

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Craig Cloud
TELEPHONE NO. 501-320-6439 FAX NO. 501-404-4619 EMAIL: Craig.Cloud@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Living Choices Assisted Living Waiver Renewal

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐
2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐
3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

If an agency is proposing a more costly rule, please state the following:

- (a) How the additional benefits of the more costly rule justify its additional cost;

- (b) The reason for adoption of the more costly rule;

- (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain.

- (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

- (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Next Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year

General Revenue	\$2,533
Federal Funds	\$5,972
Cash Funds	_____
Special Revenue	_____
Other (Identify)	_____
Total	\$8,505

Next Fiscal Year

General Revenue	\$184,831
Federal Funds	\$426,586
Cash Funds	_____
Special Revenue	_____
Other (Identify)	_____
Total	\$611,417

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year

\$ _____

Next Fiscal Year

\$ _____

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year

\$ 2,533

Next Fiscal Year

\$ 184,831

This will be a cost of state general revenue to the Medicaid program.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars (\$100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

The purpose of increasing the point in time cap is to delay the need for a waiting list. If the cap is not increased, it is projected that a waiting list will be needed by June 2016.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

The problem is the current point in time cap is too low to meet projected growth. Increasing the point in time cap is not required by statute. CMS does not require a point in time cap. The point in time cap is used as a management tool for the agency. DAAS seeks to delay the point in time cap without changing the unduplicated cap of 1,300. Due to the critical need for individuals in need of assisted living, individuals waiting on a slot for assisted living will most likely choose more costly nursing home care.

- (3) a description of the factual evidence that:
- (a) justifies the agency's need for the proposed rule; and

Individuals in need of assisted living services face a critical need for the service. It is often determined that the individual can no longer remain safely in their own home. The need for round-the-clock care is evident. If an individual in need of these services is faced with a lengthy wait for admittance in an assisted living facility because a waiver slot is not available, they will be forced to seek more costly care in a nursing facility. Medicaid mandates nursing facility care, so there are no caps on the number of individuals who can receive Medicaid in a nursing facility.

- (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

There are no statutory requirements for this change. The rules cost may decrease the need for nursing facility care.

- (4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

The state could keep the point in time cap at 1,000. This will create a waiting list beginning June 2016. By delaying implementation of the waiting list, it will delay the need for more costly nursing home care.

- (5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

N/A

- (6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

N/A

- (7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

The waiver is renewed every 5 years and the cap will be reevaluated at that time.

- (a) the rule is achieving the statutory objectives;
- (b) the benefits of the rule continue to justify its costs; and
- (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.



Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789



TO: Arkansas Medicaid Health Care Providers – Living Choices Assisted Living

DATE: February 1, 2016

SUBJECT: Provider Manual Update Transmittal LCAL-2-15

REMOVE

Section	Date
200.105	1-1-13
200.230	1-1-13

INSERT

Section	Date
200.105	2-1-16
200.230	2-1-16

Explanation of Updates

Section 200.105 is updated to correct grammar and to include Home and Community Based Services Settings information.

Section 200.230 is updated to correct a misspelled word.

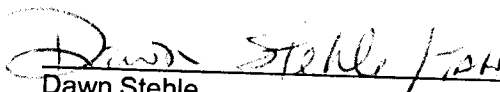
The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services 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 not required***200.105 Provider Assurances****2-1-16****A. Staffing**

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries for whom they have accepted a Living Choices Assisted Living Waiver Plan of Care.

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.
3. Staff is required to attend orientation training prior to allowing the employee to deliver any Living Choices Assisted Living Waiver service(s). This orientation shall include, but not be limited to, a:
 - a. Description of the purpose and philosophy of the Living Choices Assisted Living Waiver Program;
 - b. Discussion and distribution of the provider agency's written code of ethics;
 - c. Discussion of activities which shall and shall not be performed by the employee;
 - d. Discussion, including instructions, regarding Living Choices Assisted Living Waiver record keeping requirements;
 - e. Discussion of the importance of the Plan of Care;
 - f. Discussion of the agency's procedure for reporting changes in the beneficiary's condition;
 - g. Discussion, including potential legal ramifications, of the beneficiary's right to confidentiality.

