TOC REQUIRED

# 200.000 ARKANSAS COMMUNITY FIRST CHOICE GENERAL INFORMATION

The Arkansas Community First Choice (ACFC) program is a Medicaid State Plan option designed to make available home and community-based services and supports to eligible Medicaid beneficiaries so they may reside in the community, rather than in an institutional setting. The ACFC program offers an array of services designed to meet needs, identified by a functional assessment, of beneficiaries. Certified Division of Developmental Disabilities Services (DDS) and Division of Aging and Adult Services (DAAS) ACFC providers must provide services according to a person-centered service plan. The provider must provide services only in a setting which adheres to the Home and Community Based Settings characteristics described at 42 C.F.R. §441.530. The DAAS certifies providers who serve beneficiaries who are age 65 and older and adults aged 21 through 64 with physical disabilities. The DDS certifies providers who serve beneficiaries with intellectual and developmental disabilities.

The ACFC program operates under the authority of Section 1915(k), of the Social Security Act.

The ACFC program offers two service delivery models for the beneficiary to choose certain ACFC services. The two service delivery models are the agency-provider model and the self-directed model with service budget. The requirements of the self-directed with service budget service delivery model can be found beginning at Section 270.000.

## 201.000 Arkansas Medicaid Certification Requirements 01-01-15

All ACFC providers must meet the provider participation and enrollment requirements contained within Section 140.000 of this manual, as well as the following criteria, to be eligible to participate in the Arkansas Medicaid Program:

To enroll as an ACFC provider, an organization must be certified by the appropriate Arkansas Department of Human Services (DHS) certifying Division as having met all U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) approved, population-specific, provider criteria for the service(s) it wishes to provide to ACFC-eligible beneficiaries.

All Medicaid enrolled providers are responsible for maintaining updates to their provider files with the Medicaid fiscal agent's Provider Enrollment Unit by submitting current certification and/or license, all certification renewals and any other renewals or changes affecting their status as a Medicaid-eligible provider.

Potential providers must make application to the appropriate certifying Division to become certified to provide ACFC services to eligible beneficiaries. Potential providers must satisfy requirements such as:

1. Being licensed to do business in the State of Arkansas.
2. Having Articles of Incorporation on file with the Arkansas Secretary of State.
3. Complying with requirements for criminal background checks and Abuse Registry checks.
4. Having written policy and procedures which satisfy requirements of the certifying Division.
5. Having written descriptions of the services they wish to provide, the types of beneficiaries they wish to serve and the Arkansas counties in which they wish to provide services.

## 201.100 DAAS - Arkansas Medicaid Certification Requirements 01-01-15

The DAAS is the certifying Division for providers who serve adults aged 21 through 64 with physical disabilities, and adults aged 65 and older who are eligible for nursing home admission

at the intermediate institutional level of care. Potential providers should contact the DAAS Provider Certification for information on the DAAS certification process. **View or print the DAAS Provider Certification contact information.**

Certification by the DAAS is one of several prerequisites to enrollment as a Medicaid provider and does not guarantee participation in the Medicaid program**.** Specific provider qualifications for the services offered through ACFC are found in Section 250.000 of this manual along with the service definitions.

### 201.200 DDS - Arkansas Medicaid Certification Requirements 01-01-15

The DDS is the certifying Division for providers who serve beneficiaries of all ages who have a qualifying intellectual and/or developmental disability and who meet the intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care. Potential providers should contact the DDS Quality Assurance Unit staff for information on the DDS certification standards and process. **View or print the DDS Quality Assurance Unit contact information.**

The provider must submit of a copy of the ACFC certification to the Medicaid fiscal agent's Provider Enrollment Unit in order to maintain a current Medicaid Provider number for each service indicated on the DDS ACFC certificate.

Potential providers may find the DDS application form and a complete listing of requirements at **http://humanservices.arkansas.gov/ddds/Pages/WaiverServiceProviders.aspx**.

Upon obtaining certification as a DDS Provider of ACFC, the provider is qualified to provide the services designated on their application. Specific provider qualifications are found with service descriptions in Section 270.000 of this manual.

### 201.205 DDS - Annual On-Site Certification Review Requirements 01-01-15

DDS ACFC Providers must comply with DDS "Certification Standards for Home and Community-Based Services & Supports". **http://humanservices.arkansas.gov/ddds/ddds_docs/Certification%20Standards%20for%20ACS%20Waiver%20Services.pdf**. These standards are incorporated herein by reference. DDS Providers must undergo an annual on-site certification review by the DDS Certification and Licensure unit and must successfully comply with standards in order to be awarded an annual certification from DDS.

Providers must comply with standards specific to each service they wish to provide. The DDS certification will specify each service for which the provider has successfully met standards requirements. The DDS on-site review will include a review of the provider's compliance with standards regarding only the following services: Attendant Services and Supports, Supportive Living, Non-Medical Transportation, Relief Care, Community Transition, Crisis Intervention and Positive Behavior Supports.

## 202.000 Provider Assurances 01-01-15

### 202.100 DAAS - Provider Assurances 01-01-15

A. Staffing

The provider agrees to maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries who chose that provider of ACFC services.

The provider agrees:

2. To train personnel responsible for direct service delivery on all applicable licensure and certification requirements. The provider agrees to require personnel to participate in training mandated by, the DHS. The provider acknowledges the cost of training courses

for certification and/or licensure is not directly reimbursable through DHS but is a cost of doing business.

3. Each direct service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.
4. Each direct service worker is required to complete orientation training prior to allowing the employee to deliver any ACFC service(s). This orientation shall include, but not be limited to, a:
    a. description of the purpose and philosophy of the ACFC State plan option.
    b. discussion and distribution of the provider agency's written code of ethics.
    c. discussion of activities which shall and shall not be performed by the employee.
    d. discussion, including instructions, regarding ACFC record keeping requirements.
    e. discussion of the importance of the person-centered service plan.
    f. discussion of the agency's procedure for reporting changes in the beneficiary's condition.
    g. discussion, including potential legal ramifications, of the beneficiary's right to confidentiality.

B. Code of Ethics

The provider agrees to develop, distribute and enforce a written code of ethics with each employee providing services to an ACFC individual that shall include, but not be limited to, the following:

1. No consumption of the beneficiary's food or drink.
2. No use of the beneficiary's telephone for personal calls.
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary.
4. No acceptance of gifts or tips from the beneficiary or his/her caregiver or representative.
5. No friends or relatives of the employee or unauthorized beneficiaries are to accompany the employee to the beneficiary's home.
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery, nor in the beneficiary's home.
7. No smoking in the beneficiary's home.
8. No solicitation of money or goods from the beneficiary.
9. No breach of the beneficiary's privacy or confidentiality of records.

## 203.000 Providers in Bordering and Non-Bordering States 01-01-15

ACFC services are limited to Arkansas and bordering state trade area cities. The trade-area cities are limited to Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee; and Texarkana, Texas.

All providers must be licensed or certified by their states' appropriate licensing or certifying authorities. Copies of all appropriate licenses and certifications must be submitted to the appropriate certifying Division as documentation of certification as an ACFC provider.

Arkansas Medicaid does not provide Arkansas Community First Choice services in non-bordering

### 204.000 Organized Health Care Delivery System 01-01-15

Arkansas DHS has established the Organized Health Care Delivery System (OHCDS) option under 42 C.F.R. §447.10 (b) for ACFC program providers. Providers must agree in writing to guarantee that the services of an OHCDS sub-contractor will comply with Medicaid regulations. OHCDS providers assume all liability for non-compliance with any requirement contained in the sub-contract.

To be eligible to utilize OHCDS, providers must provide at least one ACFC service directly utilizing its own employees. OHCDS providers must have a duly executed written sub-contract that specifies the services, the time frames in which the services must be provided and completed, and stipulates that the service be satisfactory to the beneficiary. Enrolled providers must ensure and be responsible for financial accountability. They must ensure that services were delivered and must maintain proper documentation that the service was delivered under OHCDS.

Upon application to the certifying Division, providers must indicate which services they wish to provide utilizing OHCDS.

## 210.000 PROGRAM COVERAGE 01-01-15

### 211.000 Scope 01-01-15

The Arkansas Medical Assistance (Medicaid) Program through the ACFC program offers certain home and community-based services and supports to eligible beneficiaries. These services are offered as an alternative to institutionalization for beneficiaries who are eligible for medical assistance under the State Plan and who have been determined to meet the requirements for an intermediate institutional level of care in a nursing facility or an intermediate care facility for beneficiaries with intellectual disabilities (ICF/IID).

ACFC services must be provided in settings determined by the appropriate Division to be a community-based setting as defined in 42 C.F.R. 441.530. Services may not be provided to inpatients of nursing facilities, ICF/IIDs, hospitals, institutions for mental disease, or other inpatient institutions, except in those cases where in-facility relief care is allowed per the plan of care.

### 212.000 Eligibility for the Arkansas Community First Choice Program 01-01-15

ACFC is not a Medicaid eligibility category; it is a benefit option for a beneficiary already categorically eligible for the Arkansas Medicaid State Plan, as described below, who meet all the criteria for the ACFC program.

A. To qualify for the ACFC program, an individual must meet the following requirements:

   A. Be eligible for medical assistance under the State Plan and

   B. Be in an eligibility group under the State plan:

      1. That includes nursing facility services ICF/IIDs, hospitals, or institutions for mental disease; or

      2. If in an eligibility group under the State plan that does not include such services described under B1, have an income that is at or below 150 percent of the Federal poverty level (FPL); and

   C. Be determined annually to meet the institutional level of care (LOC) requirements.

      1. The annual LOC redetermination requirement may be waived if it is, determined, based on established criteria, there is no reasonable expectation of improvement or

significant change in the individual's condition because of the severity of their chronic condition or their degree of impairment or functional capacity.

2. If qualifying for medical assistance under the DDS Home and Community Based Waiver or the DAAS Aging and Physical Disability Access to Homecare Waiver 1915(c) special eligibility group, the individual must continue to meet all waiver requirements and receive at least one waiver service per month to receive services through ACFC.

## 213.000 Determination of Level of Care 01-01-15

### 213.100 DAAS Determination of Level of Care and Functional Need 01-01-15

The DAAS functional assessment process will apply to: beneficiaries ages 21 through 64 who have a physical disability, or beneficiaries ages 65 and older., who request ACFC services through the State plan but are not participating in a 1915(c) waiver

A. Beneficiaries who request ACFC services will be assessed by a DAAS RN using the standardized assessment tool.

B. Each DAAS RN is a licensed registered nurse, employed by the DHS.

C. The completed assessment is forwarded to the Division of Medical Services (DMS), Office of Long Term Care (OLTC) for final determination of the beneficiary's level of care and medical need. The determination is based on the comprehensive assessment performed by the DAAS RN, using standard criteria for functional disability in evaluating an beneficiary's need for nursing home placement in the absence of community alternatives. The level of care determination, in accordance with nursing home admission criteria, must be completed and the beneficiary deemed eligible for an intermediate level of care by a licensed medical professional prior to receiving ACFC services. The results of the level of care determination are documented on the DHS-704.

D. The DAAS RN performs the comprehensive assessment at least annually, unless waived under established criteria. DAAS may reassess an beneficiary's level of care and/or need any time it is deemed appropriate by the DAAS RN to ensure that an beneficiary is appropriately placed in the Community First Choice program and is receiving services suitable to his or her needs.

E. The Office of Long Term Care re-determines institutional level of care annually, unless annual redetermination is waived as explained in 212.000.

### 213.200 DDS Determination of Level of Care 01-01-15

Based on intellectual and behavioral assessment submitted by the provider, the ICF/IID level of care determination is performed by the Division of Developmental Disabilities. The ICF/IID level of care criteria provides an objective and consistent method for evaluating the need for institutional placement in the absence of community alternatives. The level of care determination must be completed and the beneficiary deemed eligible for ICF/IID level of care prior to receiving ACFC services.

Recertification, based on intellectual and behavioral assessments submitted by the provider at appropriate age milestones, will be performed by DDS to determine the beneficiary's continuing need for an ICF/MR level of care.

The annual level of care determination is made by a QMRP (physician).

## 220.000 PERSON-CENTERED SERVICE PLAN

### 221.100 DAAS Person-Centered Service Plan Development Process and Requirements 01-01-15

For the purposes of this manual with regard to the person-centered service **plan** development process, decision-making, self-direction and beneficiary rights, the term "beneficiary" will mean the beneficiary or their legal representative who is authorized to participate in the person-centered service plan development process or self-direction process on the beneficiary's behalf. The beneficiary may choose to appoint an individual to act as their representative.

A. For those eligible beneficiaries who choose not to enroll in a HCBS waiver program, the person-centered service plan development process will be available through the State Plan targeted case management program. The targeted case manager will develop the person-centered service plan with ACFC services along with any other services and supports.

B. Each beneficiary in the ACFC program must have a person-centered service plan developed by the DAAS RN. The person-centered service plan development process is driven by the beneficiary and must be characterized by the following:

1. Includes people chosen by the beneficiary;
2. Provides necessary information and support to ensure that the beneficiary directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
3. Is timely and occurs at times and locations of convenience to the beneficiary;
4. Reflects cultural considerations of the beneficiary;
5. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
6. Offers choices to the individual beneficiary regarding the services and supports he or she receives and from a provider of the beneficiary's choice;
7. Includes a method for the beneficiary to request updates to the plan; and
8. Records which alternative home and community-based settings were presented to and considered by the beneficiary.

The person-centered service plan must reflect the services and supports that are required for the beneficiary to meet the needs identified through the assessment of functional need, as well as reflect what is important to the beneficiary with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the beneficiary, and the scope of services and supports available under ACFC, the plan must:

A. Reflect that the setting in which the beneficiary resides is chosen by the beneficiary;

B. Reflect the beneficiary's strengths and preferences;

C. Reflect clinical and support needs as identified through an assessment of functional need;

D. Include individually identified goals and desired outcomes;

E. Reflect the services and supports (paid and unpaid) that will assist the beneficiary to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports cannot supplant needed paid services called for in the person-centered service plan unless the natural supports are unpaid supports that are provided voluntarily to the beneficiary in lieu of the services of a paid direct service worker;

F. Reflect risk factors and measures in place to minimize them, including individualized backup plans;

G. Communicate in a manner that is understandable to the beneficiary receiving services and supports, and the individuals integral in supporting him or her;

H. Identify the individual and entity responsible for monitoring the plan;

I. Be finalized and agreed to in writing by the beneficiary and signed by all individuals and providers responsible for its implementation;

J. Be distributed to the beneficiary and chosen provider(s) involved in the service plan delivery;

K. Prevent the provision of unnecessary or inappropriate care; and

L. Incorporate the person-centered service plan requirements for the self-directed model with service budget, when applicable.

M. Document that any modification of the additional conditions must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
   1. Identify a specific and individualized assessed need.
   2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
   3. Document less intrusive methods of meeting the need that have been tried but did not work.
   4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
   5. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
   6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
   7. Include informed consent of the individual; and
   8. Include an assurance that the interventions and supports will cause no harm to the individual.

The person-centered service plan must be reviewed, and revised upon reassessment of functional need, at least every 12 months, and also when the beneficiary's circumstances or needs change significantly, and at the request of the beneficiary.

## 221.200 DDS Person-Centered Service Plan Development Process and Requirements 01-01-15

**Person-Centered Plan Development Meeting Participants**

A. The case manager shall schedule person-centered service plan development meetings at a time and place that is acceptable to the person.

B. The case management Organization shall ensure that the following participants are present at the person-centered service plan meeting:

   1. The case manager,
   2. The person,
   3. Any other person invited by the person, and
   4. A representative from the direct service provider

C. The case manager may include the following persons in the person-centered service plan development meetings if the person does not object:

   1. Professionals who might assist with generic resources,

2. Professionals who conducted assessments or evaluations,
3. DDS staff, and
4. Friends and persons who support the person.

D. The case manager shall ensure that, if the person objects to the presence of any person, that person may not attend the meeting.

**Person-Centered Plan Development Meeting Process**

A. The case manager must assure that the team addresses certain issues during the person-centered plan development meeting and that the issues are incorporated in the person-centered service plan as necessary. The team must address and document the person's:

1. Strengths and clinical and support needs,
2. Abilities and preferences,
3. Cultural background,
4. Barriers,
5. Least restrictive or most appropriate environment in which to live and work, and
6. Desired goals and outcomes.

B. The case manager must provide necessary information and support to the person to ensure that they direct the process to the maximum extent possible.

C. The case manager must ensure that the team addresses health and behavioral risks as well as, risks to personal safety, either real or perceived and known or potential. The team must address and document:

1. Each identified risk and mitigation strategies which are designed to respect the needs and preferences of the person,
2. Who will be responsible for the ongoing monitoring of risk and risk management strategies,
3. How the monitoring will occur,
4. How key staff will be trained regarding the risks,
5. How the team will analyze, at least quarterly, the effectiveness of the strategies,
6. How the person negotiates the trade-offs between the choices they make as they exercise their right to choice and the risks to their safety that may result.

