ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – ARChoices In Homecare Home and Community-Based 2176 Waiver**

EFFECTIVE DATE: **October 1, 2016**

SUBJECT: **Provider Manual Update Transmittal ARCHOICES-1-15**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
—	—	201.010	10-1-16
201.105	1-1-16	201.105	10-1-16
212.000	1-1-16	212.000	10-1-16
212.300	1-1-16	212.300	10-1-16
212.310	1-1-16	212.310	10-1-16
212.311	1-1-16	212.311	10-1-16
212.312	1-1-16	212.312	10-1-16
212.322	1-1-16	212.322	10-1-16
212.324	1-1-16	—	—
212.400	1-1-16	212.400	10-1-16
212.500	1-1-16	212.500	10-1-16
213.100	1-1-16	213.100	10-1-16
213.110	1-1-16	213.110	10-1-16
213.210	1-1-16	213.210	10-1-16
213.240	1-1-16	213.240	10-1-16
213.290	1-1-16	213.290	10-1-16
213.311	1-1-16	213.311	10-1-16
213.323	1-1-16	213.323	10-1-16
213.330	1-1-16	213.330	10-1-16
213.350	1-1-16	213.350	10-1-16
213.410	1-1-16	213.410	10-1-16
213.500	1-1-16	213.500	10-1-16
213.510	1-1-16	213.510	10-1-16
213.600	1-1-16	213.600	10-1-16
213.610	1-1-16	213.610	10-1-16
213.700	1-1-16	213.700	10-1-16
213.711	1-1-16	213.711	10-1-16

261.000	1-1-16	261.000	10-1-16
262.100	1-1-16	262.100	10-1-16
262.400	1-1-16	262.400	10-1-16

Explanation of Updates

Section 201.010 has been added to include the ARChoices Transition Plan.

Section 201.105 has been updated with information regarding Provider Assurances.

Section 212.000 has been updated with information regarding Eligibility for the ARChoices Program.

Section 212.300 has been updated with information regarding Person-Centered Service Plans.

Section 212.310 has been updated with information regarding Provisional Person-Centered Service Plans.

Section 212.311 has been updated with information regarding Denied Eligibility Applications.

Section 212.312 has been updated with information regarding Comprehensive Person-Centered Service Plans.

Section 212.322 has been updated with the most current information regarding Revisions When the Person-Centered Service Plan Contains Personal Care Services.

Section 212.324 has been removed.

Section 212.400 has been updated with information regarding Temporary Absences from the Home.

Section 212.500 has been updated with information regarding Reporting Changes in Beneficiary's Status.

Section 213.100 has been updated with information regarding Adult Family Homes.

Section 213.110 has been update with information regarding Adult Family Homes Certification Requirements.

Section 213.210 has been updated with information regarding Attendant Care Services.

Section 213.240 has been updated with information regarding Environmental Accessibility Adaptations/Adaptive Equipment.

Section 213.290 has been updated with information regarding Environmental Modifications/Adaptive Equipment.

Section 213.311 has been updated with the most current information regarding Hot Home-Delivered Meal Provider Certification Requirements.

Section 213.323 has been updated with the most current information regarding Frozen Home-Delivered Meal Provider Certification Requirements.

Section 213.330 has been updated to change the word "individual" to "beneficiary".

Section 213.350 has been updated with the most current information regarding Emergency Meals.

Section 213.410 has been updated to change the word "beneficiaries" to "providers".

Sections 213.500, 213.510, 213.600, 213.610 and 262.100 have been updated with exact measurements of units and hours and to change the word "care" to "services".

Section 213.700 has been updated with information regarding Respite Care.

Section 213.711 has been updated with information regarding Facility-Based Respite Care.

Section 261.000 has been updated to rearrange the order of its information regarding Introduction to Billing.

Section 262.400 has been updated with information regarding Special Billing Procedures – Environmental Modifications/Adaptive Equipment.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

TOC required

201.010 ARChoices Transition Plan 10-1-16

The ARChoices Program began January 1, 2016. The program is the combination of the ElderChoices and Alternatives for Adults with Physical Disabilities (AAPD) waivers. Beginning January 1, 2016, beneficiaries enrolled in the ElderChoices and AAPD waiver programs became beneficiaries of the ARChoices program. The following transition plan explains the process of how services will be executed and billed until the beneficiary receives a new Person-Centered Service Plan (PCSP).

Individuals currently in the ElderChoices waiver will continue receiving current services at the same level and from the same provider until the next scheduled reassessment with the following exceptions:

- Homemaker and Adult Companion - Individuals will continue receiving Homemaker and Adult Companion hours as shown on the plan of care, except the services will be billed by the provider as Attendant Care in ARChoices.
- Respite - Individuals will continue receiving Respite and the definition will remain the same, but providers will bill for ARChoices Respite.
- Chore - This service is being eliminated due to underutilization. The number of participants who utilized the Chore service in State Fiscal Year 2015 was zero. Chore providers will be notified of the elimination of Chore services.

At reassessment, the DAAS RN will complete a new ARChoices PCSP and indicate any changes in services. A new service will be available to ElderChoices recipients, Environmental Accessibility Adaptations/Adaptive Equipment.

Individuals currently in the Alternatives for Adults with Physical Disabilities (AAPD) waiver will be converted to ARChoices in Homecare when changes are implemented with no lapse in coverage or services. Recipients will be notified of the changes at least 30 days in advance of implementation. During the reassessment and PCSP development, the AAPD individual will choose a TCM provider, and the DAAS RN will make a referral to the TCM provider of choice. The TCM provider will then make arrangements to visit the participant. The IndependentChoices counseling provider will also begin a series of visits to ensure proper support for self-direction under 1915(j). At reassessment, the DAAS RN and the recipient will complete a new ARChoices PCSP and indicate any changes in services.

Participants receiving AAPD Attendant Care under the Participant-Directed (PD) model will continue to receive the same services from the same provider until reassessment, at which time the service may continue under ARChoices Attendant Services as a PD service. The PD model for ARChoices will be different from the PD model for AAPD as ARChoices will use the 1915(j) authority approved by CMS for the operation of the IndependentChoices program and the self-directed supports offered to program participants. The same Attendant Care provider will continue to provide services under the IndependentChoices program. At the next reassessment, the IndependentChoices Counseling Support and Financial Management Services (FMS) provider will work with the recipient and Attendant Caregiver to provide training, support and assistance in understanding the changes in the PD model and in completing the paperwork necessary to transition to the new model.

Provider training will be offered to current ElderChoices and AAPD providers regarding these changes as well as training on the new billing requirements. Training will be provided to HCBS waiver staff regarding the transition from the existing waivers to one waiver.

Beginning with the first reassessment, the individual will have an expanded array of services from which to choose. Individuals will also be able to keep the same services and providers when turning age 65.

Arkansas Medicaid does not provide ARChoices Waiver services in non-bordering states.

201.105 Provider Assurances 10-1-16

A. Agency Staffing

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries for whom they have accepted an ARChoices Waiver Person-Centered Service Plan (PCSP).

