on the Waiver:	272