D. The case manager must ensure that the person is informed of and exercises their rights to make choices about each aspect of the services and supports that are available to them.

E. The case manager must ensure that each member of the team is aware that they are responsible for supporting and encouraging the person to express their wants and desires and to then incorporate those into the plan.

F. The case manager must ensure that the plan is developed so that the person may receive services while remaining as much as possible in contact with persons who do not have disabilities, may engage in community life and may control their personal resources.

G. The case manager must ensure that the plan is developed so that the person may receive services and supports in a manner and setting that is appropriate to their age, abilities and life goals, and includes persons who are important in supporting that person and who may provide unpaid supports to them.

H. The case manager must ensure that the team discussion is held in a manner that is understandable to the person and that the person understands their role in achieving their plan goals.

I. The case manager has responsibility for facilitating the meeting and establishing how the meeting will be conducted. The case manager must:
   1. Set clear guidelines regarding the timeframes for the meeting,
   2. Set the tone of the meeting by conducting themselves in a professional and impartial manner,
   3. Set guidelines for reaching agreement, such as voting to reach a majority or to reach a consensus,
   4. Ask each participant to declare any potential conflict of interest they may have,
   5. Conduct the meeting in a manner so as to reflect what is important to the person to ensure delivery of service in a way that reflects the personal preferences of the person while ensuring their health and welfare,
   6. Be sensitive to how the person reacts to the presence of others and mitigate the situation if they appear to:
      a) Be anxious about repercussions about voicing problems, or
      b) Have a tendency to defer to a service provider, and
   7. Inform each participant how they may make complaints or express concerns to DDS.

J. The case manager must, if any member of the team declares a possible conflict of interest, secure the agreement of all team members to waive the conflict or to ask the member to excuse themselves if the team does not agree to waive the conflict.

**Time Frames**

A. The case manager must, within five business days of the person-centered planning meeting, commit the plan to writing, utilizing a system mandated by the State.

B. The case manager must ensure that the person-centered service plan is finalized and agreed to, with the informed consent of the person in writing, and signed, either electronically or manually, by all individuals and all providers responsible for its implementation.

C. The case manager must ensure that the plan is distributed to the person and other people involved in the plan.

**Annual Person-Centered Service Plan Review**

A. Annually, the case manager and the direct service provider must conduct a review and analysis of the person's progress in accomplishing the goals and objectives contained in the person-centered service plan and develop a new plan. In order to adequately review progress, the case manager and the direct service provider should review and consider, at a minimum, the:
   1. Quarterly progress reports,
   2. A functional assessment, current within 30 days, and
   3. Verbal or written comments from the plan implementers and the person.

B. The case manager must re-convene the team and initiate the process described in 1305 through 1308.

Additional information regarding the person-centered service plan is found in the DDS "Certification Standards for Home and Community-Based Services and Supports" manual.

## 222.000 Conflict of Interest Standards 01-01-15

The State assures that conflict of interest standards for the independent standardized assessment and development of the person-centered service plan applies to all individuals and entities, both public and private. The State will ensure that the individuals conducting the independent standardized assessment and person-centered service plan are not:

A. Related by blood or marriage to the beneficiary, or to any paid caregiver of the beneficiary;

B. Financially responsible for the beneficiary;

C. Empowered to make financial or health-related decisions on behalf of the beneficiary; or

D. Individuals who would benefit financially from the provision of services to meet assessed needs.

### 222.100 DDS - Conflict of Interest Standards 01-01-15

In addition to the standards listed above, DDS has additional conflict of interest standards described below:

Providers of ACFC services-may not develop the person-centered service plan for the individual unless conflict of interest provisions have been devised which include separation of person-centered service planning and provider functions within the provider entity. In such cases, the beneficiary must be provided with a clear and accessible alternative dispute resolution process to ensure conflict of interest standards are met, as required by the Federal regulations governing the ACFC Program.

Providers who are certified by DDS must adhere to the conflict of interest standards described in the DDS Certification Standards for Home and Community Based Services and Supports.

## 230.000 BENEFICIARY RIGHTS

### 231.000 Beneficiary Rights 01-01-15

A. Providers must ensure that they afford the following rights to all beneficiaries they serve:

1. The right of the beneficiary to have maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record. The beneficiary determines the level of self-direction they want to have;

2. The right of the beneficiary to drive the person-centered planning process by having a central role in both the planning process and in finalizing the person-centered service plan;

3. The right of the beneficiary to expect providers of either service delivery model and those representing the provider to treat the beneficiary and his or her property with respectThe right of the beneficiary to have anyone they choose to be present when assessments and person-centered service plans are developed;

4. The right of the beneficiary to choose the services they want from the services available, based on the functional needs assessment, and to refuse services they do not want without fear of losing benefits

5. Should the person-centered service plan be developed separate from the assessment for functional need, that it is the right of the beneficiary to expect the meeting to be scheduled at a time and place that is convenient to all parties taking part in the process , but particularly to the beneficiary;

6. The right of the beneficiary to disagree with the findings of the assessment or the proposed person-centered service plan. The beneficiary can disagree at any time during the process. The beneficiary does not have to sign the person-centered service plan and retains the right to appeal the service plan.

7. The right of the beneficiary to choose who provides the beneficiary's services from the providers available in the beneficiary's area and be informed which services have an option in service delivery models;

8. The right of the beneficiary to receive a copy of the service plan with the name of the provider and phone number;

9. The right of the beneficiary to be fully informed regarding any consequences of refusing recommended services before making a decision;

10. The right of the beneficiary to privacy and confidentiality regarding their health, social and financial circumstances and about what takes place in their home;

11. The right of the beneficiary to have all communications and records treated confidentially with no information released without their written permission;

12. The right of the beneficiary to request and receive information from a provider regarding policies, including information on qualifications and supervision of personnel, hours of operation, discontinuation of services, how to request a grievance hearing about care or treatment, and how to request a new caregiver;

13. The right of the beneficiary to be afforded with clear instructions informing how to appeal any adverse decision, including discontinuation of a service or reduction in services;

14. The right of the beneficiary to have an interpreter provided by DAAS or DDA,, if needed;

15. For beneficiaries aged 18 and older the right to contact the Adult Protective Services' Adult Abuse Hotline at 1-800-482-8049 if they believe that they have been abused, neglected or exploited;

16. For beneficiaries younger than 18, the right to contact the Child Protective Services' Child Abuse Hotline at 1-800-482-5964 if they believe that they have been abused, neglected or exploited;

17. The beneficiary has the right in either service delivery model to train the direct care worker in the specific areas of supports they need, and to have the direct care staff perform the needed assistance in a manner that comports with their personal, cultural, and religious preferences;

18. The beneficiary has the right to establish additional staff qualifications beyond those required by the Provider but required based on the beneficiary's individual needs and preferences; and

B. Providers certified by DDS must ensure the rights listed in the DDS Certification Standards for Home and Community Based Services and Supports.

## 240.000 DOCUMENTATION REQUIREMENTS

### 241.000 Documentation Requirements 01-01-15

A. Providers of ACFC services must create and maintain written or electronic records for each ACFC beneficiary served.

B. Providers who utilize electronic data systems such as telephony, computer or other electronic devices to capture data, must ensure that the system collects and records data that assigns a unique identifier such as a Personal Identification Number (PIN) to each employee which is indexed to that employee's name and title.

1. The unique identifier will serve as an electronic signature for that employee during data input. The data system must be able to record the date and time of service delivery, the specific service delivered, and the employee who delivered the service.

2. The data system must be able to produce viewable or printable records or reports for review and audit purposes.

C. In addition to the required enrollment documentation, which is detailed in Section I, Subsection 142.300 the provider must maintain the following in the individual's case file:

1. The person-centered service plan;
2. A brief description of the specific service(s) provided;
3. The date and actual time during which the service(s) was provided;
4. The activities conducted, outcomes and recommendations (if appropriate);
5. The signature and title of the individual providing the service(s).
    a. For records created through an electronic data system such as telephony, computer or other electronic devices, a unique identifier such as a PIN number assigned to and entered by the employee at the time of data input may suffice as an electronic signature.
6. A copy of the prescription for any good or service that is covered by Medicaid and furnished by the provider for which a prescription is required by law, by Medicaid rule, or both.
    a. The self-directed with service budget (SDSB) requires the following to develop the budget for goods and services:
        i. During the development of the person centered service plan the HCBS RN or a case manager in working with a beneficiary identifies a need that helps sustain current functional ability, increases an individual's independence by substituting for human assistance. The RN or case manager determines an annual amount available to the beneficiary to meet the identified needs;
        ii. DAAS staff are informed and create a prior authorization to meet the identified need payable to the SDSB FMS provider;
    b. When there are needs for additional goods and services to support independence the Targeted Case Manager or the SDSB Counseling Support provider can make additional requests to DAAS. Approval is required by DDS or DAAS.
    c. The payment of goods and services by the SDSB Financial Management Services (FMS) provider's payment of goods and services for those in the SDSB service delivery model requires:
        i. The FMS provider will pay goods and services based on an invoice from a retailer or from receipts provided by the employer and per authorized budget
        ii. All single purchases above $50 must be authorized by a designee from DHS. The FMS provider will make payment and is reimbursed through a prior authorization keyed by DAAS and authorized for payment by DAAS, DDS, or DBHS.
        iii. The FMS provider must maintain all supporting documentation relative to the payment which includes but is not limited to:
            1. Name and address of the service provider
            2. Description of the purchase
            3. Scanned documents from DAAS supporting authorization from DHS
            4. Receipt, invoice, or purchase order and total payment amount
            5. Medicaid ICN linked to the prior authorization
            6. Documentation supporting annual refunds to Arkansas Medicaid if prior authorization for goods and services is greater than the annual purchased services

7. The FMS provider must report monthly on the number of individuals purchasing goods and services, the amount expended, and by categories defined by DAAS.
8. The FMS provider will be held liable for repayment should any supporting documentation not be available during a review by state and federal representatives.

D. Providers certified by DDS must maintain additional documentation required in DDS Certifications Standards for Home and Community Based Services and Supports.

### 242.000 Record Availability 01-01-15

A. Upon request, the provider must make records created or maintained by the provider available to: authorized representatives of the Arkansas DMS; DAAS or DDS; the state Medicaid Fraud Control Unit; the Office of Medicaid Inspector General; representatives of the DHS, and its authorized agents or officials; and, representatives of CMS.

1. All documentation must be available at the provider's place of business.

2. When written records are stored off-premise or are in active use, the provider may certify in writing that the records in question are in active use or in off-premise storage and set a date and hour within three working days of the request, at which time the records must be made available.

3. The provider may not request delays based on matters of convenience, including availability of personnel.

### 243.000 Retention of Records 01-01-15

Each provider must retain all records for five (5) years from the date of service or until all audit questions or review issues, appeal hearings, investigations or administrative or judicial litigation to which the records may relate are finally concluded, whichever period is later. Failure to furnish medical records upon request may result in sanctions being imposed. Federal legislation further requires that any accounting of private healthcare information (PHI) or Health Insurance Portability and Accountability Act of 1996 (HIPAA) polices or complaints must be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.

### 244.000 Penalties 01-01-15

A. Failure on the part of the provider to maintain sufficient documentation to support billing practices may result in recoupment of Medicaid payment made to the provider.

B. Failure on the part of the provider to furnish records upon request may result in sanctions being imposed on the provider.

### 245.000 Electronic Signatures 01-01-15

Medicaid will accept electronic signatures that comply with Arkansas Code Ann. §25-31-103.

## 250.000 DESCRIPTION OF SERVICES

### 251.000 Service Descriptions – General Information 01-01-15

ACFC offers an array of services that are designed to enable beneficiaries to live in a community based setting. Services include those that provide assistance with activities of daily living (ADLs), such as eating, bathing, dressing, and personal hygiene; as well as those services that

aid in the acquisition, maintenance, and enhancement of skills that are necessary to accomplish ADLs, IADLS and health-related tasks. Other services are designed to ensure continuity of services and supports such as Positive Behavioral Supports, Relief Care and Consultation. Community Transition provides funds to cover costs associated with moving from an institution into the community. Other services provide funds that allow for expenditures for items or services that increase independence or substitute for human assistance, thereby allowing the beneficiary to function unassisted. A complete list of the services and their descriptions follows.

### 252.000 Attendant Services and Supports 01-01-15

Attendant services and supports consists of assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, and cueing.

A. Hands-on assistance, supervision, cueing and other types of assistance are defined below.

1. Cueing and/or reassurance - means giving verbal or visual clues and encouragement during the activity to help the beneficiary complete activities without hands-on assistance.
2. Hands-on assistance - means a another person physically performs all or part of an activity because the beneficiary is unable to do so.
3. Monitoring - a form of supervision, means a another person must observe the beneficiary to determine if intervention is needed.
4. Redirection - a form of supervision or cueing, means to divert the beneficiary to another more appropriate activity.
5. Set-up - a form of hands on assistance, means getting personal effects, supplies, or equipment ready so that an beneficiary can perform an activity.
6. Stand-by - a form of supervision, means a another person must be at the side of an beneficiary ready to step in and take over the task should the beneficiary be unable to complete the task independently.
7. Supervision - means a another person must be near the beneficiary to observe how the beneficiary is completing a task.
8. Support - a form of supervision, means to enhance the environment to enable the beneficiary to be as independent as possible.
9. Memory care support - a blend of supervision, cueing and hands-on assistance, Includes services related to observing behaviors, supervision, and intervening as appropriate in order to safeguard the service recipient against injury, hazard or accident. These specific supports are designed to support beneficiaries with cognitive impairments.

B. Activities of daily living:

1. Eating
2. Bathing
3. Dressing
4. Personal hygiene (grooming, shampooing, shaving, skin care, oral care, etc.)
5. Toileting
6. Mobility/ambulating, including mastering the use of adaptive aids and equipment

C. Instrumental activities of daily living:

1. Meal planning and preparation
2. Managing finances
3. Laundry

4. Shopping and errands
5. Communication
6. Traveling and participation in the community
7. Light housekeeping
8. Chore services
9. Assistance with medications (to the extent permitted by the Nurse Practice Act

Attendant services and supports may include Homemaker/Chore services that consist of general household tasks and are intended to ensure that the beneficiary's home is safe and allows for independent living. Examples of "general household tasks" may include meal preparation, routine household care, laundry, etc. These services must be incidental to other attendant services and supports and may not exceed 20% of total service time provided.

The provision of ADLs and IADLs does not entail nursing care.

D. Health-Related Tasks:

Health-related tasks are tasks beyond activities of daily living that are delegated or assigned by a licensed medical professional. Arkansas recognizes two types:

1. Consumer Directed Care (assigned by licensed medical professional): All health maintenance activities (to include oral medication administration/assistance, shallow suctioning, catheterization, oxygen supplementation, maintenance and use of intral-feeding and breathing apparatus /device), except injections and IV's, can be done in the home by a designated care aide. With the exception of injectable medication administration, tasks that beneficiaries would otherwise do for themselves, or have a family member do, can be performed by a paid designated care aide at their direction, as long as the criteria (numbers 1 through 5 below), specified in the Arkansas Nurse Practices Consumer Directed Care Act has been met:

   a. The task is being performed in the client's home, not in a nursing facility, assisted living facility, residential care facility, intermediate care facility, or hospice facility.
   b. A competent adult, or caretaker of a child or incompetent adult, has authorized the aide to perform the task;
   c. The aide has adequately demonstrated to the competent adult or caretaker that the aide can safely perform the task;
   d. The attending physician, advanced practice nurse or registered nurse has determined a designated care aide under the direction of the competent adult or caretaker can safely perform the activity in the child or adult's home; and
   e. The task is not among those exceptions stated above.

2. Delegated Nursing Services and Consultation (delegated by licensed medical professional). The state will reimburse nursing services to support health related tasks within the state's Nurse Practice Act. These services include nurse delegation. They do not include direct nursing care. "Delegation" means that a licensed nurse authorizes an unlicensed person to perform a task of nursing care in selected situations and indicates that authorization in writing and pursuant to other criteria promulgated by the State Board of Nursing (ASBN Rules, Chapter 5, Delegation). The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed person and reevaluating the task at regular intervals." These services are designed to assist the beneficiary and care

provider in maximizing the beneficiary's health status and ability to function at the highest possible level of independence in the least restrictive setting.

Services include:

Evaluation and identification of supports that minimize health risks, while promoting the beneficiary's autonomy and self-management of healthcare; Medication reviews; assist in monitoring safety and well-being and to address needed changes to the person-centered service plan; and Delegation of nursing tasks, within the requirements of Arkansas' nurse practice act, to an beneficiary's caregivers so that caregivers can safely perform health related tasks.

**Benefit Limit:**

DAAS : One unit of service is equal to 1 hour.