B. Quality Controls

The Provider agrees to continually monitor beneficiary satisfaction and quality of service delivery and to document his or her findings in the beneficiary's record every ninety days via the Quarterly Monitoring Form (AAS-9506). **View or print the AAS-9506 form.**

C. Code of Ethics

The Provider agrees to develop, distribute and enforce a written code of ethics with each employee providing services to a Living Choices Assisted Living Waiver beneficiary that shall include, but not be limited to, the following:

1. No consumption of the beneficiary's food or drink;
2. No use of the beneficiary's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;
4. No acceptance of gifts or tips from the beneficiary or their caregiver;
5. No friends or relatives of the employee or unauthorized individuals are to accompany the employee to the beneficiary's assisted living facility apartment unit;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery nor in the beneficiary's assisted living facility apartment unit;
7. No smoking in the beneficiary's assisted living facility apartment unit;
8. No solicitation of money or goods from the beneficiary;

9. No breach of the beneficiary's privacy or confidentiality of records.

D. Home and Community Based Services (HCBS) Settings

All Level II Assisted Living Facilities licensed by the OLTC and participating in the Arkansas Medicaid waiver must meet the following Home and Community Based Services (HCBS) Settings regulations as established by CMS. The federal regulations for the new rule is 42 CFR 441.301(c) (4)-(5). Facilities who enroll in the waiver on or after the date of this policy change must meet these HCBS settings requirements prior to certification. Those facilities already enrolled in the waiver before this policy change must comply with the HCBS settings requirements under the timeframe established by the HCBS settings transition plan.

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

HCBS settings must have the following characteristics:

1. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
 - a. Choice must be identified/included in the person-centered service plan.
 - b. Choice must be based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
2. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
3. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
4. Facilitates individual choice regarding services and supports and who provides them.
5. In a provider-owned or controlled residential setting (e.g., Assisted Living Facilities), in addition to the qualities specified above, the following additional conditions must be met:
 - a. The unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
 - b. Each individual has privacy in their sleeping or living unit:
 - i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
 - ii. Beneficiaries sharing units have a choice of roommates in that setting.
 - iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
 - c. Beneficiaries have the freedom and support to control their own schedules and activities, and have access to food at any time.
 - d. Beneficiaries are able to have visitors of their choosing at any time.
 - e. The setting is physically accessible to the individual.
 - f. Any modification of the additional conditions specified in items a through d above must be supported by a specific assessed need and justified in the

person-centered service plan. The following requirements must be documented in the person-centered service plan:

- i. Identify a specific and individualized assessed need.
- ii. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- iii. Document less intrusive methods of meeting the need that have been tried but did not work.
- iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
- v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- vii. Include the informed consent of the individual.

200.230**Staffing Requirements for Living Choices Assisted Living Agencies****2-1-16**

Living Choices Assisted Living Agencies have available two methods by which they may engage staff to furnish Living Choices bundled services.

- A. The traditional method is using only employees, not contractors, to furnish the services. Its home health license confirms that the agency is qualified to provide home health services. The provider meets the state's qualification requirement by virtue of its licensure, and its enrollment as a Living Choices services provider, which is based on the agency's contract with a Level II ALF. These qualification criteria easily pass the CMS test of reasonableness.
- B. Another method is to use both employees and contractors to provide services. Federal regulations allow home health agencies to contract for provision of component parts (but not all component parts) of the full service (home health) they are licensed to provide. However, the enrolled provider is held responsible for the provision of the service "in total" and each component of the service (whether furnished directly by the provider or by someone else under contract to the provider) must meet the applicable standards set forth by the Medicaid agency for the provision of that component of care.

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Appendix B-3: Number of Individuals Served - b. Increased the maximum number of participants served at any point during the year from 1,000 individuals to 1,200 individuals.

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

1. Request Information (1 of 3)

- A. The State of Arkansas requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. Program Title (optional - this title will be used to locate this waiver in the finder):

Living Choices Assisted Living Waiver

C. Type of Request: renewal

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

☐ 3 years ☒ 5 years

Original Base Waiver Number: AR.0400

Draft ID: AR.016.03.00

D. Type of Waiver (select only one):

Regular Waiver

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

02/01/16

1. Request Information (2 of 3)

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

☐ Hospital

Select applicable level of care

☐ Hospital as defined in 42 CFR §440.10

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

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

☒ Nursing Facility

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

☒ Not applicable

☐ Applicable

Check the applicable authority or authorities:

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

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

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

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

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

☐ §1915(b)(2) (central broker)