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Department of Human Services (DHS), Division of Aging and Adult Services (DAAS), requires mandatory training. The provider must attend one of the two provider workshop trainings in the calendar year. Failure to attend one of these trainings could jeopardize the provider's certification for the waiver. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS. Direct care workers must be trained prior to providing services to an ARChoices beneficiary.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any ARChoices Waiver service(s). This orientation shall include, but not be limited to:
    a. Description of the purpose and philosophy of the ARChoices Waiver Program;
    b. Discussion and distribution of the provider agency's written code of ethics;
    c. Discussion of activities which shall and shall not be performed by the employee;
    d. Discussion, including instructions, regarding ARChoices Waiver record keeping requirements;
    e. Discussion of the importance of the PCSP;
    f. Discussion of the agency's procedure for reporting changes in the beneficiary's condition;
    g. Discussion, including potential legal ramifications, of the beneficiary's right to confidentiality;
    h. Discussion of the beneficiary's rights regarding HCBS Settings as discussed in C of this section.

B. Code of Ethics

The Provider agrees to follow and/or enforce for each employee providing services to an ARChoices Waiver beneficiary a written code of ethics that shall include, but not be limited to, the following:

1. No consumption of the beneficiary's food or drink;
2. No use of the beneficiary's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;

4. No acceptance of gifts or tips from the beneficiary or their caregiver;
5. No friends or relatives of the employee or unauthorized beneficiaries are to accompany the employee to beneficiary's residence;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery;
7. No smoking in the beneficiary's residence;
8. No solicitation of money or goods from the beneficiary;
9. No breach of the beneficiary's privacy or confidentiality of records.

C. Home and Community-Based Services (HCBS) Settings

All providers must meet the following Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR 441.301(c) (4)-(5).

Settings that are HCBS must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

1. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
    a. Choice must be identified and included in the PCSP.
    b. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.
2. Ensures an individual's rights of privacy, dignity and respect and freedom from coercion and restraint.
3. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
4. Facilitates individual choice regarding services and supports and who provides them.
5. The setting is integrated in and supports full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.
6. In a provider-owned or controlled residential setting (e.g., Adult Family Homes), in addition to the qualities specified above, the following additional conditions must be met:
    a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

b. Each individual has privacy in their sleeping or living unit:
   i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
   ii. Beneficiaries sharing units have a choice of roommates in that setting.
   iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

c. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.

d. Beneficiaries are able to have visitors of their choosing at any time.

e. The setting is physically accessible to the individual.

f. Any modification of the additional conditions specified in items 1 through 4 above must be supported by a specific assessed need and justified in the PCSP. The following requirements must be documented in the PCSP:
   i. Identify a specific and individualized assessed need.
   ii. Document the positive interventions and supports used prior to any modifications to the PCSP.
   iii. Document less intrusive methods of meeting the need that have been tried but did not work.
   iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
   v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
   vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
   vii. Include the informed consent of the individual.
   viii. Include an assurance that interventions and supports will cause no harm to the individual.

212.000 Eligibility for the ARChoices Program 10-1-16

A. To qualify for the ARChoices Program, a person must be age 21 through 64 and who are determined to have a physical disability through the Social Security Administration or the Department of Human Services (DHS) Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or be 65 years of age or older and require an intermediate level of care in a nursing facility. Persons determined to meet the skilled level of care, as determined by the Office of Long Term Care, are not eligible for the ARChoices Program.

The beneficiary intake and assessment process for the ARChoices Program includes a determination of categorical eligibility, financial eligibility, a nursing facility level of care determination, the development of a PCSP and the beneficiary's notification of his or her choice between home and community-based services and institutional services.

B. Applicants for participation in the program (or their representatives) must make application for services at the DHS office in the county of their residence. Medicaid eligibility is determined by the DHS County Office, and the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist and is based on non-functional and functional criteria. Income and resources comprise the non-functional criteria. The individual must be an individual with a functional need.

C. To be determined an individual with a functional need; an individual must meet at least one of the following three criteria, as determined by a licensed medical professional:

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

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

b. At least 2 of the 3 ADLs of transferring/locomotion, eating, or toileting without limited assistance from another person; or

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

3. Functional assessments results in a Change in Health, End-Stage Disease and Signs and Symptoms (CHESS) score of three or more.

4. Definitions:

a. CHESS means the Changes in Health, End-Stage Disease, Signs and Symptoms Scale was designed to identify individuals at risk of serious decline. It can serve as an outcome where the objective is to minimize problems related to declines in function, or as a pointer to identify persons whose conditions are unstable.

CHESS, originally developed for use with nursing home residents, has been adapted for use with other instruments in the interRAI suite. It creates a 6-point scale from 0 = not at all unstable to 5 = highly unstable, with higher levels predictive of adverse outcomes such as mortality, hospitalization, pain, caregiver stress and poor self-rated health. (RE: **http://www.interrai.org/scales.html**)

b. COGNITIVE PERFORMANCE SCALE (CPS) combines information on memory impairment, level or consciousness and executive function, with scores ranging from 0 (intact) to 6 (very severe impairment). The CPS has been shown to be highly correlated with the MMSE in a number of validation studies. (RE: **http://www.interrai.org/scales.html**)

c. EATING means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.

d. EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.

e. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.

f. LIMITED ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.

g. LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.

h. INTELLECTUAL AND DEVELOPMENTAL DISABILITIES means a level of intellectual disability as described in the American Association on Intellectual and Developmental Disabilities' Manual on Intellectual Disability: Definition Classification, and systems and supports. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.

i. SERIOUS MENTAL ILLNESS OR DISORDER means schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other psychotic disorder. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.

j. SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount.

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

ii. Intravenous injections and hypodermoclysis or intravenous feedings.

iii. Levin tubes and nasogastric tubes.

iv. Nasopharyngeal and tracheostomy aspiration.

v. Application of dressings involving prescription medication and aseptic techniques.

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

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

viii. Initial phases of a regimen involving administration of medical gases.

ix. Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.

x. Ventilator care and maintenance.

xi. The insertion, removal and maintenance of gastrostomy feeding tubes.

k. SUBSTANTIAL SUPERVISION means the prompting, reminding or guidance of another person to perform the task.

l. TOILETING means the act of voiding of the individual's bowels or bladder and includes the use of a toilet, commode, bedpan or urinal; transfers on and off a toilet, commode, bedpan or urinal; the cleansing of the individual after the act; changes of incontinence devices such as pads or diapers; management of ostomy or catheters and adjustment to clothing.

m. TOTAL DEPENDENCE means the individual needs another person to completely and totally perform the task for the individual.

n. TRANSFERRING means the act of an individual in moving from one surface to another and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids and chairs.

D. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition that is temporary and expected to last no more than 21 days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition that would render the individual ineligible if the condition or change in condition is expected to last more than 21 days.

E. Beneficiaries diagnosed with a serious mental illness or intellectual disability are not eligible for the ARChoices Program unless they have medical needs unrelated to the diagnosis of mental illness or intellectual disability and meet the other qualifying criteria. A diagnosis of severe mental illness or intellectual disability must not bar eligibility for beneficiaries having medical needs unrelated to the diagnosis of serious mental illness or intellectual disability when they meet the other qualifying criteria.