DDS: Benefit limits do not apply to bundled episode services.

## 252.100 Provider Qualifications - Attendant Services and Supports 01-01-15

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| **DAAS** | *Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency and certified by DAAS to provide ACFC Attendant Services and Supports |
| | *Licensed by the Arkansas Department of Health as a private care agency enrolled as an Arkansas Medicaid Personal Care Provider and certified by DAAS to provide ACFC Attendant Services and Supports |
| | *Licensed by the Arkansas Department of Human Services, Office of Long Term Care as an Adult Day Care agency and certified by DAAS to provide ACFC Attendant Services and Supports |
| | *Licensed by the Arkansas Department of Human Services, Office of Long Term Care as an Adult Day Health Care agency and certified by DAAS to provide ACFC Attendant Services and Supports |
| **DDS** | Certified by DDS as an ACFC provider of Attendant Services and Supports |
| | Licensed Provider of Center-Based Community Services |

Providers denoted with an asterisk (*****) are required to recertify with DAAS every three years; Annually, providers must submit to DAAS a copy of the agency's current license upon receipt.

All other providers must be recertified annually by the appropriate certifying Division.

## 253.000 Chore Services 01-01-15

Chore services are services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe access and egress; and yard and sidewalk maintenance. Chore services are provided only in extreme circumstances when lack of these services would make the home uninhabitable. Yard and sidewalk maintenance does not include routine lawn mowing, trimming, raking or mulching leaves for aesthetic purposes.

Chore services must be provided according to the person-centered service plan.

**Benefit Limit:**

DAAS: One (1) unit of service equals 15 minutes. Chore services are limited to a maximum of 80 units (20 hours) per month.

DDS: Benefit limits do not apply to bundled episode services.

### 253.100 Provider Qualifications –Chore Services 01-01-15

Providers must be certified by DDS to provide at least one of the following ACFC services; Attendant Services and Supports, Supportive Living, Non-Medical Transportation, Relief Care, community Transition, Crisis Intervention or Positive Behavioral Supports. Providers may use that certification to provide this service to beneficiaries with developmental disabilities as defined in DDS Policy 1035.

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| **DAAS** | *Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency and certified by DAAS to provide ACFC Chore Services |
| **DDS** | DDS Certification as an ACFC Chore provider of Chore Services |

Providers denoted with an asterisk (*****) are required to recertify with DAAS every three years; Annually, providers must submit to DAAS a copy of the agency's current license upon receipt.

All other providers must be recertified annually by the appropriate certifying Division.

### 254.000 Supportive Living Services 01-01-15

Supportive Living services are an array of individually tailored services and activities to enable beneficiaries to reside successfully in the community. Services include functional skills training, coaching, prompting or other means to enable the beneficiary to acquire, maintain, or enhance skills necessary to accomplish ADLs, IADLs or health related tasks. Services will be specifically tied to the assessed needs and person-centered service plan and are a means to increase independence, preserve functioning, and reduce dependency of the service recipient. These services can be provided integrally with the performance of ADLs, IADLs, and health related tasks as described in the earlier section. Assistance may entail hands-on assistance, supervision and/or cueing, as defined above.

Supportive Living includes:

A. Decision making - an essential element in performing ADLs such as eating, bathing, dressing, personal hygiene activities and toileting as well as IADLs such as meal planning, finances, laundry, shopping, and traveling in the community. It includes the identification of and response to dangerously threatening situations, making decisions and choices affecting the beneficiary's life and initiating changes in living arrangement or life activities;

B. Money management - an essential element in performing IADLs such as meal planning, managing finances, shopping, and traveling and participation in the community. It includes handling personal finances, making purchases and meeting personal financial obligations;

C. Socialization - an essential element in performing IADLs such as shopping and errands, communication and traveling and participation in the community. It includes participation in general community activities, and includes establishing and maintaining relationships with peers and other significant persons in the beneficiary's life.

D. Community integration experiences - an essential element in performing IADLs such as include activities intended to instruct the beneficiary in community living skills in a clinic and integrated settings. Included are such activities as shopping, church attendance, sports, participation in clubs, etc. Community experiences include activities and supports to accomplish individual goals or learning areas including recreation and specific training or leisure activities. Each activity is then adapted according to the beneficiary's individual needs.

E. Communication - an essential element in all ADLs and IADLs. It includes training in vocabulary building, use of augmentative communication devices, receptive and expressive language;

F. Behavior shaping and management - an essential element in implementing behavior management plans and in ADLs such as eating, dressing and toileting and IADLs such as communication and participation in the community. It is an essential element for the health and safety of beneficiaries who exhibit inappropriate behaviors and require a behavior management plan. It includes developing appropriate expressions of emotions or desires, compliance, assertiveness, acquisition of socially appropriate behaviors or reduction of inappropriate behaviors;

G. Reinforcement of therapeutic services - an essential element in performing all ADLs, and IADLs such as communication, participation in the community, housekeeping, shopping and errands. It consists of conducting exercises or otherwise reinforcing physical, occupational, speech and other therapeutic services, including range of motion exercises, to the extent permitted by state scope of practice laws. The success of therapy is contingent upon reinforcement of related tasks in the beneficiary's day-to-day activities and routines.

H. Employment Supports - an essential element in performing IADLs such as communication and participation in the community and ADLs such as bathing, dressing, personal hygiene and toileting. It increases the possibility for the beneficiary to become fully integrated into the community as a valued member of the workforce. It includes supports that enable the beneficiary to acquire, retain or improve skills that directly affect the beneficiary's ability to work and live in the community as independently as possible. Activities may include but not be limited to assistance getting ready for work, including personal hygiene, packing lunch etc.; help with ADLs and IADLs, and health-related needs in the workplace including hand-on assistance and cueing, help with transportation to work and job interviews, coaching on use of public transportation, cueing to help beneficiaries manage behaviors and symptoms while in the workplace, cueing to help beneficiaries stay focused on employment tasks, shopping for work clothing.

I. Appropriate use of leisure time and exercise are included based on needs identified in the functional assessment. These are critical to the health and welfare of a beneficiary. For example, beneficiaries who are overweight or obese experience health risks. Those risks pose challenges to performing many or all ADLs and IADLs.

J. Motor skills - an essential element in performing all ADLs and IADLs such meal preparation, shopping, communication participation in the community and housekeeping.

K. Cognitive skills - an essential element in performing all ADLs and IADLs.

L. Communication - an IADL essential to all ADLs and IADLs.

M. Community nursing services are also in this category of services. Community nurses, within the scope of the state's Nurse Practice Act requirements, assist beneficiaries in the acquisition, maintenance, and enhancement of skills necessary for the beneficiary to accomplish health related tasks.

Supportive Living services must be provided according to the person-centered service plan.

**Benefit Limit:**

DAAS: One (1) unit of service equals 1 hour.

DDS: Benefit limits do not apply to bundled episode services.

## 254.100 Provider Requirements – Supportive Living 01-01-15

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| **DAAS** | *Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency and certified by DAAS to provide ACFC Supportive |

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| | Living |
| | *Licensed by the Arkansas Department of Health as a private care agency enrolled as an Arkansas Medicaid Personal Care Provider and certified by DAAS to provide ACFC Supportive Living |
| | *Licensed by the Arkansas Department of Human Services, Office of Long Term Care as an Adult Day Care agency and certified by DAAS to provide ACFC Supportive Living |
| | *Licensed by the Arkansas Department of Human Services, Office of Long Term Care as an Adult Day Health Care agency and certified by DAAS to provide ACFC Supportive Living |
| **DDS** | Certified by DDS as an ACFC provider of Supportive Living |
| | Licensed Provider of Center-Based Community Services |

Providers denoted with an asterisk (*****) are required to recertify with DAAS every three years; Annually, providers must submit to DAAS a copy of the agency's current license upon receipt.

All other providers must be recertified annually by the appropriate certifying Division.

## 255.000 PERS – Personal Emergency Response System 01-01-15

Personal Emergency Response System (PERS) is a 24-hour support system with a two-way verbal electronic communication, with a battery backup and an emergency control/response center. PERS includes an electronic device that enables certain beneficiaries at high risk of institutionalization to secure help in the event of a physical, emotional, or environmental emergency. The beneficiary may also wear a portable waterproof "help" button to allow for mobility. For beneficiaries with limited or no hand function, PERS devices may include hands-free or voice-activated devices. The system is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein.

For beneficiaries with limited or no hand function, PERS devices may include hands-free or voice activated devices. Allowable items under this service may also include a cellular telephone, other cellular devices, and cellular service when a conventional PERS system is not feasible.

Included in this support are assessment, purchase, installation, maintenance (such as replacing batteries or charger cords) and monthly rental fee.

The goals of the personal emergency response system are:

A. To provide a high-risk beneficiary with the security and assurance of immediate assistance in an emergency, making it possible for them to remain in their home.

B. To eliminate the need for costly in-home supervision provided by a paid attendant that also affords the beneficiary the emotional satisfaction of independent living.

PERS services are limited to those beneficiaries who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision to protect their safety. Beneficiaries receiving PERS services must be physically and mentally capable of utilizing the service. .

PERS providers must contact each beneficiary receiving the service at least once per month to test the system's operation. The provider shall maintain a log of test calls that includes the date and time of the test, specific test results, corrective actions and outcomes.

The provider must ensure that a log of all service recipient calls received must be maintained by the emergency response center. The log must reflect the date, time and nature of the call and the response initiated by the center. All calls must be documented in the beneficiary's record.

PERS may only be offered when the need for the service has been identified through a functional assessment.

PERS services must be provided according to the person-centered service plan.

**Benefit Limit:**

DAAS: One (1) unit of service equals one (1) day. PERS is limited to a maximum of thirty-one (31) units per month. PERS installation is limited to one install per eligibility segment per lifetime.

DDS: Benefit limits do not apply to bundled episode services.

### 255.100 Provider Qualifications – Personal Emergency Response System 01-01-15

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| **DAAS** | Alarm or Security Company - Provider must possess Certificate of Compliance for Protective Signaling Services issued by the Underwriters Laboratories Safety Standards, and be certified by DAAS as a provider of PERS |
| **DDS** | Certified ACFC Provider of Assistive Technology and Adaptive Equipment Services |

All PERS providers must recertify annually with the appropriate certifying Division.

### 256.000 Relief Care Services 01-01-15

Relief Care is a service designed to provide temporary, short-term support to a beneficiary who has an assessed need for support and whose non-paid or paid caregiver is absent or is in need of relief from their care giving duties. The service is designed to meet an emergency need or to provide scheduled relief periods for the regular paid or non-paid caregiver.

The beneficiary's multi-disciplinary care team assists with identifying a regularly-scheduled relief care provider as part of the person-centered service plan or identifies back-up providers or care setting alternatives as part of the person-centered service plan in case the beneficiary's primary attendant(s) or supportive living worker becomes ill or is suddenly no longer available or is otherwise in need of relief. Providers may utilize 24 hour, community-based care settings if they are unable to locate an in-home worker to meet immediate care needs.

Relief Care services must be provided according to the person-centered service plan.

**Benefit Limit:**

DAAS: One (1) unit of service equals 1 hour. Eligible beneficiaries may receive up to 24 units of relief care per date of service. For the state fiscal year (SFY), July 1 through June 30 each year, eligible beneficiaries may receive up to 1200 units of relief care.

DDS: Benefit limits do not apply to bundled episode services.

### 256.100 Provider Qualifications – Relief Care Services 01-01-15

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| **DAAS** | *Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency and certified by DAAS to provide ACFC |

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| | Relief Care |
| | *Licensed by the DHS Office of Long-Term Care as a Residential Care Facility, and certified by DAAS to provide ACFC Relief Care |
| | *Licensed by the DHS Office of Long-Term Care as a Level I or Level II Assisted Living Facility, and certified by DAAS to provide ACFC Relief Care |
| | *Licensed by the Arkansas Department of Human Services, Office of Long Term Care as an Adult Day Care agency and certified by DAAS to provide ACFC Relief Care |
| | *Licensed by the Arkansas Department of Human Services, Office of Long Term Care as an Adult Day Health Care agency and certified by DAAS to provide ACFC Relief Care |
| | Certified by DAAS as an Adult Family Home provider eligible to provide ACFC Relief Care |
| | *Licensed as hospital and certified by DAAS to provide ACFC Relief Care (in-facility). |
| | *Licensed by the DHS Office of Long-Term Care as a nursing facility and certified by DAAS to provide ACFC Relief Care (in-facility). |
| | *Licensed Residential Care Facility by the Arkansas Department of Human Services, Office of Long Term Care as s a Residential Care Facility and certified by DAAS to provide ACFC Relief Care |
| **DDS** | Certified by DDS as an ACFC provider of Relief Care. |

Providers denoted with an asterisk (*****) are required to recertify with DAAS every three years; Annually, providers must submit to DAAS a copy of the agency's current license upon receipt.

All other providers must be recertified annually by the appropriate certifying Division.

## 257.000 Consultation Services 01-01-15

Consultation may be in the form of Risk Management Plans and Crisis Intervention. It may also be in the form of training or support. Crisis Intervention may be provided as a Consultation service or it may be offered directly by the provider as a service, as described in Section 230.500 below.

The person-centered service plan identifies the individual or organization that will provide backup supports in the form of consultation, training, or support to the beneficiary, family members, and service providers. The services are indirect and include, but are not limited to such services as:

A. Training direct services staff or family members in carrying out the person-centered service plan.

B. Providing information and assistance to individuals responsible for developing the person-centered service plan.

C. Designing a behavior management plan to be followed by staff and family members.

   1. Providers who are certified by DDS must adhere to the requirements in DDS Standards which describe the essential elements of the plan, who is qualified to write the plan and who is qualified to implement the plan.

D. Training staff or family members in de-escalation techniques that are developed as part of a behavior management plan.

E. Designing special meal plans, as identified in the person-centered service plan.

F. Assisting with exercise regimens , as identified in the person-centered service plan.

G. Training the beneficiary, family or staff to address special medical conditions, as identified in the person-centered service plan.

H. Determining the need for and assisting in the selection of assistive technology and environmental modifications,, as identified in the person-centered service plan.

I. Training or assisting in the set up and use of assistive technology and environmental and home modifications, as identified in the person-centered service plan.

J. Training regarding self-advocacy, as identified in the person-centered service plan.

**Benefit Limit:**

DAAS: The maximum annual amount for this service is $2,000.00, not to exceed 24 units per day, unit = 1 hour.

DDS: Benefit limits do not apply to bundled episode services

## 257.100 Provider Qualifications – Consultation Services 01-01-15

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| **DAAS** | *Licensed by the Arkansas Department of Health as a Class A or Class B Home Health Agency and certified by DAAS to provide ACFC Consultation Services. |
| | Certification by DAAS as an Attendant Care Provider.<br><br>*Licensed by the Arkansas Department of Health as a Private Care Agency and enrolled as an Arkansas Medicaid Personal Care Provider and certified by DAAS to provide attendant care services.<br><br>Certified by DAAS as an Adult Family Home provider. |
| | *Licensed by the Arkansas Department of Human Services, Office of Long Term Care as an Adult Day Care agency and certified by DAAS to provide ACFC Consultation Services. |
| | *Licensed by the Arkansas Department of Human Services, Office of Long Term Care as an Adult Day Health Care agency and certified by DAAS to provide ACFC Consultation Services. |
| **DDS** | Certified by DDS as an ACFC provider of Consultation Services |

Providers denoted with an asterisk (*****) are required to recertify with DAAS every three years; Annually, providers must submit to DAAS a copy of the agency's current license upon receipt.

All other providers must be recertified annually by the appropriate certifying Division.

## 258.000 Crisis Intervention 01-01-15

Crisis Intervention is a backup support that offers immediate, short-term help to beneficiaries who experience an event that produces emotional, mental, physical, or behavioral distress or problems. A number of events or circumstances can be considered a crisis, including, but not limited to:

A. Life-threatening situations, such as natural disasters, power outages, sexual assault or other criminal victimization

B. Medical illness

C. Mental illness

D. Cognitive impairment

E. Behavioral issues

F. Income/financial issues

G. Safety/cleanliness of a residence

H. Loss of natural supports

I. Poor access to services

J. Thoughts of suicide or homicide

K. Loss or drastic changes in relationships

The service is provided as a nonscheduled emergency intervention. Activities include, but are not limited to:

A. Assessing the situation and the beneficiary's response to the situation,

B. Making contact with the beneficiary receiving services and beginning to establish a collaborative relationship with that beneficiary,

C. Identifying dangers, problems, or crisis triggers,

D. Educating the beneficiary about alternative responses and new coping strategies, as established in a written behavior management plan,

E. Restoring positive functioning through implementation of the person-centered service plan,

F. Planning to follow-up to avoid further crises.

**Benefit Limit:**

DAAS: The maximum annual amount for this service is $2000.00, not to exceed 24 units per day, unit = 1 hour.

DDS: Benefit limits do not apply to bundled episode services.