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

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

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

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

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

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

☐ A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Living Choices Assisted Living waiver program allows individuals to live in apartment-style living units in licensed level II assisted living facilities and receive individualized personal, health and social services that enable optimal maintenance of their individuality, privacy, dignity and independence. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation. The environment promotes participants' personal decision-making while protecting their health and safety. The major goal of this program is to delay or prevent institutionalization of these individuals. Living Choices includes 24-hour on-site response staff to assist with participants' known physical dependency needs or other conditions, as well as to manage unanticipated situations and emergencies. Assisted living facility staff will perform their duties and conduct themselves in a manner that fosters and promotes participants' dignity and independence. Supervision, safety and security are essential components of the assisted living environment. Living Choices includes therapeutic, social and recreational activities suitable to the participants' abilities, interests and needs.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
 - ☐ Yes. This waiver provides participant direction opportunities. Appendix E is required.
 - ☒ No. This waiver does not provide participant direction opportunities. Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
 - ☒ Not Applicable
 - ☐ No
 - ☐ Yes
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
 - ☒ No
 - ☐ Yes

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

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

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

5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

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

Updates and revisions to the waiver are posted on the DMS website to allow for external public comment. Notices of updates or revisions are also published in a statewide newsletter for 30 days to allow for public review and comment.

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

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

7. Contact Person(s)

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

Last Name:

Blomeley

First Name:

Seth

Title:

DHS/DMS Business Operations Manager

Agency:

Arkansas Dept. of Human Services, Division of Medical Services

Address:

PO Box 1437, Slot S-295

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 320-6425

Ext:

☐

TTY

Fax:

(501) 682-2480

E-mail:

seth.blomeley@dhs.arkansas.gov

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

Last Name:

Blocker

First Name:

Stephenie

Title:

Assistant Director

Agency:

Arkansas Dept. of Human Services, Division of Aging & Adult Services

Address:

PO Box 1437, Slot S-530

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 320-6569

Ext:

☐

TTY

Fax:

(501) 682-8155

E-mail:

stephenie.blocker@dhs.arkansas.gov

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Arkansas

Zip:

Phone:

 Ext: ☐ TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

- ☐ Replacing an approved waiver with this waiver.
- ☐ Combining waivers.
- ☐ Splitting one waiver into two waivers.
- ☐ Eliminating a service.
- ☐ Adding or decreasing an individual cost limit pertaining to eligibility.
- ☐ Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- ☐ Reducing the unduplicated count of participants (Factor C).
- ☒ Adding new, or decreasing, a limitation on the number of participants served at any point in time.

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

Specify the transition plan for the waiver:

The current unduplicated count will remain at 1300 during each of the 5 waiver years. The point in time cap will increase from 1000 to 1200 for each of the 5 waiver years. There are no additional changes to the waiver.

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

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

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

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

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

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

The following is DAAS's transition plan to ensure these providers are in full compliance. The plan outlines the process and timeline DAAS and stakeholders will follow to identify and assess at-risk providers, remediate any areas of non-compliance, and outreach and engage providers and other stakeholders.

Section 1: Identification

A. Obtain action committee breakdown by role

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

- ☐ The waiver is operated by the State Medicaid agency.

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

- ☐ The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

The state utilizes the Interagency Agreement to define each agency's responsibilities in administering the Living Choices waiver program. This agreement is reviewed annually and updated as needed. DMS monitors this agreement to assure that the provisions specified are executed.
As part of the Interagency Agreement, DMS requires DAAS to develop and implement a Quality Assurance Protocol, which is reviewed annually, that demonstrates how the operating agency will meet the following criteria:
- assuring the health and welfare of waiver participants;
- assuring the adherence of service plans for waiver participants.

Appendix A: Waiver Administration and Operation

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

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

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

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

Appendix A: Waiver Administration and Operation

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

- ☒ Not applicable

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

Check each that applies:

- ☐ Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level.

There is an interagency agreement or memorandum of understanding between the State and these agencies that sets forth

responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☒
Waiver expenditures managed against approved levels	☒	☐
Level of care evaluation	☒	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☐	☐
Utilization management	☒	☐
Qualified provider enrollment	☒	☐
Execution of Medicaid provider agreements	☒	☐

Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

No Waiver Service Report

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Quarterly QA Report (Chart Reviews)

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

		☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☒ Other Specify: DMS performs a validation review of 20% of charts reviewed by DAAS during the Chart Record Review process.
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of unduplicated participants served within approved limits specified in the approved waiver. Numerator: Number of unduplicated participants served within approved limits; Denominator: Number of unduplicated participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

PDQA Request Forms

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

Data Aggregation and Analysis:

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

	☒ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Quarterly QA Report (Chart Reviews)

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and	Frequency of data aggregation and
--	-----------------------------------

analysis (check each that applies):	analysis(check each that applies):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☒ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of waiver claims on the Overlapping Services Report having the same date of service as a claim for institutional services, which correctly paid only for the date of discharge. Numerator: Number of waiver claims on the Overlapping Services Report which correctly paid only for the date of discharge; Denominator: Number of waiver claims reviewed from the Overlapping Services Report.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Overlapping Services Report