F. Eligibility for the ARChoices Waiver program begins the date the DAAS LTSS Program Specialist approves the application unless there is a provisional plan of care. (If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process.)

G. The ARChoices Waiver provides for the entrance of all eligible persons on a first-come, first-served basis, once beneficiaries meet all functional and financial eligibility requirements. However, the waiver dictates a maximum number of unduplicated, and active, beneficiaries who can be served in any waiver year. Once the maximum number of unduplicated, or active, beneficiaries is projected to be reached considering the number of active cases and the number of pending applications, a waiting list will be implemented for this program and the following process will apply:

1. Each ARChoices application will be accepted and medical and financial eligibility will be determined.
2. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services, that all waiver slots are filled and that the applicant is number X in line for an available slot.
3. Entry to the waiver will then be prioritized based on the following criteria:
    a. Waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error;
    b. Waiver application determination date for persons being discharged from a nursing facility after a 90- day stay; waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;
    c. Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);
    d. Waiver application determination date for all other persons.

212.300 Person-Centered Service Plan (PCSP) 10-1-16

A. Each beneficiary in the ARChoices Program must have an individualized ARChoices PCSP. The authority to develop an ARChoices PCSP is given to the Medicaid State agency's designee, the Division of Aging and Adult Services Registered Nurse (DAAS RN). At the discretion of the beneficiary, the ARChoices PCSP is developed with the ARChoices beneficiary, representative, the participant's family or anyone requested by the participant, including the provider, if requested by the beneficiary. At the request of the beneficiary or their representative, the DAAS RN can assist in coordinating and inviting any requested beneficiaries.

B. When developing the waiver PCSP, the beneficiary may freely choose a family member or individual to appoint as a representative. The beneficiary and representative may participate in all decisions regarding the types, amount and frequency of services included in the PCSP. The representative may participate in choosing the provider(s) for the beneficiary. If anyone other than the beneficiary chooses the provider, the DAAS RN will identify that individual on the PCSP. Should the self-directed service delivery model be selected by an individual other than the beneficiary, that individual may not be the paid

employee for one year unless the DAAS approves a release based upon extenuating circumstances and in the best interest of the beneficiary.

C. The ARChoices PCSP developed by the DAAS RN includes, but is not limited to:

1. Beneficiary identification and contact information, including full name and address, phone number, date of birth, Medicaid number and the effective date of ARChoices Waiver eligibility;
2. Contact person;
3. Physician's name and address;
4. The amount, frequency and duration of ARChoices Waiver services to be provided and the name of the service provider chosen by the beneficiary or representative to provide the services. **Note: Attendant Care hours are authorized on the waiver PCSP based on the Resource Utilization Group (RUG) score produced from the ArPath assessment. Attendant Care hours are authorized in a monthly amount on the waiver PCSP. The provider and beneficiary determine how to use the Attendant Care hours based on the beneficiary's needs and preferences.**
5. Other services outside the ARChoices services, regardless of payment source, identified and/or ordered to meet the beneficiary's needs including the option for the self-directed service delivery model;
6. The election of community services by the waiver beneficiary or representative; and,
7. The name and title of the DAAS RN responsible for the development of the beneficiary's PCSP.

D. If waiver eligibility is approved by the DHS county office, and the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist, a copy of the PCSP signed by the DAAS RN and the waiver beneficiary or representative, will be forwarded to the beneficiary or representative and the Medicaid enrolled service provider(s) included in the PCSP. The service provider and the ARChoices beneficiary must review and follow the signed authorized PCSP. Services cannot begin until the Medicaid provider receives the authorized PCSP from the DAAS RN. The original PCSP will be maintained by the DAAS RN.

The implementation of the PCSP by a provider must ensure that services are:

1. Individualized to the beneficiary's unique circumstances;
2. Provided in the least restrictive environment possible;
3. Developed within a process ensuring participation of those concerned with the beneficiary's welfare;
4. Monitored and adjusted as needed, based on changes authorized and reported by the DAAS RN regarding the waiver PCSP;
5. Provided within a system that safeguards the beneficiary's rights to quality services as authorized on the waiver PCSP; and,
6. Documented carefully, with assurance that required information is recorded and maintained.

NOTE: Each service included on the ARChoices PCSP must be justified by the DAAS RN. This justification is based on medical necessity, the beneficiary's physical, cognitive and functional status, other support services available to the beneficiary and other factors deemed appropriate by the DAAS RN.

Each ARChoices service must be provided according to the beneficiary PCSP. For services included in the waiver PCSP, Medicaid reimbursement is limited to the amount and frequency

that is authorized in the PCSP. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

NOTE: PCSPs are updated annually by the DAAS RN and sent to the ARChoices provider prior to the expiration of the current PCSP. However, the provider has the responsibility for monitoring the PCSP expiration date and ensuring that services are delivered according to a valid PCSP. At least 30 and no more than 45 days before the expiration of each PCSP, the provider shall notify the DAAS RN via email and copy the RN supervisor of the PCSP expiration date.

Services are not compensable unless there is a valid and current PCSP in effect on the date of service.

REVISIONS TO A BENEFICIARY PCSP MAY ONLY BE MADE BY THE DAAS RN.

NOTE: All revisions to the waiver PCSP must be authorized by the DAAS RN. A revised PCSP will be sent to each appropriate provider. Regardless of when services are provided, unless the provider and the service are authorized on an ARChoices PCSP, services are considered non-covered and do not qualify for Medicaid reimbursement. Medicaid expenditures paid for services not authorized on the ARChoices PCSP are subject to recoupment.

212.310 Provisional Person-Centered Service Plan (PCSP) 10-1-16

The ARChoices registered nurse (DAAS RN) may develop a provisional PCSP prior to establishment of Medicaid eligibility, based on information obtained during the in-home functional assessment, when recommending functional approval based on the nursing home criteria. The DAAS RN must discuss the provisional PCSP policy and have the approval of the applicant prior to completing and processing the provisional PCSP. The PCSP will be developed by the applicant and the DAAS RN and signed by the applicant or the applicant's representative and the DAAS RN.

The provisional PCSP will include all current PCSP information, except for the waiver eligibility date and the Medicaid beneficiary ID number.

The provisional PCSP will be mailed to the waiver applicant and each provider included on the PCSP. If the beneficiary and the provider accept the risk of ineligibility, the provider must begin services within an established time frame as determined by the Division of Aging and Adult Services (DAAS) and notify the DAAS RN, via Start Services form AAS-9510, that services have started. The DAAS RN will track the start of care dates and give the applicant options when services are not started.

The provisional PCSP will expire 60 days from the date signed by the applicant and the DAAS RN. A PCSP that has been approved with a Medicaid number and waiver eligibility date must be in place no later than the expiration date of the provisional PCSP.

A. A provisional PCSP may be developed and sent to providers only when the assessment outcome indicates functional eligibility and the DAAS RN believes, in his or her professional judgment, that the applicant meets the level of care criteria for an adult with a functional need, as explained in Section 212.000, Eligibility for the ARChoices Program.