### 258.100 Provider Qualification - Crisis Intervention 01-01-15

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| **DAAS** | Certified by DAAS as an ACFC provider of Crisis Intervention. |
| **DDS** | Certified by DDS as an ACFC provider of Crisis Intervention. |

Providers must be recertified annually be the appropriate certifying Division.

### 259.000 Positive Behavioral Support Services 01-01-15

Positive Behavioral Support Services are provided to assist beneficiaries with behavioral challenges due to their disability, that prevent them from accomplishing ADLs, IADLs, and health related tasks. Positive Behavior Support Services include coaching and support of positive behaviors, behavior modification and intervention supports to allow beneficiaries to develop, maintain and enhance skills to accomplish ADLs, IADLs and health related tasks. The need for these services is determined through a functional needs assessment and the beneficiary's goals as identified in the person-centered planning process. Positive Behavioral Support Services may also include consultation to the care provider on how to mitigate behavior that may place the beneficiary's health and safety at risk and prevent institutionalization.

Services may be implemented in the home or community, based on a beneficiary's assessed needs. All activities must be for the direct benefit of the Medicaid beneficiary.

Positive Behavioral Support Service providers must work with the beneficiary and, if applicable, the caregiver or other key persons, to assess the environmental, social, and interpersonal factors influencing the beneficiary's behaviors.

The provider will develop, in collaboration with the beneficiary and if applicable, caregivers, to develop a behavior management plan.

Providers who are certified by DDS must adhere to the requirements in DDS Standards which describe the essential elements of a behavior management plan, who is qualified to write the plan and who is qualified to implement the plan.

These services do not include rehabilitation or treatment of mental health conditions. The provision of this service will not supplant the provision of personal attendant services that are based on the beneficiary's assessed needs that are identified in the person-centered service plan. Services must be provided according to processes directed by best practice.

**Benefit Limit:**

DAAS: The maximum annual amount for this service is $2000.00, not to exceed 24 units per day, unit = 1 hour (

DDS: Benefit limits do not apply to bundled episode services

### 259.100 Provider Qualifications –Positive Behavior Support Services 01-01-15

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|---|---|
| **DAAS** | Certified by DAAS as an ACFC provider of Positive Behavior Support Services |
| **DDS** | Certified by DDS as an ACFC provider of Positive Behavior Support Services. |

Positive Behavior Support Services providers must be recertified annually by the appropriate certifying Division.

### 260.000 Community Transition Services 01-01-15

Community Transition Services are non-recurring, set-up expenses linked to an assessed need for beneficiaries who are transitioning from a nursing facility, institution for mental disease, or ICF/IID to a home and community-based setting where the beneficiary is directly responsible for their own living expenses.

Providers may utilize this service for up to 90 days prior to the day the beneficiary is discharged from the institution and moves into the community. Either the beneficiary's Targeted Case Manager or Waiver Case Manager is responsible for maintaining documentation of reasonable expectation that the beneficiary will transition to the community within the 90 day period.

A. Allowable expenses are those which do not constitute room and board, and are necessary to enable an beneficiary to establish a basic household and may include:
   1. Security deposits that are required to obtain a lease on an apartment or home;
   2. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
   3. First month's rent;
   4. First month's utilities;
   5. Moving expenses;
   6. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
   7. Services necessary for the beneficiary's health and safety, such as one-time cleaning prior to occupancy.

B. Necessary home accessibility adaptations. Community Transition Services are furnished only to the extent:

1. Expenditures are reasonable and necessary, as determined through the person-centered service plan development process;
2. Services are clearly identified in the person-centered service plan;
3. Beneficiaries are unable to meet such expense; or
4. Services cannot be obtained from any other source.

C. Exclusions – Community Transition Services may not include payment for:

1. Room and board, except for the first month's rent;
2. Monthly rental or mortgage expense;
3. Regular utility charges, except for the first month's utilities;
4. Food;
5. Household appliances or items that are intended purely for diversional or recreational purposes (e.g., televisions, cable TV access, or video players); or
6. Furnishing of living arrangements that are owned or leased by a Medicaid provider where the provision of these items and services are inherent to the service provided.

**Benefit Limit:**

DAAS: The maximum benefit is $5,000 per transition from nursing facility or ICF/IID; Lifetime maximum of $10,000. If MFP funds are available, they must be used first.

DDS: Benefit limits do not apply to bundled episode services.

Community Transition Services must be provided according to the person-centered service plan.

### 260.100 Provider Qualifications – Community Transition Services 01-01-15

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| **DAAS** | Certified by DAAS as an ACFC provider of Community Transition Services |
| **DDS** | Certified by DDS as an ACFC provider of Community Transition Services. |

Community Transition Services providers must be recertified annually by the appropriate certifying Division.

### 261.000 Non-Medical Transportation 01-01-15

Non-Medical Transportation services can be provided for eligible beneficiaries receiving ACFC services.

Non-Medical Transportation services are offered to enable ACFC beneficiaries to gain access to ACFC services and other community services, activities and resources, as specified by the person-centered service plan.

A. This service is offered in addition to non-emergency medical transportation services available under the State Plan, and does not replace those services. For example, transportation of an ACFC beneficiary to receive medical care that is provided under the State plan must be provided and billed as a State Plan non-emergency medical transportation service, and not a ACFC service.

B. Payment for ACFC Non-Medical Transportation services is limited to the costs of transportation needed to access ACFC services included in the beneficiary's person-centered service plan, or to access other activities and resources identified in the person-centered service plan.

C. ACFC Non-Medical Transportation covers only the part of the trip in which the ACFC beneficiary is a passenger in the provider's non-medical transportation vehicle and is being transported between the home and community-based setting(s) where services, activities or resources identified in the person-centered service plan will be delivered. Non-Medical Transportation does not cover costs for a provider alone to drive to and from the beneficiary's home or the community-based setting.

D. If more than one ACFC beneficiary is transported at the same time to the same location in the same vehicle, the Non-Medical Transportation provider should pro-rate the mileage amount of non-medical transportation services between the beneficiaries.

E. The route taken when transporting the beneficiaries must be reasonable.

F. Providers billing for ACFC Non-Medical Transportation are required to keep written documentation of records to support the services furnished, as follows:
   1. Provider's name and identification number;
   2. Date and time of each pickup and delivery;
   3. Vehicle description, including vehicle identification number and license plate number;
   4. Driver's name;
   5. Attendant's name, if applicable;
   6. Odometer reading and total mileage;
   7. Names of all beneficiaries transported; and
   8. Medicaid identification number of each beneficiary.

G. The provider or the owner of the vehicle must maintain appropriate insurance and registration.

H. The provider must ensure that all vehicles owned or operated by the organization are maintained according to manufacturer's recommendations.

I. The provider must ensure that transportation services shall be provided by personnel or contractors in a safe manner consistent with the regulations of the local authorities.

J. The provider must ensure that vehicles equipped for transporting a passenger who remains in a wheelchair must be equipped with permanently installed floor wheelchair restraints for each wheelchair position.

K. The provider must ensure that each driver completes a safety checklist prior to each trip. The checklist must include at least:
   1. Fire extinguisher,
   2. First Aid kit,
   3. Tire pressure, and
   4. Properly operating lights and windshield wipers.

L. The provider must ensure that, in the event of an accident that occurs during working hours, the provider will conduct or obtain a chemical test or test of the driver's blood, breath, or urine for the purpose of determining the alcohol or drug content of the applicant's blood, breath or urine.

M. Providers who are certified by DDS must adhere to any and all requirements for Transportation Services contained in the DDS Standards for Home and Community Based Services and Supports.

Non-Medical Transportation Services must be provided according to the person-centered service plan.

### 261.100 Provider Qualifications – Non-Medical Transportation 01-01-15

All certified providers of Community Transition Services, Attendant Services and Supports, Supportive Living, Relief Care Services, Consultation Services/Crisis Intervention Services and Positive Behavioral Supports Services can provide Non-Medical Transportation if the provider meets transportation standards listed above.

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| **DAAS** | Certified by DAAS as an ACFC provider of Non-Medical Transportation Services. |
| **DDS** | Certified by DDS as an ACFC provider of Non-Medical Transportation Services |

Non-Medical Transportation Services providers must be recertified annually by the appropriate certifying Division.

## 262.000 Environmental Modifications 01-01-15

Environmental Modifications are physical adaptations to the beneficiary's private residence, that are necessary to ensure the health, welfare, and safety of the beneficiary, or enable the beneficiary to function with greater independence in the home.

A. Environmental modifications may be provided through ACFC only if such adaptations are related to an identified need in the beneficiary's person-centered service plan, and:
   1. Increase the beneficiary's independence; or
   2. Substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

B. Such adaptations include, but are not limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the beneficiary.

C. Those adaptations or improvements to the beneficiary's private residence that are of general utility, and are not of direct medical or remedial benefit to the beneficiary are excluded.

D. Adaptations that add to the total square footage of the home are excluded from this service except when necessary to complete an adaptation such as improving entrance into the residence or to configure a bathroom to accommodate a wheelchair.

E. Adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of ACFC services.

F. Providers who make adaptations to the private residence of an beneficiary during the time that beneficiary is in transition, the provider may not bill for that adaptation until the date the beneficiary leaves the institution and returns to the community to participate in ACFC.

G. The case management provider must secure three itemized bids for the same service. The provider supplying the lowest bid for comparable service must be used. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be maintained. The case management provider must maintain copies of the bids for review.

Environmental Modifications Services must be provided according to the person-centered service plan.

**Benefit Limit:**

DAAS: A beneficiary's annual expenditure for environmental modifications cannot exceed $7,700.00 per year. If the beneficiary is also receiving assistive technology/adaptive equipment services and vehicle modifications, the combined total cannot exceed $7,700.00.

DDS: Benefit limits do not apply to bundled episode services.

## 262.100 Provider Qualifications – Environmental Modifications 01-01-15

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| **DAAS** | Builder, Tradesman or Contractor certified by DAAS as an ACFC provider of Environmental Modifications Services. The provider must be licensed (where applicable) as appropriate for the environmental modifications. Proof of a plumber or electrician's license must be provided prior to performing electrical or plumbing work. |
| **DDS** | Certified by DDS as an ACFC Provider of Environmental Modification Services |

Environmental Modifications providers must be recertified annually by the appropriate certifying Division.

## 263.000 Specialized Medical Supplies 01-01-15

A. Specialized medical supplies and equipment may be provided through ACFC only if such items are related to an identified need in the beneficiary's person-centered service plan; and are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design and installation. Specialized Medical Supplies must:
   1. Increase the beneficiary's independence; or
   2. Substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

B. Specialized medical supplies and medical equipment covered under ACFC include:
   1. Specialized medical supplies and equipment as available under the State Plan;
   2. Items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items;
   3. Such other durable and non-durable medical equipment not otherwise available under the State plan that is necessary to address beneficiary functional limitations;
   4. Necessary medical supplies not otherwise available under the State Plan.

      **NOTE:** Items reimbursed with ACFC funds are in addition to any medical supplies and equipment furnished under the State Plan. When an beneficiary has exhausted the benefit limit and any extensions of benefits under the State Plan for specific medical supplies and equipment, ACFC funds may be used to provide for such items, provided the criteria specified in A are met. A denial of extension of benefits by Utilization Review will be required prior to approval.

C. A physician must order all specialized medical supplies and equipment for which the unit cost exceeds $500.00.

D. All items shall meet applicable standards of manufacture, design and installation.

E. Additional items covered by ACFC include:
   1. Nutritional supplements;
   2. Non-prescription medications. Alternative medicines not Federal Drug Administration approved are excluded from coverage;
   3. Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under the State plan are exhausted.

Specialized Medical Supplies must be provided according to the person-centered service plan.

**Benefit Limit:**

DAAS: A beneficiary's annual expenditure for specialized medical supplies cannot exceed $1,000.00 per person per year.

DDS: Benefit limits do not apply to bundled episode services.

### 263.100 Provider Qualifications – Specialized Medical Supplies 01-01-15

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| **DAAS** | Durable medical equipment/oxygen, orthotic appliances or prosthetic device providers. Providers must meet qualifications as defined in Section II of the Prosthetics Provider Manual, 201.000. Durable Medical Equipment, Prosthetics, Orthotics and Medical Suppliers must be enrolled in the Title XVII (Medicare) Program as a durable medical equipment/oxygen, orthotic appliances or prosthetic device provider. |
| **DDS** | Certified by DDS as an ACFC Specialized Medical Supplies Services provider. |

Specialized Medical Supplies providers must recertify annually with the appropriate certifying Division.

### 264.000 Assistive Technology/Adaptive Equipment 01-01-15

Assistive Technology/Adaptive Equipment is an item, piece of equipment, product system, hardware or software, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities of the beneficiary, in accordance with assessed functional need and the person-centered service plan. This includes devices, controls and appliances that will enable beneficiaries to perceive, control or communicate with the environment in which they live, and to perform daily life tasks that would not be possible otherwise.

A. Assistive technology/adaptive equipment may be provided through ACFC only if such items are related to an identified need in the beneficiary's person-centered service plan, and:
   1. Increase the beneficiary's independence; or
   2. Substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

B. Assistive technology/adaptive equipment encompasses a broad range of devices from "low tech" (e.g., pencil grips, adaptive spoons, paper stabilizers) to "high tech" (e.g., computers, voice synthesizers, braille readers, vehicle modifications).

C. The service includes:
   1. Evaluating the technology needs of the beneficiary, including a functional evaluation in the beneficiary's customary environment;
   2. Purchasing, leasing, or otherwise providing for the acquisition of the assistive technology device/adaptive equipment;
   3. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices/adaptive equipment;
   4. Training or providing technical assistance to the beneficiary or beneficiary's family, where appropriate;
   5. Training or providing technical assistance to professionals, employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the beneficiary's life.

D. A physician must order all assistive technology/adaptive equipment for which the unit cost exceeds $100.00.

E. All assistive technology/adaptive equipment must be intended solely for the beneficiary and used only by the beneficiary.

F. Educational aids and therapeutic tools that therapists employ in the course of therapy are not included.

G. Monitoring/Surveillance/Video-Telecommunication Equipment.

H. Medication Monitoring Device.

Assistive Technology/Adaptive Equipment services must be provided according to the person-centered service plan.

**Benefit Limit:**

DAAS: A beneficiary's annual expenditure for assistive technology and adaptive equipment cannot exceed $7,700.00 per person per year. If the beneficiary is also receiving environmental modification services and vehicle modification, the COMBINED total cannot exceed $7,700.00.

DDS: Benefit limits do not apply to bundled episode services.

### 264.100 Provider Qualifications – Assistive Technology/Adaptive Equipment 01-01-15

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| **DAAS** | Be licensed (where applicable) as appropriate for the environmental accessibility adaptation/adaptive equipment provided, and certified by DAAS as a provider of Assistive Technology/Adaptive Equipment. |
| **DDS** | Certified by DDS as an ACFC provider of assistive technology/adaptive equipment services. |

Assistive Technology/Adaptive Equipment providers must be recertified annually by the appropriate certifying Division.

### 265.000 Vehicle Modifications 01-01-15

Vehicle modifications are adaptations to an automobile or van, owned by the beneficiary or the beneficiary's legal representative, to accommodate the special needs of the beneficiary. Vehicle modifications must be specified in the person-centered service plan as necessary to increase the independence of the beneficiary, to enable the beneficiary to integrate more fully into the community, and to ensure the health, welfare and safety of the beneficiary.

A. Payment for permanent modification of a vehicle is based on the cost of parts and labor, which must be quoted and paid separately from the purchase price of the vehicle to which the modifications are or will be made.

B. Transfer of any part of the purchase price of a vehicle, including preparation and delivery, to the price of a modification is fraudulent activity.

C. Reimbursement for a permanent vehicle modification cannot be used or considered as down payment for a vehicle.

D. The provider may use these funds to replace permanent vehicle modifications if the vehicle is stolen, damaged beyond repair (as long as the damage is not through negligence of the vehicle owner), or used for more than its reasonable useful lifetime.
   1. A vehicle has reached its reasonable useful lifetime when repairs are required to make the vehicle useable, and the cost of the repairs exceeds the fair market value of the vehicle in repaired condition.
   2. The provider must obtain three repair estimates from three qualified repairers.
   3. Vehicle value shall be determined by reference to sales listings for similar vehicles within a 200 mile radius of the beneficiary's home, and to listings in Dallas, Kansas City, Saint Louise, and Memphis.
   4. The provider must maintain documentation of bids and calculation of the value of the vehicle.