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Monthly Activity Report

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

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Average Days Report

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Quarterly QA Report (Chart Reviews)

Responsible Party for data	Frequency of data	Sampling Approach(<i>check each</i>)
----------------------------	-------------------	--

collection/generation(<i>check each that applies</i>):	collection/generation(<i>check each that applies</i>):	<i>that applies</i> :
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☒ Other Specify: DMS performs a validation review of 20% of charts reviewed by DAAS during the Chart Record Review process.
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of LOC assessments completed by a DAAS qualified evaluator according to the

agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by a DAAS qualified evaluator; Denominator: Number of LOC assessments reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Quarterly QA Report (Chart Reviews)

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

Data Aggregation and Analysis:

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

	☐
	☐ Other Specify:

Performance Measure:

Number and percent of active participants served within approved limits specified in the approved waiver.

Numerator: Number of active participants served within approved limits; Denominator: Number of active participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

ACES Report of Active Cases (Point in Time)

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly

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

Performance Measure:

Number and percent of providers licensed by the Office of Long-Term Care. Numerator: Number of current providers licensed by the Office of Long-Term Care; Denominator: Number of providers participating in the waiver program.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Quarterly QA Report (Record Reviews)

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider File Review

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

Data Aggregation and Analysis:

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

	Specify:
--	---

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging & Adult Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation. DAAS and DMS have an Interagency Agreement for measures related to administrative authority of the waiver.
In cases where the numbers of active participants and unduplicated participants served in the waiver are not within approved limits, remediation includes waiver amendments and possibly implementing a waiting list. DMS reviews and approves all policy and procedures (including waiver amendments) developed by DAAS prior to implementation, as part of the Interagency Agreement. In cases where policy or procedures were not reviewed and approved by DMS, remediation includes DAAS reviewing the policy or procedures and approving or revising the policy.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

☒ No

☐ Yes

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

Appendix B: Participant Access and Eligibility

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

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

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

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

N/A

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

- ☐ Not applicable. There is no maximum age limit
- ☒ The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

The participant remains in the waiver under the Aged group.

Appendix B: Participant Access and Eligibility

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

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

- ☒ **No Cost Limit.** The State does not apply an individual cost limit. Do not complete Item B-2-b or item B-2-c.
- ☐ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. Complete Items B-2-b and B-2-c.

The limit specified by the State is (select one)

- ☐ A level higher than 100% of the institutional average.

Specify the percentage:

- ☐ Other

Specify:

- ☐ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ☐ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

- ☐ The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

- ☐ Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- ☐ The participant is referred to another waiver that can accommodate the individual's needs.
- ☐ Additional services in excess of the individual cost limit may be authorized.

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

- ☐ Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1300
Year 2	1300
Year 3	1300
Year 4	1300
Year 5	1300

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	1200

Year 2	1200
Year 3	1200
Year 4	1200
Year 5	1200

Appendix B: Participant Access and Eligibility

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

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

- ☒ Not applicable. The state does not reserve capacity.
- ☐ The State reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

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

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

- ☒ The waiver is not subject to a phase-in or a phase-out schedule.
- ☐ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.**

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.
- ☐ Waiver capacity is allocated to local/regional non-state entities.

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

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

Entrance onto the Living Choices waiver program is on a first come, first-served basis, once individuals meet all medical and financial eligibility requirements. However, once the unduplicated number of participants is reached, a waiting list will be implemented for this program and the following process will apply. Each Living Choices application will be accepted and eligibility will be determined. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services; that all waiver slots are filled; and that the applicant is number _____ in line for an available slot. It is not permissible to deny any eligible person based on the unavailability of a slot in the Living Choices program.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ☒ §1634 State

- ☐ SSI Criteria State
☐ 209(b) State

2. Miller Trust State.

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

- ☐ No
☒ Yes

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

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

- ☐ Low income families with children as provided in §1931 of the Act
☒ SSI recipients
☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
☐ Optional State supplement recipients
☐ Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- ☐ 100% of the Federal poverty level (FPL)
☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii) (XIII) of the Act)
☐ Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii) (XV) of the Act)
☐ Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
☐ Medically needy in 209(b) States (42 CFR §435.330)
☐ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
☐ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

☒ A special income level equal to:

Select one:

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

Specify percentage:

- ☐ A dollar amount which is lower than 300%.