   The waiver eligibility date will be established retroactively, effective on the day the provisional PCSP was signed by the applicant or applicant's representative and the DAAS RN, if:

   1. At least one waiver service begins within 30 days of the development of the provisional PCSP

      AND

   2. The waiver application is approved by the Division of County Operations.

B. If waiver services begin within 31 through 60 days of the development of the provisional PCSP, the retroactive eligibility date will be the effective date that a waiver service is started.

C. If waiver services do not begin within 60 days from the date the provisional PCSP is signed by the DAAS RN, the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist will establish the waiver eligibility date as the date the application is entered into the system as an approved application. There will be no retroactive eligibility.

D. Provisional PCSPs may not include the non-waiver self-directed service delivery model.

212.311 Denied Eligibility Application 10-1-16

A. If the DHS county office, and the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist denies the Medicaid eligibility application for any reason, Medicaid and waiver services provided during a period of ineligibility will be the financial responsibility of the applicant. The DAAS LTSS Program Eligibility Specialist will notify the DAAS RN. The DAAS RN will notify the providers via form AAS-9511 immediately upon learning of the denial. Reasons for denial include but are not limited to:

1. Failure to meet the nursing home admission criteria
2. Failure to meet financial eligibility criteria
3. Withdrawal of the application by the applicant
4. Death of the applicant when no waiver services were provided

NOTE: If waiver services were provided and the applicant dies prior to approval of the application, waiver eligibility will begin (if all other eligibility requirements are met) on the date waiver service(s) began and end on the date of death.

B. The applicant has the right to appeal by filing for a fair hearing. When an appeal ruling is made in favor of the applicant, the actions to be taken by the DHS county office are as follows:

1. If the individual has no unpaid ARChoices Waiver charges, Medicaid coverage will begin on the date of the appeal decision. However, the waiver portion of the case will not be approved until the date the DHS county office, and the DAAS LTSS Program Eligibility Specialist completes the case.
2. If the individual has unpaid waiver charges and services were authorized by the DAAS RN, eligibility for both Medicaid and waiver services will begin on the date service began unless the hearing decision sets a begin date.

NOTE: Under no circumstances will waiver eligibility begin prior to the date of application or the date the provisional PCSP is signed by the DAAS RN and the applicant or the applicant's representative, whichever is later.

212.312 Comprehensive Person-Centered Service Plan (PCSP) 10-1-16

Prior to the expiration date of the provisional PCSP, the DAAS RN will send the comprehensive PCSP to the waiver beneficiary and all providers included on the PCSP. The comprehensive PCSP will replace the provisional PCSP. The comprehensive PCSP will include the Medicaid beneficiary ID number, the waiver eligibility date established according to policy and the comprehensive PCSP expiration date.

The comprehensive PCSP expiration date will be 365 days from the date of the DAAS RN's signature on form AAS-9503, the ARChoices PCSP. Once the application is either approved or denied by the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist, the providers will be notified by the DAAS RN. The notification for the approval will be in writing via

a PCSP that includes the waiver eligibility date and Medicaid ID number. The notification for a denial will be via a form AAS-9511 reflecting the date of denial.

212.322 Revisions when the Person-Centered Service Plan (PCSP) Contains Personal Care Services 10-1-16

Requested changes to the personal care services included on the ARChoices PCSP may originate with the personal care RN or the DAAS RN, based on the recipient's circumstances. Unless requested by an IndependentChoices beneficiary, the individual or agency requesting revisions to the Personal Care services on the ARChoices PCSP is responsible for securing any required signatures authorizing the change prior to the ARChoices PCSP being revised.

If revised by the DAAS RN, a copy of the revised ARChoices PCSP and a Start of Care Form (AAS-9510) will be mailed to the personal care provider within 10 working days after being revised. If authorization is secured by the Personal Care agency, a copy of the revised personal care order, signed by the physician, must be sent to the DAAS RN prior to implementing any revisions. Once received, the ARChoices PCSP will be revised accordingly within 10 working days of its receipt. If any problems are encountered with implementing the requested revisions, the DAAS RN will contact the personal care provider to discuss possible alternatives. These discussions and the final decision regarding the requested revisions must be documented in the nurse narrative. The final decision rests with the DAAS RN.

212.400 Temporary Absences from the Home 10-1-16

Once an ARChoices eligibility application has been approved, waiver services must be provided in a home and community-based services setting for eligibility to continue. Unless stated otherwise below, the county Department of Human Services (DHS) office must be notified immediately by the Division of Aging and Adult Services Registered Nurse (DAAS RN) when waiver services are discontinued and action will be initiated by the DAAS LTSS Program Eligibility Specialist to close the waiver case. Providers will be notified by the DAAS RN.

A. Absence from the Home due to Institutionalization

An individual cannot receive ARChoices Waiver services while in an institution. The following policy applies to any inpatient stay where Medicaid pays the facility for the date of admission, i.e., hospitals, nursing homes, rehab facilities, etc., for active waiver cases when the beneficiary is hospitalized or enters a nursing facility for an expected stay of short duration.

1. When a waiver beneficiary is admitted to a hospital, the DAAS LTSS Program Eligibility Specialist will not take action to close the waiver case unless the beneficiary does not return home within 30 days from the date of admission. If, after 30 days, the beneficiary has not returned home, the DAAS RN will notify the DAAS LTSS Program Eligibility Specialist and action will be initiated to close the waiver case.
2. If the DHS county office becomes aware that a beneficiary has been admitted to a nursing facility and it is anticipated that the stay will be short (30 days or less), the waiver case will be closed effective the date of the admission, but the Medicaid case will be left open. When the beneficiary returns home, the waiver case may be reopened effective the date the beneficiary returns home. A new assessment and medical eligibility determination will not be required unless the last review was completed more than 6 months prior to the beneficiary's admission to the facility.

NOTE: Nursing facility admissions, when referenced in this section, do not include ARChoices beneficiaries admitted to a nursing facility to receive facility-based respite services.

NOTE: The Arkansas Medicaid Program considers an individual an inpatient of a facility beginning with the date of admission. Therefore, payment to the inpatient facility begins on the date of admission. Payment to the inpatient facility does not include the date of discharge.

Payment for ARChoices services may be allowed for the date of a beneficiary's admission to an inpatient facility if the provider can provide verification that services were provided before the beneficiary was admitted. In order for payment to be allowed, providers are responsible for obtaining the following:

- **Copies of claim forms or timesheets listing the times that services were provided**
- **A statement from the inpatient facility showing the time that the beneficiary was admitted**
- **This information must be submitted to DAAS within 10 working days of receiving a request for verification.**

If providers are unable to provide proof that ARChoices services were provided before the beneficiary was admitted to the inpatient facility, then payments will be subject to recoupment. ARChoices services provided on the same day the beneficiary is discharged from the inpatient facility are billable when provided according to policy and after the beneficiary was discharged.