E. Sale or trade of a permanently modified vehicle by the beneficiary or the beneficiary's legal representative before the vehicle reaches its reasonable useful lifetime will preclude full replacement of the modification on any replacement vehicle.
   1. In this instance, the residual value of the vehicle modification will be calculated in considering approval of the replacement of the modification.
   2. Estimated residual value shall be determined by comparing the purchase price of the modified vehicle when acquired by the beneficiary or beneficiary's legal representative with the value of the modified vehicle at the time of sale or trade.
   3. Vehicle value (including modification) shall be determined as stated in D(3) above.
   4. EXAMPLE: A permanently modified vehicle purchased for $30,000 is sold with a value of $20,000 (66% residual value.) Since the beneficiary or the beneficiary's legal representative recovered 66% of the value of the permanent modification in the selling price, only 34% of the cost of parts and labor for modification to the replacement vehicle will be covered. If parts and labor for the modification of the replacement vehicle are $10,000, the amount covered by this service would be $3,400 (34%).

F. Exclusions – the following are specifically excluded:
   1. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the beneficiary;
   **2. Purchase, down payment or lease of a vehicle; or**
   3. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications.

Vehicle Modifications services must be provided according to the person-centered service plan and based on an assessed need.

**Benefit Limit:**

DAAS: A beneficiary's annual expenditure for vehicle modifications cannot exceed $7,700.00 per person per year. If the beneficiary is also receiving adaptive equipment services and environmental modification, the COMBINED total cannot exceed $7,700.00.

DDS: Benefit limits do not apply to bundled episode services.

### 265.100 Provider Qualifications – Vehicle Modifications 01-01-15

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| **DAAS** | Builder, Tradesman or Contractor certified by DAAS as an ACFC provider of Environmental Modifications Services. The provider must be licensed (where applicable) as appropriate for the environmental modifications. Proof of a plumber or electrician's license must be provided prior to performing electrical or plumbing work. |
| **DDS** | Certified by DDS as an ACFC Provider of Environmental Modifications Services provider. |

Vehicle Modifications providers must recertify annually with the appropriate certifying Division.

### 266.000 Home-Delivered Meals 01-01-15

Home-Delivered Meals services provide eligible beneficiaries one meal per day of nutritional content equal to 33 1/3 of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with the DAAS Nutrition Services Program Policy Number 206.

A. The goals of home-delivered meals are:

1. To facilitate beneficiary independence by allowing beneficiaries the choice to remain in their own homes rather than entering an institution;
2. To provide one daily nutritious meal (as defined above) to beneficiaries at risk of institutionalization;
3. To provide daily social contact to beneficiary to ensure the participant's safety and wellbeing.

B. Home-delivered meals under ACFC are allowed for beneficiaries:

   1. Who have an assessed need for meal preparation and shopping; and

   2. For whom the provision of a home-delivered meal is the most-cost effective method of ensuring a nutritionally adequate meal.

C. Home-delivered meals are provided either as hot home-delivered meals, or frozen home-delivered meals.

D. Home-delivered meals are must be provided according to the person-centered service plan.

E. The provider must assure that the beneficiary has adequate freezer storage prior to delivering frozen meals.

F. The provider must deliver the meals regardless of whether the meals are hot or frozen. The provider may not send meals to the beneficiary via the United States Postal Service or paid carriers such as FedEx or UPS.

**Benefit Limit:**

A. The maximum number of Home-Delivered Meals eligible for Medicaid reimbursement per month is one for each day of the month. This includes hot, frozen or a combination of the two. There is no separate benefit limit for frozen meals.

B. The maximum number of emergency meals per State Fiscal Year is four (4). This includes hot, frozen or a combination of the two.

C. Frozen Home-Delivered Meals may be provided daily to eligible beneficiaries. A maximum of seven meals may be delivered at one time unless the requirements below are met.
   1. The beneficiary has the means of storing 14 frozen meals (as verified by the case manager).

D. An ACFC beneficiary may not be provided with a Hot or Frozen Home-Delivered Meal on any day during which the individual receives more than five hours of in-home or facility-based Relief care services, or more than five hours of Adult Day Care, Adult Day Health Care, (Licensure mandates that providers of these services provide a meal or meals; therefore, a Home-Delivered Meal on these dates is a duplicative service and prohibited.)

## 266.100 Hot Home-Delivered Meals 01-01-15

Hot Home-Delivered Meal services provide one daily nutritious meal to eligible beneficiaries who are homebound. Homebound is defined as a person with normal inability to leave home without assistance (physical or mental) from another person; a person who is frail, homebound by reason of illness or incapacitating disability or otherwise isolated; or for whom leaving home requires considerable and taxing effort by the individual and absences from the home are infrequent, relatively short in duration or are attributable to the need to receive medical treatment.

Additionally, the beneficiary must:

A. Be unable to prepare some or all of his or her own meals, and

B. Have no other individual to prepare his or her own meals, and

C. Have the provision of the Home-Delivered Meals included on his or her plan of care

The provision of a Home-Delivered Meal is the most cost-effective method of ensuring a nutritiously adequate meal.

The Home-Delivered Meals provider must maintain a log sheet signed by the beneficiary each time a meal is delivered to document receipt of the meal.

Hot Home-Delivered Meals must be provided according to the beneficiary's written person-centered service plan.

### 266.200 Frozen Home Delivered Meals 01-01-15

Frozen Home-Delivered Meals service provides one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with DAAS Nutrition Services Program Policy Number 206.

The goal of the Frozen Home-Delivered Meals service is to supplement, not replace, the Hot Home-Delivered Meal service by providing one daily nutritious meal to homebound persons at risk of being institutionalized who:

A. Reside in remote areas where daily hot meals are not available,

B. Choose to receive a frozen meal rather than a hot meal or

C. Are at nutritional risk and are certified to receive a meal for use on weekends or holidays when the hot meal provider is not in operation.

Frozen Home-Delivered Meals must be documented on, and provided in accordance with, the ACFC person-centered service plan.

### 266.300 Combination of Hot and Frozen Home-Delivered Meals 01-01-15

Providers may provide a combination of hot and frozen meals to the beneficiary if indicated by the assessment and included in the person-centered service plan.

## 266.400 Provider Qualifications – Home-Delivered Meals 01-01-15

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| **DAAS** | Certified by DAAS as an ACFC provider of Home-Delivered Meals |
| **DDS** | Certified by DDS as an ACFC provider of Home Delivered Meals |

Home-Delivered Meal providers must be recertified every three years by the appropriate certifying Division. Providers must submit annual food establishment permit to certifying division.

To be certified as a provider of Home-Delivered Meals services, a provider must:

A. Be a nutrition services provider whose kitchen is approved by the Department of Health and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33-1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences, and comply with the Dietary Guidelines for Americans and DAAS Nutrition Services Program Policy Number 206;*

B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*

C. If applicable, assure that the provider's intermediate source of delivery meets or exceeds federal, state and local laws regarding food transportation and delivery;*

D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law;*

1. For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meals providers located in bordering states, all providers must meet their states' applicable laws and regulations.

E. Notify the DDS case manager or DAAS RN immediately if:
1. There is a problem with delivery of service;
2. The beneficiary is not consuming the meals;
3. A change in the beneficiary's condition is noted.

In addition to the criteria specified above, to be certified as a provider of Frozen Home-Delivered Meals services, a provider must:

A. Provide frozen meals that:
1. Were prepared or purchased according to the Department of Health and DAAS Nutrition Services Program Policy guidelines, in freezer-safe containers that can be reheated in the oven or microwave;
2. Are kept frozen from the time of preparation through placement in the beneficiary's freezer;
3. Have a remaining freezer life of at least three months from the date of delivery to the home;
4. Are part of a meal cycle of at least four weeks (i.e., four weeks of menus that differ).
5. Are properly labeled, listing food items included and non-frozen items that are delivered with the frozen components to complete the meal (which must include powdered or fluid milk, whichever is preferred by the ACFC beneficiary); menu analysis as required by DAAS Nutrition Services Program Policy if other than DAAS menus are used; and, both packaging and expiration dates.

6. The milk must be delivered to the beneficiary at least seven days prior to its expiration date.

B. Instruct each beneficiary, both in orally and in writing, in the handling and preparation required for frozen meals and provide written re-heating instructions with each meal, preferably in large print.

C. Ensure that meals that are not commercially prepared but produced on-site in the production kitchen:
   1. Are prepared and packaged only in a central kitchen or on-site preparation kitchen;
   2. Are prepared specifically to be frozen;
   3. Are frozen as quickly as possible;
   4. Are cooled to a temperature of below 40 degrees Fahrenheit within four hours;
   5. Have food temperatures taken and recorded at the end of food production, at the time of packaging and throughout the freezing process, with temperatures recorded and kept on file for audit;
   6. Are packaged in individual trays, properly sealed and labeled with the date, contents and instructions for storage and reheating;
   7. Are frozen in a manner that allows air circulation around each individual tray;
   8. Are kept frozen throughout the storage, transport and delivery to the individual; and
   9. Are discarded after 30 days.

D. Verify quarterly that all beneficiaries receiving Frozen Home-Delivered Meals continue to have the capacity to store and heat meals and are physically and mentally capable of performing simple associated tasks, unless other appropriate arrangements have been made and approved by DAAS or DDS. Any changes in the beneficiary's circumstances must be reported to the case manager.

## 267.000 Goods and Services 01-01-15

Providers may use funds from this service to purchase those items and services that help the beneficiary receive assistance that best meets his or her assessed needs and beneficiary preferences. The service supports the purchase of goods and services that lessen the need for human assistance while increasing the beneficiary's ability to maintain independence in the community. The expenditure must relate to a need identified on the beneficiary's person-centered service plan.

A. Goods and Services may be provided through ACFC only if such items and services are related to an identified need in the beneficiary's person-centered service plan, and
   1. Increases the beneficiary's independence i.e. encompassing purchasing of innovative goods and services to make assistance more effective or helping to sustain current functional ability or increases the individual's independence by preventing further decline;; or
   2. Substitutes or decreases the need for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

B. Following is a list of possible uses for goods and services:
   1. Safety devices;
   2. Education/training – excluding special education and related services provided under the Individuals with Disabilities Education Act (IDEA) that are related to education only, and vocational rehabilitation services provided under the Rehabilitation Act of 1973;
   3. Other items and services that directly address the assessed need of an beneficiary and increase independence or reduce the need for human assistance, to the extent expenditures would be made for human assistance.

Goods and Services must be provided according to the person-centered service plan.

**Benefit Limit:**

### 267.100 Provider Qualifications – Goods and Services 01-01-15

Providers must be certified by DDS or DAAS to provide at least one ACFC service.

## 270.000 SUPPORT SERVICES FOR THE SELF-DIRECTED SERVICE DELIVERY MODEL

### 271.000 DAAS Responsibilities 01-01-15

Arkansas Community First Choice providers contracted by DMS to provide Self-Directed with Service Budget (SDSB) Counseling Support Services and Financial Management Services (FMS) must meet acceptable performance measurements as reviewed and approved by DHS prior to contract release. DAAS is one of the DHS entities that will ensure that the ACFC SDSB service delivery model and its providers perform to meet contract and policy standards. In addition DAAS will ensure that the SDSB program operates within CMS intent when a state offers the self-directed service delivery model. DAAS will:

A. Monitor the SDSB providers who will hire counselors that can work one-on-one with an individual to fulfill employer and programmatic responsibilities to hire, train, supervise, and ensure, as the employer, the beneficiary possesses a readiness to ensure their assessed needs met. The employer will receive supports to the frequency necessary to be successful in the role as an employer. The counselors hired will come from vast backgrounds, but each will bring expertise and skills to serve all ACFC populations.

B. DAAS has set forth skills training requirements that each counselor will present to employers. Both DAAS and the contracted entity will ensure that all materials and presentation effectively conveys the philosophy of self-direction and completely meets the performance standards . The DAAS and the contracted entity will monitor how effectively the counselors present the training program. Each training session is electronically captured, followed by calls from the SDSB Counseling Support provider's call-center to review with the potential employer previous day skills training. Subsequent visits by the counselor start with previous employer materials covered. In addition to the centrally located management team each counselor reports to a regional manager.

C. Monitor performance standards to assure that counselors and fiscal agents are meet the terms of the contract;

D. Conduct on-site survey reviews of fiscal agents as needed, but no less than annually.

E. In addition to monitoring the contracts DAAS is responsible for managing referrals from representatives of DDS, DAAS, and DBHS of individuals who voice during the person-centered service (plan of care) a choice for the self-directed with service budget service delivery model. DAAS will monitor the SDSB Counseling Support provider's progress in meeting referral standards. DAAS is also responsible for creating and maintaining the flow of the Medicaid funds for SDSB services. DAAS performs weekly quality assurance checks to ensure SDSB funds stop with loss of Medicaid eligibility or nursing home placement.

### 272.000 Employer Responsibilities 01-01-15

A. Individuals designated as an employer accept the responsibilities to direct their care to ensure services authorized are received by their paid employee. If the beneficiary is unable to fulfill all responsibilities as an employer a legal guardian or appointed representative can fulfill the employer designation. Individuals who fail to fulfill employer responsibilities, after receiving documented skill services supports, by their SDSB counselor will be involuntarily disenrolled from the SDSB service delivery model. This is not considered an adverse action

as the agency provided model is available to support the assessed needs, but does not require the beneficiary to fulfill individual responsibilities of the SDSB service delivery model.

The SDSB service delivery model option is not an option that everyone will be successful with, but the option to try the SDSB service delivery option cannot be restricted, but is available to all populations. SDSB Counseling Support offers the supports necessary for one to succeed, but ultimately it is up to the employer to realize the success of directing one's care with the supports the service delivery model offers. Demonstrating the ability to fulfill employer and programmatic responsibilities from the skills training supports is a requirement of participation. It is not the responsibility of the SDSB Counseling Support entity to train the employee in the needed services, but is the responsibility of the designated employer.

### 273.000 Employer Authority 01-01-15

The ACFC beneficiary who participates in the Self-Directed with Service Budget service delivery model is the employer of record, as is the provider in the agency-provider model. The beneficiary has to ensure the needs of only one beneficiary are met and in doing so accepts the risks and responsibilities of self-direction. CMS refers to this as the "dignity of risk". As the employer, the beneficiary, establishes the job description, hires the employee, establishes work schedule, monitors performance and when necessary dismisses the employee. The beneficiary submits timesheet for services rendered to the SDSB FMS provider. The beneficiary, as the employer can hire family members, or any other individuals, to provide CFC services and supports identified in the person-centered service plan (of care), provided they meet the qualifications to provide the services and supports established by the individual, including additional training. The selected employee is:

A. A US citizen or legal alien with approval to work in the US;

B. Has a valid Social Security number;

C. Signs a Work Agreement with the beneficiary/representative;

D. Must be able to provide references if requested;

E. Submits to a criminal background check Arkansas' Adult Maltreatment Central Registry and Child Maltreatment Central Registry, and Medicaid and Medicare excluded provider lists and drug testing.

F. Obtains a Health Services card from the Department of Health, if requested;

G. May not be an individual who is considered legally responsible for the beneficiary, e.g., spouse, guardian, nor the authorized representative selected or appointed by the beneficiary to participate in the planning and direction of services and supports under ACFC;

H. Must be 18 years of age or older; and

I. Must be able to perform the essential job functions as determined and trained by the beneficiary.

The beneficiary understands employer and programmatic responsibilities and understands failure to uphold the required responsibilities can result in transition to the agency-provider service delivery model.

The beneficiary understands knowingly participating in any fraudulent activities will result in permanent exclusion from the self-directed service delivery model.

Repeated programmatic offenses of the self-directed service delivery model can also result in permanent exclusion from the self-directed service delivery model.

## 274.000 Counseling Support 01-01-15

A. Counseling support services is one of two required services the State provides to support ACFC beneficiaries in a self-directed service model with a service budget (SDSB). ACFC beneficiaries in the SDSB model have chosen to self-direct their attendant services and supports, supportive living, chore and/or respite care services, and purchase goods and services through their service plan budget. The SDSB Counseling Support provider will help beneficiaries who choose the self-directed service delivery model by meeting assurances of the contract directly related to the one-on-one in-the-home services that empowers individuals to be the employer and be in full control over home and community-based services and supports. Each individual who chooses the self-directed service delivery model must be able to fulfill employer and programmatic responsibilities.

## 274.100 SDSB Counseling Support Responsibilities 01-01-15

A. The SDSB Counseling Support provider is responsible for the following:

1. Accepting referrals from DAAS to assess needs and determine preferences for the SDSB service delivery model
2. Provide orientation and endorse beneficiary's ability to fulfill employer and programmatic responsibilities
3. Develop and monitor the Risk Assessment and Back-up Plan
4. Provide information and assistance while working with the proposed employer to develop or modify the person-centered self-directed service plan and spending plan
5. Provide support to advertise, select, train, and manage the employee and include the employee in additional training and skills building, if requested by employer
6. Monitor service delivery
7. Serve as a mandated reporter of incidents of abuse, neglect, and exploitation
8. Report suspected fraud
9. Coordinate with the SDSB FMS provider, DMS, DAAS, DDS, DBHS,
10. Inform DAAS of the initiation, pending, or termination of any SDSB services
11. Ensure continuity of services if termination is planned

B. The SDSB Counseling Support provider assists beneficiaries by:

1. Informing of the philosophy of participant-direction;
2. Informing of person-centered and directed planning;
3. Facilitating the beneficiary's independence and preferences;
4. Helping the beneficiary develop budget plans and ensure appropriate documentation; and
5. Informing of the resources available in the beneficiary's community and how to access them.