Specify dollar amount:

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

Select one:

- ☐ 100% of FPL
☐ % of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- ☒ Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act.
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g, unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

- ☒ Use spousal post-eligibility rules under §1924 of the Act.
(Complete Item B-5-b (SSI State) and Item B-5-d)
- ☐ Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- ☐ Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- ☐ The following standard included under the State plan

Select one:

- ☐ SSI standard
- ☐ Optional State supplement standard
- ☐ Medically needy income standard
- ☐ The special income level for institutionalized persons

(select one):

- ☐ 300% of the SSI Federal Benefit Rate (FBR)
- ☐ A percentage of the FBR, which is less than 300%

Specify the percentage:

- ☐ A dollar amount which is less than 300%.

Specify dollar amount:

- ☐ A percentage of the Federal poverty level

Specify percentage:

- ☐ Other standard included under the State Plan

Specify:

- ☐ The following dollar amount

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

- ☐ The following formula is used to determine the needs allowance:

Specify:

☒ Other

Specify:

Up to 200% of the Individual SSI Federal Benefit Rate (FBR) which includes:
~ 90.8 % of the Individual SSI FBR, rounded up to the nearest dollar, to cover room and board; refer to appendix I-5 for the explanation of the method used by the state to exclude Medicaid payment for room and board.
~ 9% of the SSI FBR, rounded up to the nearest dollar, for personal needs
~ Up to 100% of the Individual SSI FBR of earned income to cover work-related expenses for participants whose physician's service plan prescribes an employment activity as a therapeutic or rehabilitative measure

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

☒ Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

- ☐ SSI standard
☐ Optional State supplement standard
☐ Medically needy income standard
☐ The following dollar amount:

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

☐ The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

- ☐ Not Applicable (see instructions)
☒ AFDC need standard
☐ Medically needy income standard
☐ The following dollar amount:

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

☐ The amount is determined using the following formula:

Specify:

☐ Other

Specify:

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

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

Select one:

- ☐ Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☒ The State does not establish reasonable limits.
- ☐ The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

- ☐ SSI standard
- ☐ Optional State supplement standard
- ☐ Medically needy income standard
- ☐ The special income level for institutionalized persons
- ☐ A percentage of the Federal poverty level

Specify percentage:

- ☐ The following dollar amount:

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

- ☐ The following formula is used to determine the needs allowance:

Specify formula:

☒ Other

Specify:

Up to 200% of the Individual SSI Federal Benefit Rate (FBR) which includes:

- 90.8 % of the Individual SSI FBR, rounded up to the nearest dollar, to cover room and board, refer to appendix 1-5 for the explanation of the method used by the state to exclude Medicaid payment for room and board.
- 9% of the SSI FBR, rounded up to the nearest dollar, for personal needs
- Up to 100% of the Individual SSI FBR of earned income to cover work-related expenses for participants whose physician's service plan prescribes an employment activity as a therapeutic or rehabilitative measure.

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

Select one:

- ☒ Allowance is the same
☐ Allowance is different.

Explanation of difference:

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

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

Select one:

- ☐ Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
☒ The State does not establish reasonable limits.
☐ The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. **Minimum number of services.**

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

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

- ☒ The provision of waiver services at least monthly
☐ Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

- ☐ Directly by the Medicaid agency
☒ By the operating agency specified in Appendix A
☐ By an entity under contract with the Medicaid agency.

Specify the entity:

- ☐ Other
Specify:

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

Individuals who perform the initial evaluation of level of care for waiver applicants, and all annual re-evaluations, are state employed registered nurses licensed in the state of Arkansas. DAAS RNs receive extensive training on the tool used to perform LOC evaluations before any evaluations are performed. New DAAS RNs are trained by an RN supervisor who is experienced in completing the level of care evaluation using the InterRAI Homecare Assessment tool. In addition, new RNs shadow experienced RNs in performing LOC evaluations before ever performing them on their own.

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

INSTRUMENTS/TOOLS USED - The electronic InterRAI home care instrument, called ArPath is the instrument/tool used to collect information to determine the initial and continuing level of care and functional need eligibility for home and community-based services (HCBS) waiver participants. Based on the information that the participant and/or parties on behalf of the participant provide during the assessment, ArPath uses algorithms to evaluate and categorize participant information into scales, Client Assessment Protocols (CAPs), Resource Utilization Groups (RUGs) and levels of care, which correspond to the eligibility criteria listed in this section.

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

- ☐ The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
☒ A different instrument is used to determine the level of care for the waiver than for institutional care under the State Plan.