B. Absence due to Reasons Other than Institutionalization

When a waiver beneficiary is absent from the home for reasons other than institutionalization, the DAAS LTSS Program Eligibility Specialist will not be notified unless the beneficiary does not return home within 30 days. If, after 30 days, the beneficiary has not returned home and the providers can no longer deliver services as authorized on the Person-Centered Service Plan (PCSP) (e.g., the beneficiary has left the state and the return date is unknown), the DAAS RN will notify the DAAS LTSS Program Eligibility Specialist. Action will be taken by the DAAS LTSS Program Eligibility Specialist to close the waiver case.

NOTE: It is the responsibility of the provider to notify the DAAS RN immediately via form AAS-9511 upon learning of a change in the beneficiary's status.

212.500 Reporting Changes in Beneficiary's Status 10-1-16

Because the provider has more frequent contact with the beneficiary, many times the provider becomes aware of changes in the beneficiary's status sooner than the Division of Aging and Adult Services Registered Nurse (DAAS RN), Case Manager, or DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist. It is the provider's responsibility to report these changes immediately so proper action may be taken. Providers must complete the Waiver Provider Communication – Change of Participant Status Form (AAS-9511) and send it to the DAAS RN. A copy must be retained in the provider's beneficiary case record. Regardless of whether the change may result in action by the DAAS LTSS Program Eligibility Specialist, providers must immediately report all changes in the beneficiary's status to the DAAS RN.

The Targeted Case Manager is responsible for monitoring the beneficiary's status on a regular basis for changes in service need, referring the beneficiary for reassessment if necessary and reporting any beneficiary complaints and changes in status to the DAAS RN, or DAAS RN Supervisor immediately upon learning of the change.

213.100 Adult Family Homes 10-1-16

Procedure Code	Modifier	Description
S5140	U1	Adult Family Homes Level A
S5140	U2	Adult Family Homes Level B
S5140	U3	Adult Family Homes Level C

Adult Family Homes services are personal care and supportive services (e.g., Attendant Care, transportation and medication oversight (to the extent permitted under State Law)), provided in a certified private home by a principal care provider who lives in the home.

Payment for Adult Family Home services is not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for Adult Family Home services does not include payments made, directly or indirectly, to members of the beneficiary's immediate family.

Adult Family Home services provide a family living environment for adults who are functionally impaired and who, due to the severity of their functional impairments, are considered to be at imminent risk of death or serious bodily harm and, as a consequence, are not capable of fully independent living.

The number of beneficiaries served by an Adult Family Home may not exceed three (3) and beneficiaries must be unrelated to the adult family home provider. "Unrelated" is defined as any person who is not related to the provider by virtue of blood, marriage, or adoption. Other than the Adult Family Home provider, immediate family members or caregivers residing in the adult family home with the waiver beneficiary are prohibited from receiving Medicaid reimbursement for direct provision of any ARChoices services.

Adult Family Home services shall be included in the Person-Centered Service Plan (PCSP) only when it is necessary to prevent the permanent institutionalization of a beneficiary as determined by the Division of Aging and Adult Services Registered Nurse (DAAS RN). The Adult Family Home provider is responsible for meeting the needs of the waiver beneficiary, as defined by this waiver service description, 24 hours/day, 7 days/week.

Adult Family Homes add a dimension of family living to the provision of supportive services and personal care services such as:

A. Bathing

B. Dressing

C. Grooming

D. Care for occasional incontinence (bowel/bladder)

E. Assistance with eating

F. Enhancement of skills and independence in daily living

G. Transportation to allow access to the community

Services are provided in a home-like setting. The provider must include the beneficiary in the life of the family as much as possible. The provider must assist the beneficiary in becoming or remaining active in the community.

Services must be provided according to the participant's written ARChoices PCSP.

There are three (3) different reimbursement rates for Adult Family Homes based on the Level of Care required for the individual beneficiary. Level of Care is indicated by using a modifier with CPT Code **S5140**.

One (1) unit of service equals one (1) day. Adult Family Homes are limited to a maximum of thirty-one (31) units per month. Room and board costs are not included as a part of this service. Service payments are for the provision of daily living care to the beneficiary.

For any given year of the ARChoices Waiver, Adult Family Homes shall charge waiver residents no more than 90.8% of the current Individual SSI Benefit amount rounded to the nearest dollar for room and board. For any given year of the ARChoices Waiver, ARChoices Waiver beneficiaries shall receive 9% of the current Individual SSI Benefit amount rounded to the nearest dollar for personal needs allowance.

The waiver eligible person will cover the cost of room and board in the Adult Family Home. In addition, the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist will determine individual liability for care services based on the waiver eligible person's available resources. Medicaid will cover the remaining cost of waiver services provided to the waiver eligible person. The personal needs allowance is adequate to meet the other expenses of the waiver eligible person in the Adult Family Home and exceeds the personal needs allowance for beneficiaries in long term care facilities.

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

BENEFICIARIES RECEIVING ADULT FAMILY HOMES SERVICES ARE NOT ELIGIBLE TO RECEIVE ANY OTHER ARCHOICES SERVICE, EXCEPT FOR LONG-TERM FACILITY-BASED RESPITE.

213.110 Adult Family Homes Certification Requirements 10-1-16

Enrollment as an ARChoices Adult Family Homes provider requires certification by the Department of Human Services, Division of Aging and Adult Services (DAAS), as an Adult Family Home. Adult Family Homes providers must complete an application packet including Medicaid Provider forms; be tested over designated training materials and achieve a passing score and submit the home for inspection by designated DAAS staff. If substitute caregivers are identified, these beneficiaries must meet the same training and testing requirements as the Adult Family Homes provider. In addition, drug screens and background checks are required for the provider, substitute care givers and provider family members residing in the home and who are over the age of sixteen (16). Providers must recertify with DAAS annually. This requires submission of a renewal application packet and home inspection, as well as documentation of at least twelve hours of related training activities.

An Adult Family Home, for the purpose of the ARChoices Program, does not include any house, institution, hotel or other similar living situation that supplies room and board only, room only, or board only.

As a condition of certification, each Adult Family Homes provider shall execute with and provide to each beneficiary an admission agreement specifying services to be provided, the beneficiary's cost for room and board, conditions and rules governing the beneficiary and grounds for termination of residency. Each Adult Family Homes provider will also be required to develop and maintain written program policies. Program policies must include and comply with the HCBS Settings rules found in section C of 201.105.

NOTE: The Adult Family Home provider's ElderChoices certification will be valid as an ARChoices Adult Family Home provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

NOTE: At the next annual certification, the Adult Family Home provider must have policies in place that include and comply with the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

213.210 Attendant Care Services 10-1-16

Procedure Code	Modifier	Description
S5125	U2	Attendant Care Services
S5125		Attendant Care Self-Directed Model

Attendant Care services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible beneficiary's functioning in his or her own home or elsewhere in the community where the beneficiary engages in activities, including work-related activities.

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

Hands-on assistance, supervision and/or cueing are defined as:

A. "Hands-on assistance" means a provider physically performs all or part of an activity because the individual is unable to do so.

B. "Set-up", a form of hands on assistance, means getting personal effects, supplies, or equipment ready so that an individual can perform an activity.

C. "Supervision" means a provider must be near the individual to observe how the individual is completing a task.

D. "Cueing and/or reassurance" means giving verbal or visual clues and encouragement during the activity to help the individual complete activities without hands-on assistance.