C. The counseling support system must be available to the beneficiary prior to enrollment in Community First Choice, and throughout the period of the beneficiary's enrollment. Counseling support services must:

1. Be accessible to the ACFC beneficiary who chooses the SDSB service delivery model;
2. Consist of regularly scheduled phone and in-person contacts with the beneficiary;

3. Inform the targeted case manager when there is a change in the beneficiary's health status;

D. The supports offered by the counselor to the beneficiary include the following activities:

1. Provide information on the range and scope of individual choices and options;
2. Inform the beneficiary about disenrollment during the initial counseling session;
3. Include information about preventing worker discrimination and violation of labor laws and regulations during the initial counseling session and on-going counseling sessions;
4. Provide information and assistance, skills training, counseling, as desired by the beneficiary, to assist by empowering the beneficiary to meet employer-related responsibilities, including management of workers and budgets and to help effectively manage the services and the service budget;
5. Assist the beneficiary to develop the service budget plan by involving family, friends and professionals as the beneficiary desires;
6. Assist the beneficiary to the degree requested to define the job description, post a help wanted ad, help write interview questions, participate in the interviews to secure providers of attendant services and supports, supportive living, chore and/or respite care needed by the beneficiary;
7. Provide skills training and supports to assist the beneficiary in managing his or her attendant services and supports, supportive living, chore and/or respite care services and service budget plan, including supports in training, how to hire the person(s) most suitable to the beneficiary, and how to discharge the worker(s) if necessary;
8. Provide support services so that the beneficiary is informed of:
    a. The specific dollar amount available for attendant services and supports, supportive living, chore, respite care and/or goods and services;
    b. How to adjust the service budget plan, if needed;
    c. Identify goods and services that increase independence or help sustain current functional ability that can substitute or decrease human assistance to the extent expenditures would otherwise be made for human assistance;
    d. How the beneficiary may request a fair hearing if a request for a service budget adjustment is denied or the amount of the service budget is reduced.
9. Provide additional skills training to the beneficiary prior to recommending that a beneficiary is unable to self-direct his or her attendant services and support;
10. Inform the traditional targeted case manager should a beneficiary's health condition change for the worse and if the beneficiary is the employer determine if the employer can continue in the role of the employer or if a representative is needed
11. Provide information on the risks and responsibilities of self-direction and assist the beneficiary to develop a Risk Assessment including a backup plan.

Counseling support is a contracted service and payment to the contracted provider is "per member per month." The service is an administrative function of the ACFC State plan option and is not deducted from the beneficiary's individual service budget. The established benefit limit is 12 months per state fiscal year.

### 274.200 Skills SDSB Training and Claim Submission 01-01-15

The counselor provides skills training covering multiple training sessions. The pace of the training sessions is determined by the skill level of the individual who fulfill employer responsibilities. Multiple training sessions may occur on the same date of service if the counselor keeps the beneficiary engaged in the skill training activities. All face-to face skills training will cover but is not limited to:

A. The initial skills training is arranged with the beneficiary's circle of support and

a. Provides an overview of the self-directed model

b. The philosophy of self-direction

c. Covers the risks and responsibilities of self-direction.

d. The beneficiary is informed that anticipation in SDSB service delivery model is voluntary and should the beneficiary choose to return to agency services the counselor will help coordinate that transition back to the referring agency.

e. The counselor will inquire how services are currently being met and ask if the beneficiary knows who they would like to hire.

f. If the beneficiary does know who they would like to hire a short discussion describes the FMS services and the requirements for criminal background checks and the coordination of a drug screen consent forms.

g. The counselor and the beneficiary will develop a job description and discuss authorized tasks.

h. If a potential employee is not known the counselor will offer assistance with developing a job description, placing an ad, interviewing and selecting an employee, and coordination with FMS provider to the degree requested by the beneficiary.

B. During the **second skills training** the counselor reviews skills training session 1 to determine the beneficiary's retention. This skills training will cover:

a. Developing the Risk Agreement to address and plan for emergency situations by:

i. Identifying who will serve as a back-up worker with non-emergency needs if the paid worker cannot arrive as scheduled.

ii. Document important phone numbers, hot lines for abuse, fraud, and neglect

iii. Address risk factors such as emergency contingent plan in the event of a natural disaster by describing:

a. Communication issues

b. Evacuation or environmental concerns

c. Living arrangements if living alone with little support from others.

iv. Finalize the job description and authorized tasks.

v. The counselor listens as the beneficiary describes:

a. Employee's duties

b. When services are needed

c. How the employee will train and supervise the employee

d. How the beneficiary will address the employee should requirements of the job not be performed

e. How the employee will be evaluated.

vi. The counselor explains Fair Labors Standards Act applicable to minimum wage and overtime and Department of Labor standards.

vii. The counselor informs of the consequences of not abiding by these employer responsibilities.

viii. The counselor and the beneficiary develop the SDSB person-centered service plan together and the budget.

ix. The counselor will explain that the FMS provider will finalize the preliminary budget with the appropriate tax rates.

x. The counselor must rate how well the beneficiary understood the skills training session.

C. During the **third skills training** the counselor reviews skills training sessions 1 and 2 to determine the beneficiary's retention and to observe and offer additional skills training to:

a. Listen as the beneficiary explains:

i. The tasks the employee will provide

ii. The time involved in relation to authorized hours

iii. How the beneficiary wants the tasks performed.

b. Discuss with the beneficiary:

i. How emergency information is shared;

ii. How the beneficiary will establish personal boundaries to avoid:

a. Borrowing or loaning money

b. Keeping valuables, including medications, in a safe place

c. Manipulative or abusive behaviors by recognizing and reporting abuse

iii. Describing and demonstrating timesheet requirements and bi-weekly payroll schedules

iv. Discuss fraud and the consequences of fraud

v. The counselor must rate how well the beneficiary understood the skills training session.

D. During the **fourth skills training** occurs after the beneficiary and employee have met to discuss the tasks the employee will provide. The beneficiary has self-declared their readiness to perform employer duties. The counselor reviews skills training sessions 1, 2, and 3 to determine the beneficiary's retention.

a. Counselor makes home visit within 3 days of being informed beneficiary has declared they are ready to fulfill employer responsibilities. DAAS is informed in writing to discontinue any duplicative services.

b. The counselor listens as the beneficiary will make employee aware that the timesheet must be maintained by the beneficiary and beneficiary must submit to the SDSB FMS provider

c. The counselor reviews with the beneficiary the beneficiary's readiness to assume employer duties.

d. The counselor listens as the beneficiary describes:

i. Tasks the employee will provide

ii. How and when services are delivered and received

iii. Submission of the timesheet and how to avoid fraud.

e. The counselor will summarize:

a. Flexibilities employer authority offers and the subsequent employer and program expectations

b. Responsibilities of each individual

c. Caution about fraud and consequences of fraud.

f. The counselor will inform the employee is a mandated reporter.

g. The counselor will observe the beneficiary convey to the employee

a. The authorized tasks to be performed

b. How time is entered on the timesheet, who controls the timesheet, and when the timesheet is submitted.

h. The individual affirms their readiness to perform these duties.

i. If the individual is employer ready the counselor and the beneficiary establish the date the employee may begin providing these services.

j. Should the beneficiary not be ready to fulfill these responsibilities the counselor will provide additional supports

The SDSB Counseling Support provider submits claims to the Arkansas Medicaid fiscal intermediary for documented training sessions. The SDSB Counseling Support provider will submit claims as either Initial New Employer Orientation using procedure code Z3045 or New Employer Orientation using procedure code Z3046. Initial New Employer Orientation represents all of the training sessions relative to the first employer designation of pending SDSB beneficiaries. Active employers or a change in employer designation receive New Employer Orientation instead of Initial New Employer Orientation.

The SDSB Counseling Support provider submits claims for Z3045 or Z3046 prior to the employer designation. Should employer designation not occur the SDSB Counseling Support provider will adjust the earlier paid claims for Z3045 or Z3046 and resubmit the claims using procedure code Z3044 SDSB Information and Assistance Inactive.

The SDSB Counseling Support provider may not provide more than 20 fifteen increments of Z3045 or Z3046 per date of service. Training may not continue when a beneficiary is no longer absorbing the information presented by the counselor. Z3044 is also limited to 20 fifteen increments per date of service. All three services are payable only in the beneficiary's home unless DAAS and the beneficiary give permission for training to occur in an alternate location.

The SDSB Counseling Support provider will make initial contact with the beneficiary within 3 calendar days of the referral. A status of the referral is required within 60 calendar days and can be extended to 80 calendar days with a written request to DAAS. The SDSB Counseling Support provider provides daily written updates on the status of pending referrals designated employer status.

The ratio established counselor to participant is set at 1:50 per caseload. A caseload is defined as no more than 50 beneficiaries per month. Supervisors must reside within the region supervised.

## 274.400 SDSB Frequency Based Home Monitoring Post Employer Designation 01-01-15

In the first six months post employer designation the SDSB Counseling Support provider is required to make home monitoring visits to the degree necessary to ensure the beneficiary possesses the skills necessary to independently perform the duties of the employer. Some beneficiary's will fulfill these duties more quickly than others and will require less monitoring such as with a phone call instead of a home visit. The SDSB counselor will refer back to skills training to reinforce weak performance. Monitoring begins in the first week post employer designation with a documented phone call. Monitoring will occur in each of the six months and will include:

A. **First Month** Monitoring includes:

a. Documented phone call by the SDSB counselor during the **first week** inquiring of the following:

i. If authorized tasks were delivered

ii. How time was entered on the time sheet

iii. Answer any questions the beneficiary may have

b. S**econd week** the SDSB counselor makes an in-home visit to:

i. Review how authorized tasks are delivered

ii. How time is entered on the timesheet

iii. Answer any questions the beneficiary may have

iv. Observe any differences in the environment or in the beneficiary's personal hygiene

v. Address any deficiencies observed

vi. Ask the employer to verbalize how authorized tasks are delivered

vii. If the employee is present ask the employee how well the employer/employee relationship is progressing

viii. Based on the observations the counselor will either make one or two or more in-home visits each week for the remainder of the two weeks in the month

ix. The counselor electronically in a narrative format documents all phone and in-home monitoring visits.

c. **Second month** the SDSB counselor will use observation and skill level present in the first month to determine and provide:

i. Frequency of phone and home visits

ii. Answer any questions the beneficiary may have

iii. Noting identified needs the SDSB counselor will provide additional skills training during the monitoring visits

iv. The counselor electronically in a narrative format documents all phone and in-home monitoring visits.

d. **Third month** the SDSB counselor based on the skill level observed in the two previous months the counselor will:

i. Observe if the beneficiary is fulfilling employer responsibilities with few supports offered

ii. Answer any questions the beneficiary may have

iii. At a minimum one home visit and one phone contact is required

iv. The counselor electronically in a narrative format documents all phone and in-home monitoring visits.

e. **Fourth month** the SDSB counselor based on the skill level observed in the three previous months the counselor will:

i. Provide at a minimum one home visit and one phone contact

ii. Answer any questions the beneficiary may have

iii. Observe if the beneficiary is independently managing their services to meet their care needs

iv. If the beneficiary is not independently managing their services and ensuring needs are met the counselor will look to the beneficiary to define a corrective action plan the beneficiary determines is needed to successfully fulfill employer responsibilities. The counselor will address any deficiencies in the corrective action plan and if accepted the counselor will monitor the corrective action plan the remainder of the month

v. The counselor electronically in a narrative format documents all phone and in-home monitoring visits.

f. **Fifth month** the SDSB counselor based on the skill level observed in the four previous months the counselor will:

i. Provide at a minimum one phone contact

ii. Answer any questions the beneficiary may have

iii. If a corrective action plan was implemented during the fourth month the SDSB counselor must make two home monitoring visits to monitor the effectiveness of the corrective action plan

iv. The counselor electronically in a narrative format documents all phone and in-home monitoring visits.

g. **Sixth month** the SDSB counselor based on the skill level observed in the five previous months the counselor will:

i. Document the results of an unannounced home visit

ii. Answer any questions the beneficiary may have

iii. Assist with transition back to the referring agency, while maintaining continuity of care, for any beneficiary who has not improved in their knowledge and ability to fulfill the employer and programmatic responsibilities

iv. Any transition requires documentation of the supports offered, home observations, skills lacking in the beneficiary hindering the ability of the beneficiary to direct their care, and results of the beneficiary's corrective action plan

v. Send a Hearings and Appeals letter that meets the requirements of DHS and notify DAAS of the transition.

vi. The counselor electronically in a narrative format documents all phone and in-home monitoring visits.

h. **After the first six month** post employer designation the SDSB counselor will:

i. Make quarterly in-home visits with at least one of the four an unannounced visit.

ii. Answer any questions the beneficiary may have

iii. Endorse that the employer is fulfilling employer and programmatic responsibilities

iv. If the counselor cannot make the endorsement the counselor must address areas needing improvement and ask that the beneficiary create a corrective action plan to improve employer outcomes

v. The counselor electronically in a narrative format documents all phone and in-home monitoring visits.

The SDSB Counseling Support provider will use procedure code Z3047 – Frequency Based Home Monitoring for all in-home monitoring services occurring in the six months post employer designation. Should there be additional changes to the employer designation after the Initial New Employer Orientation the training and monitoring begins anew using procedure code Z3046.

Z3047 – Frequency Based Home Monitoring is limited to 14 fifteen minute increments per date of service and is limited to 14 individual visits per twelve month period without a change in employer designation.

## 274.500 SDSB Issue Based Home Monitoring 01-01-15

Issue Based Home Monitoring requires the SDSB Counseling Support provider to address concerns attributed to negative employer outcomes. Negative employer consequences can based on the severity result in disenrollment from the self-directed service budget service delivery model or prosecution. The listing below, but is not limited to, are examples of performance that can result in negative employer outcomes:

a. Services not provided

b. Service delivery is poor as noted in a scheduled or unscheduled monitoring visit

c. Timesheets repetitively not submitted timely

d. Timesheets falsified

e. Repetitive changes in the employer role

f. Labor violations

g. Sexual harassment of employee

h. Reports of abuse, neglect, or exploitation

i. Actively participating in fraudulent activities.

The SDSB counselor responds and addresses these negative employer outcomes by:

A. Make an in-home monitoring visit within one business day when:

a. It is reported self-directed state plan services are not being provided

b. *The home visit shall be immediate if health and welfare concerns are communicated and cannot exceed 24 hours*

c. *Ask probing questions to ascertain what limits beneficiary from fulfilling employer duties*

d. Counselor documents observations and findings.

e. If the counselor determines the beneficiary is not being assertive and is unable to assure authorized services are provided, the counselor must determine:

i. If someone else can fulfill the role of employer or

ii. If the beneficiary will be better served in the agency delivered model.

f. Depending upon the condition of the individual and the environment the counselor must request and review timesheets to determine:

i. When services were last provided or

ii. Determine if timesheets were submitted without provision of services

iii. The SDSB Counseling Support provider must file a report to the Office of the Medicaid Inspector General when timesheets were submitted without provision of services.

B. Counselor must make a home visit to determine appropriate actions when there are *reoccurring* instances of:

a. Change in employees as informed by the SDSB FMS provider to determine if the individual can hire, train, supervise, manage, and evaluate employee's performance

b. Hospitalizations or rehab stay to determine if change in condition warrants any modifications with self-direction

c. Inability to contact beneficiary through home visits or by phone to determine if the individual is still actively participating in the program and inform beneficiary of future expectations

d. Underutilization of services to determine why authorized services are not received and evaluate capabilities of beneficiary to ensure needs are met

e. Reports from current or former employee reports of sexual harassment, employer placing inappropriate demands on employee's earnings, labor violations, or falsification of timesheets requiring the counselor to address the allegations with a corrective action plan or recommendation for disenrollment. The SDSB Counseling Support provider based on the severity of the findings will file a report with the Office of Medicaid Inspector General and inform DAAS.

f. Any evidence of coercion, neglect, or abuse is immediately reported by the SDSB Counseling Support provider to Adult Protective Services or Child Protective Services.

g. When the SDSB Counseling Support provider is informed of a report filed with Adult Protective Services or Child Protective Services the counselor must make a home visit within 3 calendar days to determine if the self-directed service delivery model is the best service delivery model for the individual.

h. A founded report by either Adult Protective Services or Child Protective Services requires a change in service delivery models to protect health and safety.

i. Any time concerns noted do result in Issue Based Home Monitoring the beneficiary is required to develop a corrective action plan that is acceptable to and monitored by the SDSB counselor. Monitoring can be by phone, but does require follow-up home visit(s). The follow-up home visit(s) can be classified as either Frequency Based Home Monitoring or Issue Based Home Monitoring based on outcomes during the visit.