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

The instrument used to evaluate institutional level of care is form DHS-703 (Evaluation of Medical Need Criteria). The DHS-703 is completed by a nurse and includes information obtained from the participant, family members, caregivers and others. The DHS-703 was designed based on the MDS and the state's nursing home admission criteria. It is the nurse's personal assessment of the participant and includes observations and evaluation of the participant's ability to perform activities of daily living, along with other relevant information regarding the individual's medical history. ArPath, the electronic InterRAI home care instrument is used to evaluate level of care for the Living Choices Assisted Living program. Both the ArPath and the DHS-703 assess needs and are person-centered, focusing on the participant's functioning and quality of life. However, ArPath applies algorithms in the system that automatically determine functional eligibility and where assistance is needed. Based on the information revealed during the assessment, ArPath uses algorithms to evaluate and categorize participant information into scales, Client Assessment Protocols (CAPs), Resource Utilization Groups (RUGs) and levels of care.

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

The process for the initial evaluation and re-evaluation of level of care for waiver participants is different. An initial individual assessment of the participant is performed by the waiver DAAS RN utilizing the electronic InterRAI home care instrument, called ArPath. Each DAAS RN is a licensed registered nurse, employed by the Department of Human Services, Division of Aging and Adult Services. Once the assessment is completed by the DAAS RN, ArPath will generate a DHS-704, Decision for Nursing Home Placement, which reflects the level of care. Functional need eligibility is valid for one year, unless specified otherwise on the DHS-704. The Office of Long Term Care reviews the assessments to ensure the assessment tool continues to reflect the correct nursing home level of care.

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

- ☐ Every three months
☐ Every six months
☒ Every twelve months
☐ Other schedule

Specify the other schedule:

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

- ☒ The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
☐ The qualifications are different.

Specify the qualifications:

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

The waiver DAAS RN is responsible for tracking the review dates and initiating timely reevaluations prior to the level of care review date and prior to the expiration of the service plan (of care). The DAAS RN establishes a tracker file to track these dates and begins the reassessment process two months prior to the expiration date on the service plan (of care) or two months prior to the date the ArPath assessment was signed in the previous year, whichever is earlier. This process ensures timely reevaluations prior to the level of care review date and the expiration of the service plan (of care) so that no lapse in service occurs. The DAAS RN supervisory staff, through the record review process and through routine monitoring and auditing procedures, notifies the appropriate DAAS RN and RN supervisor if a re-assessment has not been completed within the specified DAAS policy timeframe. The ACES report produced by the Division of County Operations is used as a tool by the DAAS RN and RN supervisor to determine if the assessment is current or has expired. Persons of non-compliance per departmental and disciplinary action to address if necessary. The DAAS RN will then complete the reassessment.

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

Records of evaluations and re-evaluations of level of care are maintained by both the Division of Aging & Adult Services (DAAS), the primary authority for the daily operation of the waiver program, and the Division of Medical Services (DMS), Office of Long Term Care (OLTC), which is responsible for the final level of care evaluations and re-evaluations. DAAS maintains records for a period of six years from the date of closure/denial or until all audit questions, appeal hearings, investigations or court cases are resolved for a participant, whichever is longer.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAAS uses the Rausoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a ±6.4% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check	Frequency of data collection/generation (check	Sampling Approach (check each that applies):
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<i>each that applies):</i>	<i>each that applies):</i>	
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAAS uses the Raosoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 4% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to

the approved description to determine participant level of care.

Performance Measures

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

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

Performance Measure:

Number and percentage of participants' LOC determinations made by a qualified evaluator.

Numerator: Number of participants with LOC made by a qualified evaluator; Denominator:

Number of records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAAS uses the Rausoft Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 4% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Monthly Level of Care Report

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

	Specify: 	
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Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Case Record Review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = DAAS uses the Rao-Blackwell Calculation System to determine the sample size. The system provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:

	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

The state currently implements a system of monitoring that assures timeliness, accuracy, appropriateness and quality. Data is collected from individual participant assessments, aggregated to produce summation reports, and compared with periodic randomly sampled record reviews and sampled Program Integrity reviews.
Participant records undergo record reviews performed by DAAS RN supervisors. Monthly activity reports track assessments and reassessments performed by DAAS RNs. DAAS RN reports are submitted to program RN supervisors and the HCBS Director, who then review for timeliness and accuracy. The 45 Day Review tracks all waiver applications and identifies needs arising within 45 days. In addition, DAAS maintains a study log of assessments and reassessments sent to the DMS Office of Long Term Care for medical determination. Data from all assessment and review activity is summarized in...