E. "Monitoring", a form of supervision, means a provider must observe the individual to determine if intervention is needed.

F. "Stand-by", a form of supervision, means a provider must be at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.

G. "Support", a form of supervision, means to enhance the environment to enable the individual to be as independent as possible.

H. The following forms of assistance combine elements of Hands-on assistance, supervision and/or cueing:

I. "Redirection", a form of supervision or cueing, means to divert the individual to another more appropriate activity.

J. "Memory care support", a blend of supervision, cueing and hands-on assistance. Includes services related to observing behaviors, supervision and intervening as appropriate in order to safeguard the service beneficiary against injury, hazard or accident. These specific supports are designed to support beneficiaries with cognitive impairments.

Activities of daily living include:

A. Eating

B. Bathing

C. Dressing

D. Personal hygiene (grooming, shampooing, shaving, skin care, oral care, etc.)

E. Toileting

F. Mobility/ambulating, including mastering the use of adaptive aids and equipment

Instrumental activities of daily living include:

A. Meal planning and preparation

B. Managing finances

C. Laundry

D. Shopping and errands

E. Communication

F. Traveling and participation in the community

G. Housekeeping

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

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

Beneficiaries may choose to self-direct this service through Arkansas's IndependentChoices program under 1915(j) authority; or may receive services through an agency. The IndependentChoices Medicaid Provider Manual describes the self-directed service delivery model.

Attendant Care services must be provided according to the beneficiary ARChoices written PCSP.

A brief description of the service(s) provided, including the signature and title of the individual rendering the service, must be documented in the beneficiary's case record. See Section 214.000 for additional documentation requirements.

Benefit limits will be determined on a client basis based on the assessed level of need by the DAAS RN. The highest RUG level allows a maximum allocation of 324 units (81 hours) per week, 1,436 units (359 hours) per month, or 16,848 units (4,212 hours) per year.

Fifteen (15) minutes of service equals one (1) unit.

An ARChoices beneficiary who spends more than five (5) hours (20 units) at an adult day services or adult day health services facility or who is receiving short-term, facility-based respite care will not be eligible for Attendant Care services on the same date of service unless authorized by the DAAS RN.

An ARChoices beneficiary receiving long-term, facility-based respite care is not eligible for Attendant Care services on the same date of service.

213.240 Environmental Accessibility Adaptations/Adaptive Equipment 10-1-16

Environmental Accessibility Adaptations/Adaptive Equipment services enable the individual to increase, maintain and/or improve his or her functional capacity to perform daily life tasks that would not be possible otherwise. Environmental Accessibility Adaptations/Adaptive Equipment is physical adaptations to the home that are necessary to ensure the health, welfare and safety

of the beneficiary, to function with greater independence in the home and preclude or postpone institutionalization. Adaptive equipment also enables the ARChoices beneficiary to increase, maintain and/or improve his/her functional capacity to perform daily life tasks that would not be possible otherwise and perceive, control or communicate with the environment in which he or she lives.

Excluded are adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, air conditioning and others. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be in accordance with applicable state or local building codes. All dwellings that receive adaptations must be in good repair and have the appearance of sound structure.

Permanent fixtures are not allowed on rented or leased properties.

213.290 Environmental Modifications/Adaptive Equipment 10-1-16

Prior to payment for this service, the waiver beneficiary is required to secure 3 separate itemized bids for the same service. The bids are reviewed by the Division of Aging and Adult Services Registered Nurse (DAAS RN) or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided. All modification funds must be verified by the DAAS Provider Certification Unit prior to receiving services.

Each claim must be signed by the provider, the waiver beneficiary and DAAS RN, or designee. A statement of satisfaction form must be signed by the waiver beneficiary prior to any claim being submitted. All claim forms, bids and client satisfaction statement forms must be submitted to the DAAS Provider Certification Unit prior to submission for payment.

NOTE: The Environmental Modification provider's Alternatives for Adults with Physical Disabilities (AAPD) certification will be valid as an ARChoices Environmental Modification provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under AAPD.

213.311 Hot Home-Delivered Meal Provider Certification Requirements 10-1-16

To be certified by the Division of Aging and Adult Services (DAAS) as a provider of Hot Home-Delivered Meal 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;*

***NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located**

in bordering states, all requirements must meet their states' applicable laws and regulations.

E. Notify the 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 individual's condition is noted

NOTE: Changes in service delivery must receive prior approval by the DAAS RN who is responsible for the individual's Person-Centered Service Plan (PCSP). Requests must be submitted in writing to the DAAS RN. Any changes in the individual's circumstances must be reported to the DAAS RN via form AAS-9511.

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary's PCSP only when they are necessary to prevent the institutionalization of an individual.

Hot Home-Delivered Meals providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Food Establishment Permit at all times.

NOTE: The Home-Delivered Meals provider's ElderChoices certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.323 Frozen Home-Delivered Meal Provider Certification Requirements 10-1-16

In order to become approved providers of frozen meals, providers must meet all applicable requirements of the Division of Aging and Adult Services (DAAS) Nutrition Services Program Policy Number 206.

To be certified by DAAS as a provider of Home-Delivered Meal services, a meal 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, ensure that intermediate sources of delivery meet or exceed federal, state and local laws regarding food transportation and delivery*

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

***NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.**

E. 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 individual's freezer.
3. Have a remaining freezer life of at least three months from the date of delivery to the home.
4. Are part of a meal cycle of at least four weeks (i.e., four weeks of menus that differ).
5. Are properly labeled, listing food items included and non-frozen items that are delivered with the frozen components to complete the meal (which must include powdered or fluid milk, whichever is preferred by the ARChoices beneficiary), menu analysis as required by DAAS Nutrition Services Program Policy if other than DAAS menus are used and both packaging and expiration dates.

NOTE: The milk must be delivered to the beneficiary at least seven (7) days prior to its expiration date.

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

G. Ensure that meals that are not commercially prepared but produced on-site in the production kitchen:

1. Are prepared and packaged only in a central kitchen or on-site preparation kitchen;
2. Are prepared specifically to be frozen;
3. Are frozen as quickly as possible;
4. Are cooled to a temperature of below 40 degrees Fahrenheit within four hours;
5. Have food temperatures taken and recorded at the end of food production, at the time of packaging and throughout the freezing process, with temperatures recorded and kept on file for audit;
6. Are packaged in individual trays, properly sealed and labeled with the date, contents and instructions for storage and reheating;
7. Are frozen in a manner that allows air circulation around each individual tray;
8. Are kept frozen throughout storage, transport and delivery to the beneficiary; and
9. Are discarded after 30 days.

H. 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. Any changes in the individual's circumstances must be reported to the DAAS RN via form AAS-9511.

I. Notify the appropriate DAAS RN immediately if:

1. There is a problem with delivery of service
2. The individual is not consuming the meals
3. A change in an individual's condition is noted

NOTE: Changes in service delivery must receive prior approval by the DAAS RN who is responsible for the individual's Person-Centered Services Plan (PCSP). Requests must be submitted in writing to the DAAS RN. Any

changes in the individual's circumstances must be reported to the DAAS RN via form AAS-9511.