The SDSB counselor's documentation must support the classification of the visit as Issue Based Home Visits. Issue Based Home Visits are limited to 7 distinct date of visit occurrences within a twelve month timeframe. The SDSB Counseling Support provider will use procedure code Z3048 to submit the claim to the Medicaid fiscal intermediary. A unit of service is 15 minutes and is limited to no more than 14 fifteen minute increments per date of service.

Based on the severity of the findings a beneficiary may permanently be excluded from the self-directed service delivery model. This is not considered an adverse action. Participation in the self-directed service budget service delivery model allows budget and employer authority. Failure by the beneficiary to meet these responsibilities when provided with supports negates CMS intent of the self-directed service delivery model. The beneficiary still has an opportunity to have their needs met through the agency provider model, but without assuming the responsibilities when granted employer and budget authority.

All training and monitoring visits cannot exceed 500 fifteen increments per SFY. The training and monitoring services are inclusive of these six in-home procedure codes:

a. Z3044 – SDSB – Information and Assistance (Inactive)*

b. Z3045 – SDSB - Initial New Employer Orientation

c. Z3046 – SDSB – New Employer Orientation

d. Z3047 – SDSB – Frequency Based Home Monitoring

e. Z3048 – SDSB – Issue Based Home Monitoring

f. Z3049 – SDSB – Information and Assistance (Active)*

The defining difference between Z3044 and Z3049 is the Information and Assistance provided to an individual through Z3044 is that the training activities did not result in employer designation. The use of Z3049 does not occur until after the beneficiary is orientated and monitored six months post employer designation (Z3047). Z3049 does not substitute as one of the four required Frequency Based Home Monitoring visits post six months employer designation.

## 275.000 Provider Qualifications – Self-Directed Service Budget Counseling Support Services 01-01-15

Counseling Support services will be provided by the contracted SDSB Counseling Support Services provider. The SDSB Counseling Support provider must be a corporation, professional association, or a limited liability corporation authorized to do business in Arkansas, with a minimum of three (3) years of experience in the self-directed service delivery model as defined in regulatory language in 1915(c), 1915(j) and 1915(k) of the Federal Social Security Act. All administrative functions of the SDSB Counseling Support provider must be centrally located in Pulaski County, Arkansas. Hours of operation are Monday through Friday from 8:00 a.m. until 4:30 p.m. A trained call-center staff will answer all incoming calls within three calendar days to account for weekends. State holidays and the Governor's inclement weather policy is observed.

SDSB Counseling Support will be provided by trained counseling staff sub-contracting with the SDSB Counseling Support provider. Neither the SDSB Counseling Support provider nor any counselors may be a direct-service provider of any other Medicaid services. The counselors will have a minimum of three (3) years of experience working with the general public, with

experience in teaching, mentoring and/or coaching with outcome-based expectations. A counselor may not provide face-to-face counseling support or monitor a family member. For the purposes of this manual, a family member is defined as an individual currently related to the counselor by virtue of blood, marriage or adoption. In addition to the counselors the SDSB Counseling Support provider will support beneficiaries with a toll-free number 866.710.0456 answered by trained call-center staff who will return calls within 3 calendar days to account for weekends. If the incoming call is TDD/TTY the response is immediate. An advanced IT system supports day to day management activities and reporting requirements. All individuals representing the SDSB Counseling Support provider are trained in the philosophy of self-direction and the application of person-centeredness.

## 276.000 Financial Management Services (FMS) for Self-Directed Service Model with Service Budget (SDSB) 01-01-15

Financial management services (FMS) is the second of two required services the State provides to support ACFC beneficiaries in a self-directed service model with a service budget (SDSB). ACFC beneficiaries in the SDSB model have chosen to self-direct their attendant services and supports, supportive living, chore and/or respite care services. The contracted entity selected to provide FMS is the household employer agent for a domestic household employer as set forth in Revenue Procedure Code 70-6 per IRS Notice 2003-70. The SDSB FMS provider will also act in accordance to IRS Publication 926 Household Employer's Tax Guide. Additionally, the FMS provider will coordinate drug screening consent forms, criminal background checks, Arkansas Adult Maltreatment Central Registry and Child Maltreatment Central Registry, and Medicaid or Medicare excluded provider lists. The SDSB FMS provider must comply with the requirements of A.C.A §20-77-128 and DHS policy 1082. The FMS provider electronically maintains the results of the background checks and drug testing results. .

Beneficiaries who choose the SDSB model for delivery of ACFC services will use a budgeted amount based on the assessed functional needs identified on the person-centered service plan (of care)to purchase attendant services and supports, supportive living, chore, and/or respite care services. The purchase of goods and services will serve to increase the beneficiary's independence or help sustain current functional ability to prevent decline, or substitute or decrease the need for human assistance where expenditures would have been made for human assistance. All services must be delivered according to the person-centered service plan (of care) and the service plan.

The FMS provider will receive the beneficiary's cash payment from the Arkansas Medicaid fiscal intermediary. The Medicaid fiscal intermediary will make monthly prospective payments to the FMS provider based on active ACFC beneficiaries as indicated in the Medicaid Management Information Systems (MMIS.) DAAS is responsible for accurately maintaining the ACFC eligibility segments.

## 276.100 SDSB FMS Operating Requirements: 01-01-15

The SDSB FMS provider is responsible for establishing:

A. FMS principles in day-to-day operation to include:

   a. Staff training and staff understanding the philosophy of self-direction

   b. FMS services are goal oriented to support beneficiaries to direct their own services

   c. Maintain compliance with all Internal Revenue Services (IRS) rules and regulations, including those specific to self-direction

   d. Maintain compliance with all Department of Labor (DoL), United States Citizen and Immigration Services (USCIS) and other federal agency rules and regulations

   e. Maintain compliance with all state tax rules and regulations, including those specific to self-direction

f. Adhere to the Scope of Service of DMS Contract 4600031897

B. FMS management of documents requires:

a. Forms included in the Employer Packet

b. Forms included in the Employee Packet

c. Coordination of drug screen consent forms

d. Confirmation of criminal background checks and drug testing results received

e. Timesheets

f. Spending Plan

g. Confirmation from the IRS in the assignment of an employer FEIN and appointment as agent

h. Processing of incoming mail and faxes

C. Customer Service:

a. Provide toll-free number and sufficient call-center staff to respond to callers within 3 calendar days (3 is used to cover weekends) expectation is 1.

b. Hours of operation are Monday through Friday from 8:00 a.m. to 4:30 p.m. with state holidays and the Governor's inclement weather policy observed.

c. Complaints are entered and tracked in the data system and offer the ability to produce QA reports on pending and resolved complaints.

d. Methods of communications should include but is not limited to large print, disk, Braille, translators, interpreters, and TDD/TTY access

e. Conduct surveys on 75% of active employers and 25% of active employees for QA purposes.

D. State and federal forms required for Employer Designation include:

a. *Arkansas Limited Power of Attorney Form* - allows the FMS provider on behalf of the employer to apply for and receive a federal tax identification number, withhold and pay all state and federal unemployment taxes for SDSB services, and to receive and disburse Medicaid funds per the Medicaid employer's authorized budget

b. IRS Form SS-4 – *Application for Employer Identification Number*

c. IRS Form 2678 – *Employer/Payer Appointment of Agent*, and

d. IRS Form 8821 – *Tax Information Authorization*.

e. The SDSB FMS provider develops and coordinates the employer packet with directions written in plain language using highlights to draw attention to signature requirements. The packet will include an introduction sheet providing key information about the SDSB FMS provider and services offered. The packet includes a checklist of all documents that must be returned. The SDSB FMS provider must revoke the state and federal authorization when the SDSB FMS provider no longer serves as the agent of the employer.

E. State and federal forms required for Employee Designation include but are not limited to:

a. Direct deposit authorization

b. Medicaid provider agreement form

c. Employment application

d. Work agreement between the employer and the employee

e. Employee revocation form to terminate the employee/employer relationship

f. Accurately completed IRS Form W-4 - *Employee Withholding; Allowance Certificate*

g. AR4EC - *State of Arkansas Employee's Withholding Exemption Certificate*

h. U.S. Citizenship and Immigration Services (USCIS) Form I-9 – *Employment Eligibility Verification and*

i. *R*eport and document new hires to the Arkansas Department of Workforce Services - **http://www.state.ar.us/esd/Employers/index.htm**

j. The SDSB FMS provider will develop and coordinate employee packet with directions written in plain language using two highlight colors to draw attention to signature required by the employer or by the employee. The packet will include an introduction sheet providing key information about the SDSB FMS provider and services offered. The packet includes a checklist of all documents that must be returned

F. Drug testing and criminal background checks :

a. The SDSB FMS provider will coordinate the required consent forms for background checks and drug screens;
b. The SDSB FMS provider will develop a reasonable plan, acceptable to DAAS, to test existing employees;
c. The SDSB FMS provider will establish a retesting schedule, acceptable to DAAS.
d. The SDSB FMS provider maintains the ability to quantify the results by month, calendar year, and State Fiscal Year;
e. The SDSB FMS provider electronically maintains the results securely and confidentially;
f. The SDSB FMS provider will not make payment to any individual who undergoes and fails any of the following: (1) criminal background check; (2) Medicaid or Medicare excluded provider list; or (3) Arkansas Adult or Child Maltreatment Central Registry;
g. The SDSB FMS provider establishes the methodology for background checks with the potential employee;
h. The SDSB FMS provider electronically maintains background checks and drug testing results justifying payment for review by state or federal representatives;
i. The SDSB FMS provider quantifies the number of checks performed each month and quantifies criminal background checks in the monthly and annual report;
j. The SDSB FMS provider maintain the results of the background checks and sends a report of positive results to the AR Department of Human Services' designee the potential employer, and to the potential employee. The totals must be reported on each monthly report. The results are maintained securely and confidentially with no breaches in divulging the information beyond requirements of A.C.A. § 20-77-128 and DHS Policy 1082;

G. Bi-weekly payroll

a. The FMS provider will provide to the SDSB Counseling Support provider an electronic bi-weekly Cash Expenditure Plan (CEP) budget worksheet template.

b. The FMS provider finalizes the worksheet by using tax rates relevant to employer experiences established by the Arkansas Department of Finance and Administration.

c. The FMS provider gives a copy of the finalized CEP to the employer with a form letter written in plain language.

d. The FMS provider must have processes to:

i. Receive, track initial and revised budgets, and service authorizations as information is received from DAAS per increases or decreases identified in the assessment;

ii. Possess an information system that can track receipt, disbursements, and track budget funds and service authorizations and remaining balance per individual employer;

iii. Process timesheets in accordance with budget, authorization and program rules; and

iv. Resolve timesheets or invoices received outside of the payroll processing timeframe as agreed upon by the F/EA and DAAS.

H. Payment of Goods and Services

a. The FMS provider will pay goods and services based on an invoice from a retailer or from receipts provided by the employer and per authorized budget
b. All single purchases above $50 must be authorized by a designee from DHS. The FMS provider will make payment and is reimbursed through a prior authorization keyed by DAAS and authorized for payment by DAAS, DDS, or DBHS.
c. The FMS provider must maintain all supporting documentation relative to the payment which includes but is not limited to:
    i. Name and address of the service provider
    ii. Description of the purchase
    iii. Scanned documents from DAAS supporting authorization from DHS
    iv. Receipt, invoice, or purchase order and total payment amount
    v. Medicaid ICN linked to the prior authorization
    vi. Documentation supporting annual refunds to Arkansas Medicaid if prior authorization for goods and services is greater than the annual purchased services
    vii. The FMS provider must report monthly on the number of individuals purchasing goods and services, the amount expended, and by categories defined by DAAS.
    viii. The FMS provider will be held liable for repayment should any supporting documentation not be available during a review by state and federal representatives.

I. Coordination of FICA, FUTA, and SUTA

a. The FMS provider is responsible for timely coordination of FICA, FUTA and SUTA changes impacting the employer's Cash Expenditure Plan (CEP) and disbursements to the employee.

b. The FMS provider must provide a form letter to accompany the revised CEP written in plain language

J. Payroll Process

a. The FMS provider must pay employees for time worked as applicable to the authorized budget using a timesheet approved by DAAS

b. The FMS provider will process all required garnishments, levies, dues and lien's on worker's payroll checks and maintain appropriate documentation

c. The FMS provider will ensure employees are paid in compliance with state and federal Department of Labor wage and hour rules, including rules regarding minimum wage, overtime, bi-weekly payroll schedule, and payments for terminated employees post notification

d. The FMS provider will maintain all documentation supporting payment with Medicaid funds to include but not limited to timesheets, payroll, state and federal withholding and payments, invoices, authorizations.

e. The FMS provider must be capable of providing timesheets with service reporting categories based on the employer's eligible self-directed service delivery program of eligibility.

K. Disaster Recovery Plan

a. The FMS provider must have a disaster recovery plan for all documents, both electronic and hard copy.

b. The disaster recovery plan must be tested semi-annually.

c. The disaster recovery plan must demonstrate the ability to effectively continue all operations in the event of a disaster by simulation or other means.

d. Results of the disaster recovery test reported in the corresponding monthly report and must describe how the disaster recovery test functioned and what corrective actions to the disaster recovery plan are needed.

L. Systematic Tax Processes

a. The FMS provider must have systematic tax processes to:

i. Issue IRS Form W-2 – *Wage and Tax Statement* by January 31st of each year

ii. Issue IRS Form W-2 to the IRS/SSA by March 31;

iii. File IRS Form 941 – *Employer's Federal Tax Return (*using Schedules R and B) in the aggregate

iv. File IRS Form 940 – *Employer's Annual Federal Unemployment Tax (FUTA) Report* annually in the aggregate

v. File IRS Form 941-X – Adjusted Employer's Quarterly Federal Tax Return or Claim for Refund to make adjustments to IRS Form 941-X when any adjustment is needed, but particularly when issuing refunds for over-collected FICA tax

vi. Transmit IRS Form W-3 *Transmittal of Wage and Tax Statements* annually to the IRS/SSA by March 31 for electronic submissions

vii. File DWS-ARK-209B/C – *Employer's Quarterly Contribution and Wage Report;* (7) file ARW-3 – *Transmittal of Wage and Tax Statements* with Form W-2 by February 28th for the previous year

viii. Maintain compliance with state income tax withholding, filing, and depositing rules for workers who reside in a state other than that in which they are employed

ix. The FMS provider must follow all state and federal requirements as the agent of SDSB employer

M. Produce Reports from Data System

a. The FMS provider must produce reports from its data system to monitor daily work activities and inform DAAS of the previous month's activities. Reporting shall be inclusive of all of the FMS providers activities but is not limited to:

i. Total funds received from Medicaid
ii. Inform DAAS of any inaccurate Medicaid funding
iii. Provide a count of the active and pending populations
iv. Ratio of employer to employees
v. Expenditures by payroll process date
vi. Aggregate taxes withheld
vii. Aggregate tax payment
viii. Payment of goods and services
ix. Employee wage deduction due to a garnishment or lien
x. Notifications of suspected fraud referred to the DHS designee
xi. Refunds to Arkansas Medicaid from disenrollment or hospitalization
xii. Refunds to Arkansas Medicaid due to unspent funds meeting twelve month filing deadline
xiii. Count and amount of underutilization report issued to SDSB Counseling Support provider
xiv. Number of Cash Expenditure Plans revised due to state or federally mandated change in FICA, FUTA, SUTA or other tax rate revisions
xv. FMS provider may not disburse Medicaid funds to active employers and employees with missing documents.
xvi. Report the number of pending employers or employees with missing forms, actions taken to obtain form and the date last request was made
xvii. Report the number of employers requesting an account statement and at what frequency
xviii. Provide an annual report of the previous year's experiences by February 28th of each year by summarizing the monthly reports and including the results of these year-end activities:
    a. Number of employee W-2's issued
    b. Number of employees not reaching the threshold limit at year-end with an accounting of the amount of funds redistributed to the employer's and employee's accounts or returned to the Medicaid program
    c. Unduplicated count of individuals receiving goods and services, total expenditures, and type of services purchased by category.

N. Meeting CMS and DHS CFCO Assurances

a. The SDSB FMS provider supports the State realizes these CMS CFCO required assurances:
    a. Payment shall not be made for items or services furnished by individuals or entities excluded from participating in the Medicaid program
    b. Abide by the applicable provisions of the Fair Labor Standards Act of 1938
    c. Withhold and pay federal and state income and payroll taxes
    d. Comply with the provision of state and federal unemployment.

O. Memorandum of Understanding

a. The SDSB FMS provider will establish a Memorandum of Understanding (MOU) with the banking institution receiving established by the provider to receive Medicaid funds on the beneficiary's behalf. The MOU declares that the funds transferred by the Arkansas Medicaid fiscal intermediary belong neither to the FMS provider nor the banking institution.

b. The account established by the SDSB FMS provider with the banking institution cannot be an interest-bearing account.