b. Methods for Remediation/Fixing Individual Problems

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

The Division of Aging & Adult Services (operating agency) and the Division of Medical Services (Medicaid agency) participate in quarterly team meetings to discuss and address individual problems associated with level of care determination and system improvement, as well as problem correction and remediation. DAAS and DMS have an Interagency Agreement that includes measures related to level of care determination for the waiver.
The system currently in place for new applicants to enter the waiver program does not allow for services to be delivered prior to an initial level of care assessment. Also, DAAS requires that all initial assessments and reassessments of level of care are completed by a registered nurse. Therefore, performance measures related to these processes will always result in 100% compliance, and not allow for the possibility of remediation.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☒ Monthly

☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

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

☒ No

☐ Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

At the time of assessment and re-assessment of the waiver participant, the DAAS RN explains the services available through the Living Choices waiver, discusses the qualified assisted living providers in the state and develops an appropriate person-centered service plan. As part of the service plan development process, the participant (or representative) documents their choice to have services provided in the community setting through the HCBS waiver as opposed to receiving services in an institutional setting. In addition, freedom of choice is explained through a Freedom of Choice form and the applicable qualified provider listing; both are signed by the waiver participant or their representative. This is documented on the service plan, which includes the signature of the waiver participant (or representative) and the DAAS RN, and included in the participant's electronic record. NOTE: For reassessments, the Freedom of Choice form is utilized showing if changes are requested by the participant. If no changes are requested, no signatures are required on the provider listing; however, the Freedom of Choice form is signed and dated by the participant or representative. The participant's signature on the service plan, as entered by the participant or representative, documents that the participant (or representative) has made an informed decision to receive HCBS rather than services in an institutional setting, and that HCBS are based on the participant's assessment of needs. Freedom of Choice documentation is tracked through the group testing process, all staff performance evaluations and quality reviews.

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

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

Appendix B: Participant Access and Eligibility

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

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

All Department of Human Services (DHS) forms are available in English and Spanish. The forms can be translated into other languages when the need arises. DHS maintains an ongoing contract with a Spanish interpreter and translator agency for translation services. All accommodations are provided on an individualized basis according to the participant's needs. DHS has a contract with an interpreter to accommodate applicant/participants who are hearing impaired. DAAS RNs provide written materials to participants and will read any information to participants if needed. DAAS RNs may utilize assistance from other divisions within the Arkansas Department of Human Services, such as the Division of Services for the Blind, in these instances. When this occurs, it is documented in the participant record.

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

- ☐ The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ☒ Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- ☐ Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- ☒ No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- ☐ Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- ☒ No. The State does not employ Organized Health Care Delivery System (OHCDs) arrangements under the provisions of 42 CFR §447.10.
- ☐ Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDs and how these entities qualify for designation as an OHCDs; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDs; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDs arrangement is employed, including the selection of providers not affiliated with the OHCDs; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ☒ The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- ☐ The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ☐ This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- ☒ Appropriation of State Tax Revenues to the State Medicaid agency
- ☐ Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- ☐ Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

☐ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

☐ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

☐ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

☒ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Room and board costs are separate and excluded from payments for services provided by assisted living facilities. The waiver recipient is responsible for paying room and board costs directly to the facility from their own income. To ensure that room and board is affordable for persons on the Living Choices waiver and within the participant's income, the room and board amount is deducted from the participant's income, just as the personal needs allowance amount is deducted. To cover room and board, 90.8% of the Individual SSI Federal Benefit Rate (FBR), rounded to the nearest dollar, can be set aside from the waiver recipient's income. Nine percent of the Individual SSI FBR rounded to the nearest dollar is deducted for personal needs allowance.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ☒ No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- ☐ Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ☒ No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- ☐ Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ Nominal deductible
- ☐ Coinsurance
- ☐ Co-Payment
- ☐ Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

☒ No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

☐ Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	20363.79	2249.00	22612.79	40826.00	2249.00	43075.00	20462.21
2	20373.49	2316.00	22689.49	42046.00	2316.00	44362.00	21672.51
3	20383.47	2385.00	22768.47	43303.00	2385.00	45688.00	22919.53
4	20393.75	2457.00	22850.75	44598.00	2457.00	47055.00	24204.25
5	20404.35	2530.00	22934.35	45931.00	2530.00	48461.00	25526.65

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care: Nursing Facility
Year 1	1300	1300
Year 2	1300	1300
Year 3	1300	1300
Year 4	1300	1300
Year 5	1300	1300