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary's PCSP only when they are necessary to prevent the institutionalization of an individual.

Frozen Home-Delivered Meals providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Food Establishment Permit at all times.

NOTE: The Home-Delivered Meals ElderChoices provider's certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.330 Limitations on Home-Delivered Meals (HDMs) 10-1-16

One unit of service equals one meal. The maximum number of HDMs eligible for Medicaid reimbursement per month equals 31 meals. This includes hot, frozen or a combination of the two. There is no separate benefit limit for frozen meals.

The maximum number of emergency meals per State Fiscal Year is four (4).

Frozen HDMs may be provided daily to eligible beneficiaries. A maximum of seven (7) meals may be delivered at one time.

HDM providers may deliver more than seven meals at one time, if:

A. The waiver beneficiary receives Attendant Care services or Personal Care at least three (3) times per week,

B. Frozen HDMs are ordered on the Person-Centered Services Plan (PCSP),

C. The waiver beneficiary has the means of storing 14 frozen meals (as verified by the DAAS RN).

HDM providers delivering frozen meals may deliver 14 at one time if the DAAS RN enters 14 meals delivery approved in the comments section of the HDM entry on the PCSP. If this statement is not on the PCSP, or if any of the other factors above are not in place, the meal providers cannot deliver more than seven (7) meals at one time.

An ARChoices beneficiary may not be provided with a Hot or Frozen HDM on any day during which the individual receives more than five (5) hours of in-home or facility-based Respite care or more than five (5) hours of Adult Day Services or Adult Day Health Services. (Licensure mandates that providers of these services provide a meal or meals; therefore, a HDM on these dates is a duplicative service and prohibited under waiver guidelines.)

NOTE: Medicaid reimbursement for HDMs is not allowed on the same day to beneficiaries who are also attending Adult Day Services, Adult Day Health Services, or facility-based Respite care for more than five (5) hours. When applying this policy, the time of day the beneficiary receives day services or respite services are also a factor. Whether there is duplication of services will be determined by comparing the time of day during which services occur.

When considering whether a HDM is billable for an individual receiving Adult Day Services, Adult Day Health Services or facility-based Respite services, on a specific date of service, the following must be applied:

If an ARChoices beneficiary is receiving Adult Day Services, Adult Day Health Services or facility-based Respite at any time between the hours of 11:00 a.m. and 1:30 p.m. **and** the noon meal is routinely served to others at the facility during this timeframe, the noon meal must also be served to this individual. A HDM is not allowable on the same date of service. This is true

regardless of the total number of Adult Day Services, Adult Day Health Services or Respite hours provided.

213.350 Emergency Meals 10-1-16

Beneficiaries may receive up to four (4) emergency meals per state fiscal year. The meals must:

A. Contain 33 1/3 percent of the Dietary Reference intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and Division of Aging and Adult Services (DAAS) Nutrition Services Program Policy Number 206.

B. Be labeled “Emergency Meal” in large print, with instruction on use of the meal.

C. Be used within the limits of their shelf life, usually within six months.

213.410 Personal Emergency Response System (PERS) Certification Requirements 10-1-16

To be certified by the Division of Aging and Adult Services (DAAS) as a provider of personal emergency response services, a provider must:

A. Provide, install and maintain Federal Communications Commission (FCC) approved equipment which meets all Underwriter Laboratories Safety Standards;

B. Designate or operate an emergency response center to receive signals and respond according to specified operating protocol;

C. Establish a response system for each beneficiary and ensure responders receive necessary instruction and training; and

D. Ensure that equipment is installed by qualified providers who also provide instruction and training to beneficiaries.

PERS providers must recertify annually with DAAS.

NOTE: The PERS ElderChoices provider’s certification will be valid as an ARChoices PERS provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.500 Adult Day Services 10-1-16

Procedure Code	Required Modifier	Description
S5100	U1	Adult Day Services, 8-20 Units Per Date of Service
S5100	—	Adult Day Services, 21-40 Units Per Date of Service

Adult day services facilities are licensed by the Office of Long-Term Care (OLTC) to provide care and supervision to meet the needs of four (4) or more functionally impaired adults for periods of less than 24 hours but more than two (2) hours per day, in a place other than the beneficiaries’ own homes.

When provided according to the beneficiary’s written ARChoices Person-Centered Service Plan (PCSP), ARChoices beneficiaries may receive adult day services for 8 or more units (2 or more

hours) per day, not to exceed 40 units (10 hours) per day, according to the beneficiary's written PCSP. Adult day services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month. One (1) unit of service equals 15 minutes.

As required, beneficiaries who are present in the facility for more than 20 units (5 hours) a day (procedure code **S5100**) must be served a nutritious meal that equals one-third of the Recommended Daily Allowance. Therefore, ARChoices beneficiaries are not eligible to receive a home-delivered meal on the same day they receive more than 20 units (5 hours) of adult day services. Additionally, beneficiaries who attend an adult day service for more than 20 units (5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the Division of Aging and Adult Services Registered Nurse (DAAS RN).

NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for an individual who attends adult day services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the beneficiary is receiving day services, day health services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the DAAS RN and/or Department of Human Services (DHS) audit staff and considered when determining any duplication in services for beneficiaries participating in the ARChoices Program.

Providers must consider the following to determine whether a home-delivered meal is billable for an individual receiving day services, day health services or facility-based respite services on a specific date of service.

If an ARChoices beneficiary is receiving day services, day health services or **facility-based** respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to this individual. A home-delivered meal is not allowable on the same date of service. This is true **regardless of the total number of day services or respite units provided**.

Adult day services and day health services providers are required to maintain a daily attendance log of beneficiaries. Section 214.000 contains information regarding additional documentation requirements.

213.510 Adult Day Services Certification Requirements 10-1-16

To be certified by the Division of Aging and Adult Services (DAAS) as a provider of adult day services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by the Arkansas Department of Human Services, Office of Long-Term Care as a long-term adult day care facility. Providers in the designated trade area cities in states that border Arkansas must be licensed and/or certified by the appropriate state agency as an Adult Day Care Facility.

In order to be certified by DAAS, Adult Day Services providers must meet the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

Adult Day Services providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Adult Day Care license at all times.

In order to be recertified by DAAS, Adult Day Services providers must meet the HCBS Settings rules found in section C of 201.105.

Providers are required to submit copy of renewed license to DAAS.

NOTE: The Adult Day Services ElderChoices provider's certification will be valid as an ARChoices Adult Day Services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.600 Adult Day Health Services (ADHS) 10-1-16

Procedure Code	Required Modifier	Description
S5100	TD, U1	Adult Day Health Services, 8-20 Units Per Date of Service
S5100	TD	Adult Day Health Services, 21-40 Units Per Date of Service

Adult day health services facilities are licensed to provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, social services and activities to beneficiaries who are functionally impaired and who, due to the severity of their functional impairment, are not capable of fully independent living.