P. FMS Transition Plan

A. The SDSB FMS provider as the current SDSB FMS provider will assist in a beneficiary's transition to a new SDSB FMS provider, should a new SDSB FMS provider be selected. The current SDSB FMS provider will assist with the transition by complying with, but not limited to, these transition requirements:
    a. The SDSB FMS provider will provide the new SDSB FMS provider with the Medicaid recipients FEIN number within (7) calendar days of the transfer
    b. If the SDSB FMS provider reported its mailing address on the employer's IRS Form SS-4 – *Application for Employer Identification Number* rather than the employer's, the SDSB FMS provider should file an IRS Form 8822, *Change of Address* for each applicable employer and report each employer's address on the IRS Form 8822 occurring within (7) calendar days of transfer. A copy of the completed and filed IRS Form 8822 should be sent to the new SDSB FMS provider
    c. The SDSB FMS provider will revoke IRS Form 2678 – *Agent/Payer Authorization* with employer after all required federal tax tasks have been performed and per IRS Form 2678 instructions, then notify the new SDSB FMS provider that the revocation is complete and maintain electronic copies of all documentation in the employers archived file
    d. The SDSB FMS provider will revoke IRS Form 8821 - *Tax Information Authorization* with employer after all required federal tax tasks have been performed and per IRS Form 8821 instructions, then notify the new SDSB FMS provider that the revocation is complete and maintain electronic copies of all documentation in the employers archived file;
    e. The SDSB FMS provider will make FICA deposits for any employee portion of FICA and Federal income taxes withheld and calculates and deposits the employer portion of FICA throughout the year;
    f. The SDSB FMS provider will file IRS Form 941 quarterly in the aggregate using its separate FEIN along with IRS Form 941 Schedule R listing all employer's federal income tax and FICA tax liabilities;
    g. The SDSB FMS provider will make deposit for Federal income tax and FICA for the appropriate quarters it represented the employer per IRS depositing rules;
    h. The SDSB FMS provider verifies each worker's address using the standard address verification process;
    i. The SDSB FMS provider will file IRS Form 941-X for each quarter in which it filed the IRS Form 941 and for which over collected FICA had occurred and attach an IRS Schedule R;
    j. The SDSB FMS provider can either request a refund of the employer and employee share of over collected FICA or have the over collected FICA applied as a credit to any current or future IRS Form 941 the F/EA files. This process must be repeated for each quarter in which FICA was over collected;
    k. The SDSB FMS provider will issue a FICA refund to each applicable employee at the end of the applicable calendar year and over collected employer FICA is returned per the State's instructions;
    l. The SDSB FMS provider should process all FICA refund checks for the employee portion of FICA to qualified workers prior to issuing IRS Form W-2;
    m. The SDSB FMS provider will maintain documentation of all actions taken in the employer's archived file.

The SDSB FMS provider will provide to DAAS on or before July 1st of each year an affirmation statement agreeing to a transition plan should a change in SDSB FMS provider occur during the contracted period.

The SDSB FMS provider agrees to cooperate with any additional requirements established by the State to ensure a smooth transition for the Medicaid beneficiary, free from any incurred penalties or liabilities.

### 276.200 Provider Qualifications – Fiscal Management Services 01-01-15

SDSB Financial Management Services (FMS) is provided by the DMS contracted SDSB FMS provider. The SDSB FMS provider has at least (3) years of experience providing fiscal employer agent services. As a fiscal employer agent, the SDSB FMS provider acts as the agent for individuals who employ home-care service providers in Title XIX funded programs. *A home-care services provider is defined as a worker that provides domestic services to a service recipient under a state or local government agency in-home domestic services program funded in whole or in part with Federal, state, or local funds.* The individual is the common law employer of the home-care service providers and can designate an agent under IRS section 3504 to meet certain Federal employment tax responsibilities on behalf of the employer, such as withholding and reporting. IRS informs that a party seeking to be authorized to serve as an employer's agent by the IRS must follow the procedures set forth in Rev. Proc. 70-6, 1970-1 C.B.420. Under Section 3504, all provisions of law (including penalties) applicable in respect of employers are applicable to the agent and remain applicable to the employer. To limit the risk to the employer DMS establishes through contract SDSB FMS services.

The application for authorization to act as the agent requires completed IRS Form 2678: *Employer Appointment of Agent Under Section 3504 of the Internal Revenue Code*, executed by each service recipient for whom the agent is to act. Once the application is approved, the agent must file only one return for each tax return period using the agent's own employer identification number (EIN) regardless of the number of employer's for whom the agent acts. The SDSB FMS provider must maintain records that will disclose the full wages paid to each home-care service provider on behalf of, and identified by, each service recipient employer for whom it acts.

IRS Publication 926 – Household Employer's Tax Guide is applicable to those employing home-care service providers. The SDSB FMS provider, as the employer's agent, assures compliance to the requirements of IRS Publication 926 on behalf of the employer.

Per the requirements of the contract the SDSB FMS provider must:

A. Have a separate Federal Employer Identification Number (FEIN) to act as the agent

B. Be a corporation, professional association or a limited liability corporation authorized to do business in Arkansas

C. Be an enrolled Medicaid provider

D. All administrative functions must be centrally located in Pulaski County, Arkansas

E. May not be direct service providers of any Medicaid services

F. May not use a payroll reporting agent is prohibited.

## 280.000 REIMBURSEMENT

### 281.000 Method of Reimbursement 01-01-15

The reimbursement methodology for ACFC services for DAAS is a "fee schedule" methodology. Under the fee schedule methodology, reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowed for each procedure. Providers serving beneficiaries in the DAAS population should refer to section 292.000 of this manual for HCPCS procedure codes and modifiers authorized in the ACFC program.

The DDS will utilize assessment-based prospective episodes methodology to pay for home and community-based services for individuals with ID/DD. Under prospective assessment-based episodes, payment is based upon the results of a standardized assessment; the episode amount is determined prospectively and is informed by the assessment results. In order to qualify for an

assessment-based episode and to determine level of need, all eligible individuals must undergo a standardized assessment corresponding to their respective age, administered by an independent third party. The results of the assessment categorize the individual into a tier based on his/her level of need; this tier is then matched to an annual bundled episode amount. Prospective episode amounts are determined through analysis of costs and needs for individuals at each tier.

Payment mechanisms will vary based on the individual's selected service delivery model. In the case of an agency service delivery model, payment will go directly to the Lead Service Provider. The Lead Service Provider receives a cumulative bundled episode payment based on the combined levels of need of the entire panel of individuals served. In the case of the self-directed model, the annual episode amount is based on a specific individual's tier and will be paid in a prorated periodic payment to the fiscal intermediary.

The Program promotes efficient and economic utilization of services by matching funding amounts to levels of need and adopting a payment structure that rewards providers for delivering effective services.

To ensure quality service delivery, payments will be contingent on the submission of required information by the Lead Service provider or fiscal intermediary to verify delivery of services and report on quality. For each episode, Medicaid establishes what information is required to be submitted for payments to occur. Arkansas DHS Division of Developmental Disabilities Services (DDS) will use multiple processes to monitor the quality of community services provided under the DDS Episode, including but not limited to annual on-site review of providers. DDS has instituted processes related to choice, assessment, review, incidents, performance, reporting, and satisfaction. DDS will use a system by which to define and measure quality outcomes for people.

For detail on DD Episode Payment please refer to the DD HCBS Episode **Section of the Episode of Care Medicaid** Provider Manual.

## 282.000 Rate Appeal Process 01-01-15

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the question(s) and a recommendation will be submitted to the Director of the Division of Medical Services.

## 290.000 BILLING

### 291.000 Introduction to Billing 01-01-15

ACFC providers use form CMS-1500 to bill the Arkansas Medicaid Program on paper for services provided to Medicaid beneficiaries. Form CMS-1500 is the official paper counterpart of the Professional (837P) electronic transaction format. Each claim may contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

### 292.000 Arkansas Community First Choice HCPCS Procedure Codes 01-01-15

The following procedure codes must be billed for ACFC Services.

Electronic and paper claims now require the same National Place of Service code.

| Procedure Code | Modifiers | Description | Unit of Service | National POS for Claims |
|---|---|---|---|---|
| S5125 | U3 | Attendant Services and Supports | 1 hour | 12, 99 |
| S5125 | UA | Attendant Services and Supports – Adult Family Home Level A | 1 hour | 12, 99 |
| S5125 | UB | Attendant Services and Supports– Adult Family Home Level B | 1 hour | 12, 99 |
| S5125 | UC | Attendant Services and Supports– Adult Family Home Level C | 1 hour | 12, 99 |
| S5125 | U5 | Attendant Services and Supports– Adult Day Care | 1 hour | 12, 99 |
| S5120 | U1 | Chore Services | 1 hour | 12 |
| H2016 | U1 | Supportive Living Services | 1 hour | 02, 12,99 |
| S5150 | U1 | Relief Care Services – in home | 1 hour | 12 |
| S5135 | U2 | Relief Care Services – Short Term | 1 hour | 12, 21, 32, 99 |
| T1005 | U1 | Relief Care Services – Long Term | 1 hour | 12, 21, 32, 99 |
| S5160 | U1 | PERS – Installation | 1 install | 12 |
| S5161 | UA | PERS – Monthly Monitoring | 1 day | 12 |
| T2025 | U2 | Consultation Services | 1 hour | 12, 99 |
| T2025 | U3 | Positive Behavioral Support Services | 1 hour | 12, 99 |
| T2020 | UA, U2 | Community Transition Services | 1 hour | 12, 99 |
| T2028 | U1 | Specialized Medical Supplies | 1 year | 12, 99 |
| A0080 | U1 | Non-Medical Transportation | Per mile | 12, 99 |
| S5165 | U2 | Environmental Modifications | 1pkg | 12 |
| S5165 | U3 | Assistive Technology/Adaptive Equipment | 1pkg | 12 |
| S5165 | U4 | Goods and Services | 1pkg | 12 |
| S5165 | U5 | Vehicle Modifications | 1pkg | 12, 99 |

| Procedure Code | Modifiers | Description | Unit of Service | National POS for Claims |
|---|---|---|---|---|
| S5170 | U3 | Hot Home-Delivered Meals | 1 meal | 12 |
| S5170 | U4 | Frozen Home-Delivered Meal | 1 meal | 12 |
| S5170 | U5 | Emergency Home Delivered Meals | 1 meal | 12 |
| T2034 | UA U2 | Crisis Intervention | 1 hour | 12 |

## 293.000 Place of Service Codes 01-01-15

Electronic and paper claims require the same National Place of Service codes.

| Place of Service | Electronic and Paper Claims |
|---|---|
| Community Center | 02 |
| Beneficiary's Home (includes Adult Family Home) | 12 |
| Group Home | 14 |
| Inpatient Hospital | 21 |
| Nursing Facility | 32 |
| Other Locations | 99 |

## 294.000 Billing Instructions - Paper Only 01-01-15

DHS' fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.

Bill Medicaid for professional services with form CMS-1500. **View a sample form CMS-1500.**

Carefully follow these instructions to help the fiscal agent efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the fiscal agent's claims department. **View or print fiscal agent claims department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

## 295.000 Completion of CMS-1500 Claim Form 01-01-15

| Field Name and Number | Instructions for Completion |
|---|---|
| 1. (type of coverage) | Not required. |
| 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number. |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | Beneficiary's or participant's last name and first name. |

| Field Name and Number | Instructions for Completion |
|---|---|
| 3. PATIENT'S BIRTH DATE | Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY. |
| SEX | Check M for male or F for female. |
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | Required if insurance affects this claim. Insured's last name, first name, and middle initial. |
| 5. PATIENT'S ADDRESS (No., Street) | Optional. Beneficiary's or participant's complete mailing address (street address or post office box). |
| CITY | Name of the city in which the beneficiary or participant resides. |
| STATE | Two-letter postal code for the state in which the beneficiary or participant resides. |
| ZIP CODE | Five-digit zip code; nine digits for post office box. |
| TELEPHONE (Include Area Code) | The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone. |
| 6. PATIENT RELATIONSHIP TO INSURED | If insurance affects this claim, check the box indicating the patient's relationship to the insured. |
| 7. INSURED'S ADDRESS (No., Street) | Required if insured's address is different from the patient's address. |
| CITY | |
| STATE | |
| ZIP CODE | |
| TELEPHONE (Include Area Code) | |
| 8. RESERVED | Reserved for NUCC use. |
| 9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial) | If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial. |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | Policy and/or group number of the insured individual. |
| b. RESERVED | Reserved for NUCC use. |
| SEX | Not required. |
| c. RESERVED | Reserved for NUCC use. |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | Name of the insurance company. |
| 10. IS PATIENT'S CONDITION RELATED TO: | |
| a. EMPLOYMENT? (Current or Previous) | Check YES or NO. |

| Field Name and Number | Instructions for Completion |
|---|---|
| b. AUTO ACCIDENT? | Required when an auto accident is related to the services. Check YES or NO. |
| PLACE (State) | If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place. |
| c. OTHER ACCIDENT? | Required when an accident other than automobile is related to the services. Check YES or NO. |
| d. CLAIM CODES | The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets. |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER | Not required when Medicaid is the only payer. |
| a. INSURED'S DATE OF BIRTH | Not required. |
| SEX | Not required. |
| b. OTHER CLAIM ID NUMBER | Not required. |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | Not required. |
| d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked. |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | Enter "Signature on File," "SOF" or legal signature. |
| 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE | Enter "Signature on File," "SOF" or legal signature. |
| 14. DATE OF CURRENT:<br>ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.<br>Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period. |

| Field Name and Number | Instructions for Completion |
|---|---|
| 15. OTHER DATE | Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.<br>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:<br>454 Initial Treatment<br>304 Latest Visit or Consultation<br>453 Acute Manifestation of a Chronic Condition<br>439 Accident<br>455 Last X-Ray<br>471 Prescription<br>090 Report Start (Assumed Care Date)<br>091 Report End (Relinquished Care Date)<br>444 First Visit or Consultation |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | Not required. |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | Primary Care Physician (PCP) referral is not required for Alternatives for Adults with Physical Disabilities waiver services. |
| 17a. (blank) | The 9-digit Arkansas Medicaid provider ID number of the referring physician. |
| 17b. NPI | Not required. |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims. |
| 19. ADDITIONAL CLAIM INFORMATION | Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers. |
| 20. OUTSIDE LAB? | Not required. |
| $ CHARGES | Not required. |

| Field Name and Number | Instructions for Completion |
|---|---|
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | Enter the applicable ICD indicator to identify which version of ICD codes is being reported.<br>Use “9” for ICD-9-CM.<br>Use “0” for ICD-10-CM.<br>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.<br>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. |
| 22. RESUBMISSION CODE | Reserved for future use. |
| ORIGINAL REF. NO. | Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy. |
| 23. PRIOR AUTHORIZATION NUMBER | Not applicable to Arkansas Community First Choice claims. |
| 24A. DATE(S) OF SERVICE | The “from” and “to” dates of service for each billed service. Format: MM/DD/YY.<br>1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month.<br>2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence. |
| B. PLACE OF SERVICE | Two-digit national standard place of service code. See Section 241.200 for codes. |
| C. EMG | Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency. |
| D. PROCEDURES, SERVICES, OR SUPPLIES | |
| CPT/HCPCS | One CPT or HCPCS procedure code for each detail. See Section 241.100. |
| MODIFIER | Modifier(s) if applicable. |

| Field Name and Number | Instructions for Completion |
|---|---|
| E. DIAGNOSIS POINTER | Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed. |
| F. $ CHARGES | The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services. |
| G. DAYS OR UNITS | The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail. |
| H. EPSDT/Family Plan | Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims. |
| I. ID QUAL | Not required. |
| J. RENDERING PROVIDER ID # | The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail. |
| NPI | Not required. |
| 25. FEDERAL TAX I.D. NUMBER | Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment. |
| 26. PATIENT'S ACCOUNT N O. | Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN." |
| 27. ACCEPT ASSIGNMENT? | Not required. Assignment is automatically accepted by the provider when billing Medicaid. |
| 28. TOTAL CHARGE | Total of Column 24F—the sum all charges on the claim. |
| 29. AMOUNT PAID | Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid co-payments. |
| 30. RESERVED | Reserved for NUCC use. |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS | The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable. |

| Field Name and Number | Instructions for Completion |
|---|---|
| 32. SERVICE FACILITY LOCATION INFORMATION | If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed. |
| a. (blank) | Not required. |
| b. (blank) | Not required. |
| 33. BILLING PROVIDER INFO & PH # | Billing provider's name and complete address. Telephone number is requested but not required. |
| a. (blank) | Not required. |
| b. (blank) | Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider. |

## 296.000 Special Billing Procedures 01-01-15

Not applicable to this program.