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay on the waiver is estimated to be 255 days. This average was calculated as days of eligibility from the MMIS segments, using the Medicaid DSS (BusinessObjects). These numbers were determined by reporting the total days of waiver service (based on service eligibility days within the waiver year) for all participants and dividing by the unduplicated count of participants.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D is derived from current reporting of expenditures from the Medicaid DSS (BusinessObjects) and consideration of previous waiver estimates of utilization and growth rates.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was computed based on what was done in prior years. Using the market basket forecasts and the related DDS report of all waiver eligible recipients annual expenditures were extracted from the decision support system (DSS) component of the MMIS. Note: Costs indicated for State Category of Service AL (Assisted Living Facility), and AX (Extension of 3 prescriptions for Assisted Living) that are shown in the DSS Report on the average annual expenditures for nursing home recipients were backed out for the ALF waiver recipients.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is computed based on the average annual expenditures for nursing home recipients that were extracted from the decision support system (DSS) component of the MMIS. Using the average annual expenditures for nursing home recipients and the market basket forecasts for the next 5 years. Factor G was computed for each of the 5 years of the waiver.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was derived using the same methodology as in prior years. It was computed based on the average annual expenditures for nursing home recipients that were extracted from the decision support system (DSS) component of the MMIS. Using the average annual expenditures for nursing home recipients. Note: Costs indicated for State Category of Service 58 (Private SNF), 59 (Private SNG Crossover), 62 (Public ICF Mentally Retarded), and 63 (Public SNF) that are shown in the DSS Report on the average annual expenditures for nursing home recipients were backed out for the ALF waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Extended Medicaid State Plan Prescription Drugs	
Living Choices Assisted Living Services	

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (5 of 9)****d. Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						420046.11
Extended Medicaid State Plan Prescription Drugs	1 Month	163	9.00	286.33	420046.11	
Living Choices Assisted Living Services Total:						26052883.35
Tier Level 2	1 Day	455	255.00	75.48	8757567.00	
Tier Level 3	1 Day	481	255.00	81.89	10044217.95	
Tier Level 4	1 Day	182	255.00	85.35	3961093.50	
Tier Level 1	1 Day	182	255.00	70.89	3290004.90	
GRAND TOTAL:						26472929.46
Total Estimated Unduplicated Participants:						1300
Factor D (Divide total by number of participants):						20363.79
Average Length of Stay on the Waiver:						255

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (6 of 9)****d. Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
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Extended Medicaid State Plan Prescription Drugs Total:						432647.64
Extended Medicaid State Plan Prescription Drugs	1 Month	163	9.00	294.92	432647.64	
Living Choices Assisted Living Services Total:						26052883.35
Tier Level 2	1 Day	455	255.00	75.48	8757567.00	
Tier Level 3	1 Day	481	255.00	81.89	10044217.95	
Tier Level 4	1 Day	182	255.00	85.35	3961093.50	
Tier Level 1	1 Day	182	255.00	70.89	3290004.90	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						26485530.99 1300 20373.49 255

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

I. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						445630.59
Extended Medicaid State Plan Prescription Drugs	1 Month	163	9.00	303.77	445630.59	
Living Choices Assisted Living Services Total:						26052883.35
Tier Level 2	1 Day	455	255.00	75.48	8757567.00	
Tier Level 3	1 Day	481	255.00	81.89	10044217.95	
Tier Level 4	1 Day	182	255.00	85.35	3961093.50	
Tier Level 1	1 Day	182	255.00	70.89	3290004.90	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						26498513.94 1300 20383.47 255

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						458994.96
Extended Medicaid State Plan Prescription Drugs	1 Month	163	9.00	312.88	458994.96	
Living Choices Assisted Living Services Total:						26052883.35
Tier Level 2	1 Day	455	255.00	75.48	8757567.00	
Tier Level 3	1 Day	481	255.00	81.89	10044217.95	
Tier Level 4	1 Day	182	255.00	85.35	3961093.50	
Tier Level 1	1 Day	182	255.00	70.89	3290004.90	
GRAND TOTAL:						26511878.31
Total Estimated Unduplicated Participants:						1300
Factor D (Divide total by number of participants):						20393.75
Average Length of Stay on the Waiver:						255

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (9 of 9)****d. Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Medicaid State Plan Prescription Drugs Total:						472770.09
Extended Medicaid State Plan Prescription Drugs	1 Month	163	9.00	322.27	472770.09	
Living Choices Assisted Living Services Total:						26052883.35
Tier Level 2	1 Day	455	255.00	75.48	8757567.00	
Tier Level 3	1 Day	481	255.00	81.89	10044217.95	
Tier Level 4	1 Day	182	255.00	85.35	3961093.50	

Application for 1915(c) HCBS Waiver: Draft AR.016.03.00 - Feb 01, 2016

Tier Level 1	1 Day	182	255.00	70.89	3290004.90
GRAND TOTAL:					26525653.44
Total Estimated Unduplicated Participants:					1300
Factor D (Divide total by number of participants):					20404.35
Average Length of Stay on the Waiver:					255