Adult day health services programs provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the beneficiary that cannot be provided by adult day care programs. Adult day health services are appropriate only for beneficiaries whose facility-developed care plans specify one or more of the following health services:

A. Rehabilitative therapies (e.g., physical therapy, occupational therapy),

B. Pharmaceutical supervision,

C. Diagnostic evaluation or

D. Health monitoring

ARChoices beneficiaries may receive adult day health services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day when the service is provided according to the beneficiary's written ARChoices Person-Centered Service Plan (PCSP). Adult day health services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day health services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month.

Beneficiaries who are present in the facility for more than 20 units (5 hours) a day (procedure code **S5100**, modifier **TD**) must be served a nutritious meal that equals one-third of the Recommended Daily Dietary Allowances. Therefore, ARChoices beneficiaries are not eligible to receive a home-delivered meal on the same day they receive more than five (5) hours of adult day health services. Additionally, beneficiaries who attend an adult day health services for more than 20 units (5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the Division of Aging and Adult Services Registered Nurse (DAAS RN).

Adult day health services providers are required by licensure to maintain a daily attendance log of beneficiaries. See Section 214.000 for additional documentation requirements.

NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for an individual who attends adult day services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the beneficiary is receiving day services or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the DAAS RN and/or Department of Human Services (DHS) audit staff and considered when determining any duplication in services for beneficiaries participating in the ARChoices Program.

Providers must consider the following to determine whether a home-delivered meal is billable for an individual receiving day services or facility-based respite services on a specific date of service.

If an ARChoices beneficiary is receiving day services or facility-based respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to the individual. A home-delivered meal is not allowable on the same date of service. **This is true regardless of the total number of day services or respite units provided.**

213.610 Adult Day Health Services (ADHS) Provider Certification Requirements 10-1-16

To be certified by the Division of Aging and Adult Services (DAAS) as a provider of adult day health services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by Arkansas Department of Human Services, Office of Long-term Care as a long-term adult day health care facility. Providers in the designated trade area cities in states that border Arkansas must be licensed and/or certified by the appropriate state agency as an Adult Day Health Care Facility.

In order to be certified by DAAS, Adult Day Health Services providers must meet the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

Adult Day Health Services providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Adult Day Health Care license at all times. In order to be recertified, Adult Day Health Services providers must meet the HCBS Settings rules found in section C of 201.105.

Providers are required to submit copy of renewed license to DAAS.

NOTE: Adult day services and adult day health services are not allowed on the same date of service.

NOTE: The Adult Day Health Services ElderChoices provider's certification will be valid as an ARChoices Adult Day Health Services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.700 Respite Care 10-1-16

Procedure Code	Description
T1005	Long-Term Facility-Based Respite Care
S5135	Short-Term Facility-Based Respite Care
S5150	In-Home Respite Care

Respite care services provide temporary relief to persons providing long-term care for beneficiaries in their homes. Respite care may be provided outside of the beneficiary's home to meet an emergency need or to schedule relief periods in accordance with the regular caregiver's need for temporary relief from continuous care giving. If there is no primary caregiver, respite care services will not be deemed appropriate and subsequently will not be authorized on the Person-Centered Service Plan (PCSP).

In the event the in-home functional assessment performed by the Division of Aging and Adult Services Registered Nurse (DAAS RN) substantiates a need for respite care services, the service will be authorized as needed, via the beneficiary's PCSP, not to exceed an hourly maximum. The DAAS RN will establish the service limitation based on the beneficiary's medical need, other services included on the PCSP and support services available to the beneficiary. Respite care services must be provided according to the beneficiary's written PCSP.

An individual living in the home with the beneficiary is prohibited from serving as a Respite Services provider for the beneficiary.

213.711 Facility-Based Respite Care 10-1-16

Facility-based respite care may be provided outside the beneficiary's home on a short- or long-term basis by certified adult family homes, residential care facilities, nursing facilities, adult day care facilities, adult day health care facilities, Level I and Level II Assisted Living Facilities and hospitals.

Facility-based providers rendering services for eight (8) hours or less per date of service must bill **S5135** for short-term, facility-based respite care. One (1) unit of service for procedure code **S5135** equals 15 minutes. Eligible beneficiaries may receive up to 32 units (8 hours) of short-term, facility-based respite care per date of service.

Facility-based providers rendering services for more than 32 units (8 hours) per day must bill **T1005** for long-term, facility-based respite care. One (1) unit of service for procedure code **T1005** equals 15 minutes. A beneficiary may receive up to 96 units (24 hours) of service per date of service if the provider bills procedure code **T1005**.

Facility-based respite care services include short-term and long-term respite care services and can include any combination of billing codes **S5135** or **T1005**. A single provider may provide both long-term and short-term facility-based respite care services for a particular beneficiary, but not on the same date of service.

Eligible beneficiaries may receive up to 4800 units (1200 hours) per State Fiscal Year of Facility-Based Respite Care- or In-Home Respite Care, or a combination of the two. Adult Family Home beneficiaries are limited to 2400 units (600 hours) of long-term facility-based respite per state fiscal year.

Beneficiaries receiving long-term, facility-based respite care services may receive only ARChoices Personal Emergency Response System (PERS) services concurrently.

Please refer to the NOTE found in Section 213.500 regarding Home-Delivered Meals and facility-based respite services.

261.000 Introduction to Billing 10-1-16

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

ARChoices providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

262.100 HCPCS Procedure Codes 10-1-16

The following procedure codes must be billed for ARChoices 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
S5140	Level A – U1 Level B – U2 Level C – U3	Adult Family Homes	1 day	99

Procedure Code	Modifiers	Description	Unit of Service	National POS for Claims
S5125		Attendant Care Services	15 minutes	12
S5125	U2	Agency Attendant Care Traditional	15 minutes	12, 99
S5170	U2	Home-Delivered Meals	1 meal	12
S5170		Frozen Home-Delivered Meal	1 meal	12
S5170	U1	Emergency Home Delivered Meals	1 meal	12
S5161	UA	Personal Emergency Response System	1 day	12
S5160		Personal Emergency Response System – Installation	One install	12
S5100	U1	Adult Day Services, 8 to 20 units per date of service	15 minutes	99
S5100		Adult Day Services, 21 to 40 units per date of service	15 minutes	99
S5100	TD, U1	Adult Day Health Services, 8 to 20 units per date of service	15 minutes	99
S5100	TD	Adult Day Health Services, 21 to 40 units per date of service	15 minutes	99
S5150		Respite Care – In-Home	15 minutes	12
S5135		Respite Care – Short-Term Facility-Based	15 minutes	99, 21, 32
T1005		Respite Care – Long-Term Facility-Based	15 minutes	21, 32, 99

262.400 Special Billing Procedures – Environmental Modifications/Adaptive Equipment 10-1-16

Prior to payment for this service, the ARChoices beneficiary is required to secure three separate itemized bids for the same service. The bids are reviewed by the Division of Aging and Adult Services Registered Nurse (DAAS RN) or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided.

Each claim must be signed by the provider, the ARChoices beneficiary, and DAAS RN, or designee. A statement of satisfaction form must be signed by the ARChoices beneficiary prior to any claim being submitted. Please refer to 213.290 for additional information.